CHAPTER 6

Multidimensional Family Therapy: A Science-Based Treatment for Adolescent Drug Abuse

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Substance use and abuse during adolescence is strongly associated with other problem behaviors such as delinquency, precocious sexual behavior, deviant attitudes, or school dropout . . . Any focus on drug use or abuse to the exclusion of such correlates, whether antecedent, contemporaneous, or consequent, distorts the phenomenon by focusing on only one aspect or component of a general pattern or syndrome (Newcomb & Bentler, 1989).

BACKGROUND AND OVERVIEW

Multidimensional Family Therapy (MDFT) is an outpatient, family-based approach to the treatment of adolescent substance abuse and associated mental health and behavioral problems. MDFT integrates the clinical and theoretical traditions of developmental psychology and psychopathology, the ecological perspective, and family therapy. A manualized intervention (Liddle, 2002b), MDFT uses research-derived knowledge about risk and protective factors for adolescent drug and related problems as the basis for assessment and intervention in four domains: (1) the adolescent, as an individual and as a member of a family and peer group; (2) the parent, both as an individual adult and in his or her role as mother or father; (3) the family environment and the family relationships, as evidenced by family transactional patterns; (4) extrafamilial sources of positive and negative influence. Independent reviews identify and recommend MDFT as an exemplary (Brannigan, Schackman, Falco, & Millman, 2004; Drug Strategies, 2003; Office of Juvenile Justice and Delinquency Prevention [OJJDP], 1999), best practice (DHHS, 2002), model program (Substance Abuse and Mental Health Administration [SAMHSA], 2004), and scientifically proven and effective treatment (National Institute on Drug Abuse [NIDA], 2001) for teen drug abuse. Internationally, in Rigter and colleague's (Rigter, Van Gageldonk, & Ketelaars, 2005) volume assessing the state of

the science of evidence-based practice, MDFT received the highest rating of available research-based adolescent drug abuse interventions for its number and quality of controlled-outcome studies and investigations of the therapeutic process.

MDFT has been conceived, developed, and tested as a *treatment system* rather than a one-size-fits-all approach. A treatment system designs different versions of the clinical model depending on the characteristics of the adolescent clinical population (older versus younger adolescents, juvenile justice involved versus no involvement in juvenile justice systems), and treatment parameters, such as type of clinical setting and treatment dose. Our overall strategy of treatment development (Kazdin, 1994) seeks to create a clinically and cost-effective approach for teen substance abuse that can be used in a range of non-research clinical settings.

ADOLESCENT SUBSTANCE ABUSE: HOW CHARACTERISTICS OF THE CLINICAL PROBLEM SUGGEST THE NEEDED CLINICAL PARAMETERS AND INTERVENTIONS

Considerable scientific progress has been made in our knowledge about the causes and correlates of adolescent drug problems. We know a great deal about the ingredients, sequence, and interactions that predict initial and increased drug involvement, and the clinical utility of this still-expanding knowledge base has become increasingly apparent (Liddle, Rowe, Diamond, Sessa, Schmidt, & Ettinger, 2000). Adolescent substance abuse progresses along various, sometimes intersecting developmental pathways, hence its designation as a multidimensional and multidetermined phenomenon requiring interventions that address several domains of functioning (Hawkins, Catalano, & Miller, 1992). The accumulation of empirically based knowledge yields a new conceptualization of adolescent substance abuse—one that is more complex than previous historical periods. Drug problems are now understood through the filter of one or several theoretical lenses. Social-cognitive factors; psychological functioning; personality and temperament; values and beliefs; family factors; peer relationships; environmental influences, such as school and neighborhood/community; and sociocultural factors, such as norms and media influences, all have empirical links to the development and maintenance of teen drug abuse. On the basis of longitudinal and cross-sectional findings that have illuminated how drug problems develop and exacerbate over time, the treatment landscape for adolescent drug problems has been transformed, and family-based treatments have become the most researched intervention for teen drug misuse (Liddle, 2004).

MDFT focuses on understanding the risk and protective forces at multiple system levels and in different domains of functioning. Thus, intrapersonal factors (e.g., identity, self-competence), interpersonal factors (family and peer relationships), and contextual and environmental factors (school support and community influences) are all included in case conceptualization, treatment planning, and implementation. Drug abuse is seen as a deleterious deviation from healthy, adaptive development, and MDFT's therapeutic sensibility and its therapeutic interventions aim to place the adolescent on a more functional developmental trajectory.

OPERATING PRINCIPLES OF MDFT

Ten principles provide a framework for what a MDFT therapist should do (i.e., prescribed behaviors), and they also imply what she or he is not supposed to do (i.e., proscribed behaviors).

1. *Adolescent drug abuse is a multidimensional phenomenon.* MDFT clinical work is guided by an ecological and developmental perspective and corresponding research. Adolescent drug abuse problems are defined intrapersonally, interpersonally, and in terms of the interaction of multiple systems and levels of influence.

2. *Problem situations provide information and opportunity.* Current symptoms of the adolescent or other family members, as well as crises pertaining to the adolescent, provide critical assessment information and important intervention opportunities.

3. *Change is multidetermined and multifaceted.* Change emerges out of the synergistic effects of interaction among different systems and levels of systems, different people, domains of functioning, time periods, and intrapersonal and interpersonal processes. Assessment and interventions themselves give indications about the timing, routes, or kinds of change that are accessible and potentially efficacious with a particular case. A multivariate conception of change commits the clinician to a coordinated and sequential working of multiple change pathways and methods.

4. *Motivation is malleable.* We do not assume that motivation to enter treatment or to change will be present with adolescents or their parents. Treatment receptivity and motivation vary across individual family members and extrafamilial others. We understand resistance as normative. Resistant behaviors are communications about the barriers to successful treatment implementation, and they point to important processes requiring therapeutic focus.

5. *Working relationships are critical.* The therapist makes treatment possible through supportive but outcome-focused working relationships with family members and extrafamilial supports, and the facilitation and working through of personally meaningful relationship and life themes. These therapeutic themes emerge from discussions about generic individual and family developmental tasks and the case-specific aspects of the adolescent's and family's development.

6. *Interventions are individualized.* Although they have generic aspects (e.g., promoting competence of adolescent or parent inside and outside of the family), interventions are customized according to each family, family member, and the family's environmental circumstances. Interventions target known etiologic risk factors related to drug abuse and problem behaviors, and they promote protective intrapersonal and interpersonal processes.

7. *Planning and flexibility are two sides of the same therapeutic coin.* Case formulations are socially constructed blueprints that guide the therapist throughout the therapeutic process. These formulations are revised on the basis of new information, in-treatment experiences, and feedback. In collaboration with family members and relevant extrafamilial others, therapists continually evaluate the results of all interventions. Using this feedback process, a therapist alters the intervention plan and modifies particular interventions, or more general strategy, accordingly.

8. *Treatment and its multiple components are phasic.* MDFT is based on epigenetic principles specifying a sequential pattern of change. Thus, theme development, intervention plans and implementation, and the overall therapy process are organized and executed in stages. Progress in one area (therapeutic alliance, for instance), lays the foundation for the next step—formulation of content themes learned about early on. Then content themes become more focused, therapeutically oriented, and these focuses serve as a basis for change strategy and change attempts, all of which are followed by the therapist, who consistently adjusts treatment strategy and interventions per the frequent, sometimes daily, feedback about intervention outcomes.

9. *Therapist responsibility is emphasized.* Therapists accept responsibility for promoting participation and enhancing motivation of all involved individuals; creating a workable agenda and clinical focus; devising multidimensional and multisystemic alternatives; providing thematic focus and consistency throughout treatment; prompting behavior change; evaluating the ongoing success of interventions; and revising the interventions as needed according to the feedback from the interventions.

10. *Therapist attitude and behavior are fundamental to success.* Therapists advocate for both the adolescent *and* the parent. They are careful not to take extreme positions as either child savers or proponents of the "tough love" philosophy. Therapists are optimistic but not naive about change. They understand that their own ability to remain positive, committed, creative, and energetic in the face of challenges is instrumental in achieving success with adolescents and their families.

METHODS OF ASSESSMENT AND INTERVENTION IN MULTIDIMENSIONAL FAMILY THERAPY

Multidimensional Assessment

Assessment in MDFT creates a therapeutic blueprint. This blueprint directs therapists as to where to intervene in the multiple domains of the teen's life. A comprehensive, multidimensional assessment process involves identifying risk and protective factors in all relevant domains and then targeting these identified dimensions for change. The therapist seeks to answer critical questions that supply information about functioning in each MDFT target area, through a series of individual and family interviews and observations of both spontaneous and directed family interactions. The MDFT target areas of the approach are called *modules* and consist of the following: (1) adolescent, (2) parent, (3) family interaction, and (4) extrafamilial social systems. In their investigation of the MDFT target areas, the therapists ask questions based on research-derived knowledge about adolescent substance abusers and their life contexts. We attend to both the deficits and the areas of strength, so as to obtain a complete clinical picture of the unique combination of assets and weaknesses that the adolescent, family, and ecosystem bring to therapy. With a complete picture of the adolescent and family, which includes an understanding of how the current problems are understandable, given the adolescent's developmental history and current risk and protection profile, interventions aim to decrease risk and processes known to be related to dysfunction de-

velopment or progression, and enhance protection, first within what the therapist finds to be the most accessible and malleable domains (i.e., essentially, a "get the ball rolling" philosophy). Assessment is an ongoing process throughout therapy. Assessment findings are grist for the mill of treatment planning, recalibration, and intervention execution and redirection.

Assessment of the Family

The assessment process typically begins with a meeting that includes the entire family, allowing the therapist to observe family interaction and to begin to identify the contribution that different individuals make to the adolescent's life and current circumstances. Assessment of family interaction is accomplished using both direct therapist inquiries and observations of enactments during family sessions, as well as individual interviews with family members. The therapist meets individually with the adolescent, the parent(s), and other members of the family within the first session or two. Individual meetings clarify the unique perspective of each family member, their different views of the current problems, and how things have gone wrong (e.g., family relationships), and what they would like to see change with the youth and in the family.

Assessment of the Adolescent

Therapists elicit the adolescent's life story, an important assessment and intervention strategy, during early individual sessions. Sharing their life experiences contributes to the teen's engagement in therapy. It provides a detailed picture of the severity and nature of his or her drug abuse, family history, peer relationships, school and legal problems, and important life events. The therapist may utilize techniques such as asking the adolescent to draw a map of his or her neighborhood, indicating where he or she goes to buy and use drugs, where friends live, the location of school, and, in general, where the action is in his or her environment. Therapists inquire about the adolescent's health and lifestyle issues, including sexual behavior. The presence and severity of comorbid mental health problems is determined through the review of previous records and reports, the clinical interview process, and psychiatric evaluations.

Assessment of the Parent(s)

Assessment with the parent(s) focuses on their functioning both as parents and as individual adults, with their own unique history and current interests, goals, and concerns. We assess the parents' strengths and weaknesses in terms of parenting skills and general parenting style, as well as parenting beliefs and emotional connection to their child. In assessing parenting knowledge and competencies, the therapist asks parents about their parenting practices and observes their limit-setting, supportive expressions and communication skills in their ways of relating with the adolescent. In discussing parenting style and beliefs, the therapist asks parents about their own experiences, including their family life when they were growing up. Considerable attention must be paid to the parent's level of commitment and emotional investment to the adolescent. How do they handle their parenting responsibilities? If parental abdication exists, therapists work diligently to

elicit and rekindle even a modest degree of hope about helping their teen get back on track. What is the parent's capacity to understand what needs to change in their family and their child—are they responsive to having a role in facilitating the needed changes? A parent's mental health problems and substance abuse are also evaluated as potential obstacles to parenting and, when indicated, referrals for individual treatment of drug or alcohol abuse or serious mental health problems are also appropriate in MDFT.

Assessment of Relevant Social Systems

Finally, assessment of extrafamilial influences involves gathering information from all relevant sources and combining this information with the adolescent's and family's reports in order to compile a complete picture of each individual's functioning in relation to external systems. The adolescent's educational/vocational placement is assessed thoroughly. Alternatives are generated in order to create workable alternatives to drug use and to build bridges to a productive lifestyle. Therapists build relationships with, and work closely and collaboratively with, the juvenile court and probation officers in relation to the youth's legal charges and probation requirements. They focus the parents on the potential harm of continued negative or deepening legal outcomes, and using a nonpunitive and nonantagonizing tone, they strive to help teens adopt a reality mode about their legal situation. Assessment of peer networks involves encouraging the adolescent to talk about peers, school, and neighborhood contexts in an honest and detailed manner, and this is used to craft areas of work in treatment.

Multidimensional Interventions: Facilitating Adolescent, Parent, and Family Development

A multidimensional perspective suggests that symptom reduction and enhancement of prosocial and appropriate developmental functions occur by facilitating adaptive, risk-combating processes in important functional domains. We target behaviors, emotions, and thinking patterns implicated in substance use and abuse, as well as the complementary aspects of behaviors, emotions, and thought patterns associated with development-enhancing intrapersonal and familial functioning (Hawkins et al., 1992). Intervention targets are connected with our assessment methods. They have intrapersonal (i.e., feeling and thinking processes) and interpersonal and contextual (i.e., transactional patterns between family members or between family member and extrafamilial persons) aspects. Strategy and a logic model of what change is and how it occurs are important in multisystems clinical work. Change targets are prioritized, so that the focus for change begins in certain areas first, which are used as departure points for the next, usually more difficult, working areas for change. All roads lead to changing drug use and abuse and related problem areas. When development-enhancing interventions are effective, they create outcomes that are incompatible with previous drug using behaviors and ways of moving through life. New developmental tasks and pathways are created; they crowd out the drug-using lifestyle and replace it with a new, more adaptive way of growing up. With each case, we assess and intervene in four interdependent and mutually influencing subsystems.

Interventions with the Adolescent

Establishing a therapeutic alliance with the teenager, distinct from identical efforts with the parent, builds a critical foundation of treatment (Diamond, Liddle, Hogue, & Dakof, 1999). Sequentially applied alliance-building techniques, called Adolescent Engagement Interventions (AEI) present therapy as a collaborative process, define therapeutic goals that are meaningful to the adolescent, generate hope, and attend to the adolescent's experience and evaluation of his or her life.

The initial stage discovers and articulates treatment's focal themes. Family and peer relationships, school and the juvenile justice system, coping strategies, and identity and adaptive self expression are key areas of work (Liddle, Dakof, & Diamond, 1991). An elaboration of the youth's view of his or her friendships and social networks is also important. We help teenagers learn how to (1) communicate effectively with parents and others, (2) effectively solve interpersonal problems, (3) manage their anger and impulses, (4) enhance social competence, and (5) critically address the role of and use of drugs in their lives. Considerable work is done in individual sessions with parents and teens to prepare them to come together to talk about important issues. Individual sessions with the teen are used to assess his or her peer network and friendship patterns and to develop alternatives to impulsive and destructive coping behaviors, such as alcohol and or drug use. Core work with the adolescent involves conducting a detailed drug use history. Interventions focus on attitudes and beliefs about drugs, helping the adolescent link his or her drug use to distress or areas of dissatisfaction, learning how to deal with drug use and deviance / antisocial triggers, changing friendship networks, and developing new ways of enjoying oneself outside of a drug-using lifestyle.

Interventions with the Parent

MDFT focuses on reaching the parent as both an adult with her or his own needs and issues, and as a parent who may have lost motivation or faith in her or his ability to influence the adolescent. Parental Reconnection Interventions (Liddle, Rowe, Dakof, & Lyke, 1998) include such things as enhancing feelings of parental love and emotional connection, validating parents' past efforts, acknowledging difficult past and present circumstances, and generating hope. They are used to increase the parents' emotional and behavioral investment in their adolescent. Taking the first step toward change with the parent, these interventions facilitate the parents' motivation and, gradually, their willingness to address relationship issues and parenting strategies. Increasing parental involvement with the adolescent (e.g., showing an interest, initiating conversations, creating a new interpersonal environment in day-to-day transactions), creates a new foundation for behavioral and attitudinal change in parenting strategy. In this area of work, parenting competency is fostered by teaching and coaching about normative characteristics of parent-adolescent relationships, consistent and age-appropriate limit setting, monitoring, and emotional support—all important and research-established parental functions.

Interventions to Change the Parent-Adolescent Interaction

Family therapy originally articulated a theory and technology about changing particular dysfunctional family transactional patterns that connect to the development

of problem behaviors. Following in this tradition, MDFT interventions also change development-retarding transactions. Direct changes in the parent-adolescent relationship are usually made through the structural family therapy technique of enactment (Minuchin, 1974). Enactment is both a clinical method and a set of ideas about how change occurs (Liddle, 1999). Typically, enactment involves elicitation, in a family session, of topics or themes that are important in the everyday life of the family, and preparing family members to discuss and try to solve problems in new ways. The method actively guides, coaches, and shapes increasingly positive and constructive family interactions. In order for discussions between parent and adolescent to involve problem solving and relationship healing, parents and adolescents must be able to communicate without excessive blame, defensiveness, or recrimination (Diamond & Liddle, 1996). We help teens and parents to avoid or to exit extreme, inflexible stances that create poor problem solving, hurt feelings, and erode motivation and hope for change. Skilled therapists direct and focus in-session conversations on important topics in a patient, sensitive way (Diamond & Liddle, 1999).

Although individual and interaction work with the adolescent and parent(s) is central to MDFT, other family members can also be important in directly or indirectly enabling the adolescent's drug-taking behaviors. Thus, siblings, adult friends of parents, or extended family members must be included in assessment and interventions. These individuals are invited to be a part of the family sessions, and sessions are held with them alone per MDFT session composition guidelines. Cooperation is achieved by highlighting the serious, often life-threatening circumstances of the youth's life, and establishing an overt, discussable connection (i.e., a logic model of sorts) between his or her involvement in treatment and the creation of behavioral and relational alternatives for the adolescent. This follows the general procedure used with the parents—the attempt to facilitate caring through several means, first through a focusing and detailing of the difficult and sometimes dire circumstances of the youth and the need for his or her family to help.

Interventions with Social Systems External to the Family

MDFT also facilitates changes in the ways that the family and adolescent interact with systems outside the family. Substance-abusing youth and their families are involved in multiple social systems, and their success or failure in negotiating these systems has considerable impact on their lives. Close collaboration with the school, legal, employment, mental health and health systems influencing the teen's life is critical for initial and durable change. For an overwhelmed parent, help in dealing with complex bureaucracies or in obtaining needed adjunctive services not only increases engagement, but also improves his or her ability to parent effectively by reducing stress and burden.

SPECIFIC INTERVENTION STRATEGIES FOR TREATING ADOLESCENT SUBSTANCE ABUSE WITHIN THE MDFT FRAMEWORK

This section outlines the core interventions of MDFT according to each of the three stages of treatment and each of the four target domains—adolescent, parent, parent-adolescent transactional patterns, and extrafamilial.

MDFT INTERVENTIONS

Stage 1

Adolescent Module: Build the foundation (Engagement)

1. Motivate the adolescent to engage in treatment. "There is something in this for you" is the phrase we use to capture one of therapy's first tasks. Specify how the therapist and the therapy can address some of the adolescent's specific and practical concerns. Therapists are careful not to make false promises, but, at the same time, they communicate that they are an ally and advocate for the teen. It is important to help the teen discuss the changes he or she might like to see in his or her family, and of course in his or her life generally.

2. Encourage a collaborative process. For example, "We are going to work together to formulate goals," or, "What we do here is . . ."

3. Communicate a genuine interest in knowing about the youth as an individual. The therapist endeavors to get to know them and their world. This includes personal interests, likes and dislikes (e.g., music or sports), or anything that is important to the adolescent. The tone is positive and encouraging, nonauthoritarian and nonjudgmental. Early on, no attempts are made to change the youth. It is critical to get to know the youth in a personal way, and to express a liking, respect, and interest in the teen and what he or she has to say.

4. Get the day-to-day details of the adolescent's life. How does the teen spend his or her time? What about peer relationships, girlfriends, boyfriends, parents, siblings, clubbing, and hanging out after school and on weekends? Thoughts and feelings about his or her relationships inside and outside of the family are vital to elicit. The clinician must obtain a vivid portrayal of the sights and sounds of the teen's world. Visits to the youth's school, in-home sessions, and meeting the teen in a neighborhood locale such as a restaurant are among the best ways to obtain this rich understanding of an adolescent's world.

5. Encourage youths to voice their concerns and their complaints about anything and everything.

6. Encourage the expression of hopes, dreams, competencies, and strengths. Therapists highlight these expressions and enlarge upon them. Understanding adolescent development is indispensable to effective therapy. This knowledge base guides a therapist's exploration of core topics such as how does the teen define him- or herself now, and who do they want to be or to become.

7. Comorbidity or co-occurring problems are the norm in clinical samples of adolescents. Depression and anxiety, including sequelae from past trauma, are common in substance-abusing teens. Therefore, therapists must be knowledgeable about these complex symptom presentations, and possess skill in a variety of interventions to address these linked but distinct problems. Referral to psychiatrists for psychiatric evaluations and medications, when necessary, is part of the MDFT protocol.

Parent and Parenting Module: Build the Foundation (Engagement)

1. Change in each module proceeds in steps. The first step with the parents is the assessment of current and past stress and burden (e.g., "I know it is difficult

for you to deal with your son, considering what he's been into. You have been through a lot.") Therapists routinely highlight how well parents have done given difficult circumstances.

2. Encourage parents to detail all previous efforts to address the problems with the adolescent, including treatment failures and success, their own parenting efforts, and other family members' attempts. This discussion should be multifaceted—it seeks facts, perceptions, emotional reactions, and recounting of behavior change attempts relative to what the parent and the family have been through. Competencies and strengths are important to draw out and use as a support-providing antidote to stress and pessimism, and as a behavioral platform for new change attempts.

3. Enhance and strengthen feelings of love and commitment. We use various means to resuscitate a strong emotional connection between parent and adolescent. Generally, a number of negative events have transpired that leave all family members pessimistic about change. Parents feeling defeated, inept, embarrassed, perplexed, and certainly distant—not in a mood to try to reach out to their teen, in addition to adolescent arrests, intoxication, drug- or alcohol-influenced fights or accidents—can create a deep mood of despair. In these clinical situations, emotional distance in family relationships is common. At first we use methods that are more emotionally than cognitively or behaviorally based to close this relationship gap and increase a parent's motivation to try again. We may ask parents to reflect on and talk about successful and pleasurable experiences with their child: When were things better in the family? When did your child seem more influenced by what you said to him or her? We may invoke emotions and memories from many years ago, asking a parent about the hopes and dreams they had at one time for their child. Sharing and discussing family photos at various points in their history is one way to facilitate travel on an emotional and therapeutic pathway with a parent. This is a journey that has the intention of softening some of their currently hardened perceptions and feelings about their son or daughter. Facilitating a remembrance of a time of love and parental commitment and connection, even though it might be at a very different life stage for the parent or teen, is a relationship and commitment resuscitation project. It is a powerful way to influence a parent to take that all-important step toward committing to trying new ways of relating to and parenting their adolescent.

4. Discuss the parent's childhood, the parenting they received, and the family life they experienced. These topics are not covered in order to begin in-depth psychotherapy about a parent's past. Rather, covering this background gives a therapist clues about what is in a parent's heart and mind about her- or himself at present—their conceptions about their role and an indication of how their current feelings and behavior could be understood. As with all areas of exploration, there are strengths that will be revealed. Focus and build on them.

5. Communicate to parents that this program is for them too. Just as the therapist communicates advocacy to the teen (about school and juvenile justice problems, for example), the same kind of advocacy message is given to the parents. The stress and burden of the parent is a therapeutic target in and of itself, a means by which we motivate the parent to try anew in the parenting realm, as well as a

prognostic sign about how changes in the parenting realm are going (i.e., continued stress and feelings of burden = problems in the progress to change parenting practices).

6. Motivational work with the parents is as important as motivational work with the teen. Parents are told that "You are a powerful medicine," to help their son or daughter improve and redirect his or her life. Parents of clinically referred teens come to therapy as disbelievers about the possibilities of parental influence with adolescents. Focusing on the process of becoming influential in the life of one's adolescent takes time, it improves gradually, and as is the case in any classic mutual feedback system, it involves the teen's reciprocation and positive response to the parent's increased receptivity and attempts to relate differently. When an adolescent is helped to listen more calmly and respectfully to what a parent has to say, those actions on the teen's part (which themselves are part of the cycle of change) encourage the parent to produce more effective and heartfelt communication and sharing (versus lecturing, for example).

7. Motivational tactics. With parents, one of our standard ways of motivating them to try again with their teen is to engage in the "no regrets" conversation. Here we discuss with parents how it would be unfortunate, after all they have been through, to look back at some point and conclude that they did not do everything they absolutely could to help straighten out the life course of their son or daughter. The intention is to raise questions, gently, in the parents' mind about how much they have done and how much they still might do to reach out to and participate in the comprehensive efforts to change the course of their child's development.

Parent Relationship/Family Interaction Module: Build the Foundation (Engagement)

1. Welcome youth and family to the program. It is important to explain the MDFT treatment program and orient them to what is required in the treatment, the format and nature of the meetings, confidentiality issues, and how contacts with school and court are part of what will help create a better situation for their child.

2. Develop a temporal orientation. Orienting the treatment around the time parameters of the treatment program helps the family and therapist organize their efforts according to limits—limits within which help is available. Time limits of therapy are used as additional definers of treatment opportunity and as motivators to take advantage of the possibilities to attend to the adolescent's difficulties.

3. Assess family interactions. What happened in the past? What went wrong up to now? Is there conflict? How do they problem-solve? How do they talk to each other? Is it superficial, or do they talk about important issues? Who talks to whom? How often do they talk to each other? How and how often do they communicate warmth and love?

4. Assess family history and family story. The therapist is looking for themes of strength as well as past problems, including significant family and relationship events such as neglect or abuse. These topics need to be addressed and worked on in Stage 2.

5. Even in the first stage, the therapist works to improve how the family talks and responds to each other. More complex topics and problem-solving happens

in Stage 2, but in the beginning of treatment, family sessions focus on eliciting the family and individual history, defining the content themes to be worked on, establishing which topics are most urgent to address, and shaping family interactions in straightforward and non-stress-inducing ways.

6. Extensive focus is given to the affective component of the parent-adolescent relationship. A therapist's intention is to help the relationship progress so that it more frequently embodies ingredients such as empathy, compassion, commitment, connectedness, and love.

Extrafamilial Module

The therapist will deal with the most accessible areas first, which helps to engage the family. Although some extrafamilial interventions are more specific to some stages, (e.g., needs assessment and establishing a working relationship with outside agencies are more often used in Stage 1), extrafamilial work is done throughout the three stages.

1. *School.* In the school realm, the therapist begins by obtaining the adolescent's records to identify his or her needs (e.g., are they in the appropriate placement?). A school meeting is immediately scheduled to introduce the MDFT program and establish a collaborative relationship with teachers, counselors, and other school officials. The therapist facilitates placement in the best possible school/educational situation and monitors it closely to make adjustments as necessary. Parents are taught how to assess school problems and interact with various systems to obtain the best services for their child. At the end of treatment, the youth should be stable in the most appropriate educational system.

2. *Court.* In collaborating with the juvenile justice system, as in working with the school, the therapist begins by obtaining the youth's records. The therapist's primary goal is to advocate for the adolescent. This is accomplished by attending court appearances and by establishing a good working relationship with the probation officer and other court officials. This is important given that these individuals are influential over the disposition of a case (i.e., recommending for or against placement). Once again, the parents are involved and are taught how to advocate for their child within this system.

3. *Recreational Services for Youth.* The therapist helps the adolescent become involved with prosocial, recreational activities, such as sports, art, music, or community service.

4. *Social Services/Support for Family.* The therapist begins by assessing needs in the areas of financial assistance (e.g., Department of Children and Families), immigration, housing, food, health care, mental health care (e.g., psychiatric or more-intensive services for any family member), disability, and social support for the family. With the assessment complete, the therapist helps and guides the family in obtaining any necessary services.

Stage 2 and 3: Work the Themes/Request Change

Stage 1 interventions are carried through and administered as necessary in Stages 2 and 3.

Adolescent Module

1. Prepare the adolescent to talk about him- or herself with the parents. Employing significant planning, the therapist organizes sessions to have adolescents tell parents about their everyday world, how they think about and make sense of what is happening with them, and, over time, what they think is needed to improve their situation relative to their drug use and in other domains of their lives.

2. Facilitate self-examination. Help teens examine the positives and negatives about their drug use, drug selling, high-risk sexual behaviors, and other aspects of their everyday life that are problematic. If the adolescent is still using drugs and engaging in delinquent behaviors, help him or her talk about the positive aspects of that involvement (e.g., pleasure, esteem, money), as well as the negatives (e.g., being arrested, beaten up or injured in fights, failing in school, being fired, disappointing or causing shame to parents). If the adolescent is drug-free, this is a chance to allow him or her to talk about how he or she misses the drugs or the lifestyle, money, and so forth.

3. Examine barriers to and ambivalence about change. Sometimes a teen may say that he or she has considered any number of self-changes and has even made self-change attempts. Any inclinations about change and previous unsuccessful attempts to change should be explored in detail, as should the perceived impediments to stopping drug use, doing better in school, getting along better with parents, and so on.

4. Help the adolescent to articulate hopes and dreams for the immediate and the long term. Among other things, therapy is about the creation of concrete, short-term alternatives to the adolescent's current life. When these alternatives are achieved (e.g., being released from juvenile detention or probation, improving in and staying in school, succeeding in a job, having better relationships at home and with friends), they can have long-term implications. Discussions about the adolescent's life course, identity and self issues, plans, hopes, and dreams for his or her own future (e.g., who I have been, who I am now, and who I want to be) are all core aspects of the therapeutic focus with the teen.

5. Become more behavioral and solution-focused over time. Discuss with the adolescent how he or she is going to get to where he or she wants to be. Help him or her to imagine alternatives, new aspects of life; make a plan and take steps to realize the plan, a little bit at a time.

6. Help youth form a new and more effective way of communicating with parents, teachers, and other adults.

7. Directly address drug abuse and other problems (e.g., delinquency, high-risk sex, school failure). Help the adolescent deal with the truth, as best he or she knows it, and about his or her behaviors and thoughts about it. Help him or her explore the risks, consequences, and health implications of drug abuse and other difficulties (e.g., "Your actions hurt others, hurt people you care about" or, "What was going on with you when you did that?").

8. If the teen is depressed and is on medications, work with the psychiatrist. Regardless of medication, launch the depression module.

    a. Educate the parent and teen about depression.

    b. Have youth keep a daily activity log. Use it in therapy sessions.

    c. Have youth keep an automatic thought log. Use it in therapy sessions.

    d. Regular consultation with the psychiatrist if youth is on medications.

9. Refer the teen to sex education and HIV prevention programs to address his or her high-risk behavior. Discuss his or her experience in therapy sessions.

10. Use the drug screen in treatment. Use both positive and negative results in the session. Allow him or her to talk about all the details regarding his or her relapse or abstinence.

11. Improve functioning in areas that get him or her in trouble: anger management, impulse control, negative thoughts, self-esteem, and hopelessness. (If the adolescent needs extra assistance with anger management and impulse control, refer him or her to anger management classes. If referred to anger management class, discuss the experience in therapy.)

12. Overall: Help the adolescents see that, as long as their current situation and problems continue, they will have difficulty achieving the things they say they want. Once this dysynchrony is developed, the therapist helps the teens—with the family's help, and in the context of the new alignments and circumstances produced via extrafamilial interventions, to create new experiences and concrete options (pathways) away from an antisocial and drug-using lifestyle and toward more positive, adaptive, and non-self-harming alternatives.

Parent and Parenting Module

1. Emphasize self-care. (e.g., "You need to take care of yourself.") The therapist develops a link between doing all that is possible for one's child, achieving positive parenting outcomes, and taking care of oneself as an individual apart from one's function as a parent. Focusing on a parent's needs is important in and of itself, and it is a foundation upon which parenting practices are more effectively examined and changed.

2. Help parents assess or inventory their own life and what they want for themselves. Assess parental level of functioning and support—do they need any extra psychiatric services? If so, make the appropriate referral and follow-up.

3. Instill hope in parents (e.g., things can change, he or she can change, power of parental influence). Develop positive expectations by bringing the small changes that happen with the teen early on to the attention of parent. Small measures of success, even a teen's increased openness and honesty about his or her circumstances, can be a breath of fresh air for the parent. These small changes in the teen's attitude and behavior, useful as they are to the adolescent, are also useful in facilitating a new openness or receptivity in the parents toward their child. New perceptions and emotional receptivity are steps in the parental change process.

4. Address interparent conflict: Motivational/Inspirational. Help parents work as a team. Teamwork is very important in parenting. Help parents realize that they must put aside their differences and come together for their child. Be encourag-

ing and positive, and always stress what's at stake—the health, well-being, and future of the teen.

5. Address interparent conflict: Behavioral. Help parents work out a plan for how they will work as a team to parent the child. Problem-solve and collaborate with parents. Take an experimental framework (e.g., "We will try it, and if it doesn't work we will try something else.")

6. Prepare the parent to hear the adolescent tell his or her story without losing control (e.g., "If you want to have influence on your adolescent you have to know him or her. You may hear some things that are difficult and that you may not like. It is very important that you are able to hear about his or her world.")

7. Help parents examine their own behaviors, including drug use or other high-risk behaviors. Encourage change in relevant areas. The ideal situation is that the parent will seek treatment for serious drug or mental health problems. It is very powerful for the adolescent to see their parents make these types of changes.

8. Encourage strong anti-drug and pro-school stances. Even if the parent has used or uses illegal substances, their non-drug use stance with the adolescent is crucial.

9. Employ psychoeducation about parenting adolescents. At times the therapist needs to advise parents, respectfully of course, but in very direct terms, about how to handle a situation. Some parents need more assistance than others with their parenting practices. Therapists use their knowledge about normative adolescent development, normative adolescent-parent relationships, and normative parenting of adolescents.

10. Empower parents. Help them be parental. Help them have influence and authority.

11. Encourage age-appropriate parenting skills, including the following sequence: parents explain their own behavior to the teen (setting a context of change, respecting, and using to the developmental level of the teen [i.e., inclusion and participation versus authoritarian stance]), monitoring, limit setting, consequences, and follow-through. Help parents start with something small that they know they can follow through with and have success. It matters less how important the limit set is, than whether the parent succeeds. It is essential for the adolescent to see his or her parent in this role. Monitoring involves knowing who the adolescent is with and where he or she is most of the time. Limit setting entails setting age-appropriate limits and house rules. Consequences refer to determining age-appropriate consequences for breaking rules, as well as rewards for following rules. Be sure the parents can live with the consequences, and remind them to follow through when applying both positive and negative consequences. As important as consequences, rewards cannot be forgotten. Even a parent's mindset about rewards can shift a negative expectational set.

12. Assist parents in establishing extra support that will help them be successful with parenting their adolescent.

13. Help parents be emotionally available to their child.

14. Reinforce small steps, small changes, and small accomplishments. Use each attempt and outcome, as minor as it might seem, as a step in the right direction; a motivational force and the foundation for even larger changes.

Parent Relationship/Family Interaction Module

1. Help the family understand how important it is for them to establish a positive, supportive relationship.

2. Bring relationship conflict out in the open. Put it on the table so the family can begin dealing with it.

3. Help the family resolve conflicts. Help them establish effective ways to problem solve. Improve conflict resolution skills, and help them learn to express themselves without fighting.

4. Encourage age-appropriate negotiation between the adolescent and parent. Work together to set certain limits and consequences.

5. Help the family find ways to have positive interactions.

6. Help the adolescent to tell his or her story to the parents. Have the adolescent tell parents about his or her world while keeping the parents from interrupting, disagreeing, diverting, or judging. Help parents listen actively, respond in constructive ways, including expressing remorse or regret or apologizing (if appropriate), and explaining their own stress and burden. A positive, emotional sharing—but not a platitudinous, lecturing, or moralizing dialogue—is the process objective.

7. If the adolescent experienced past hurts, betrayal, neglect, or abuse, facilitate a discussion about the past. Help him or her communicate his or her experience and feelings to the parent. Help parents respond in a constructive way, including apologizing (if appropriate) and explaining their stress and burden. Dialogue is the key.

8. Facilitate parent-adolescent discussion about the love, worry, and concern behind parents' efforts to set limits and/or house rules, follow-through, and so forth. Help parents to communicate and the youth to understand that the rules and consequences in place are based on parental love and commitment.

9. Help the family talk about important issues by first increasing communication between family members. Have them start with something small so that they can experience positive interactions. Have them work on the important issues that are impacting their relationships.

10. Focus on the affective component of their relationship. Support and enhance family communication of warmth and love. Help family members recognize how important they are to each other (e.g., acknowledge their positive qualities).

Stage 3: All Modules. Seal the Changes. Exit

1. Seal changes. Make all changes overt. Acknowledge the progress and changes accomplished. Acknowledge what is good. Our exit is their new beginning.

2. Help the family assess their own progress and discuss how normal bumps in the road will be handled in the context of their new lives, relationships, perceptions, experiences, and skills. No therapy should strive for perfection; it is in the therapist's best interest, for him- or herself and for the clients, to accept what might be considered "rough around the edges" outcomes.

3. Help the family members create a narrative about the nature of the changes that have occurred—specifying, for example, the key ingredients of the family's

and teen's success. Talk directly about ending treatment, do not avoid the subject. Explore each family member's thoughts and feelings about ending the treatment, and get their feedback about what you did and what the program was like.

Clinical Guidelines

The preceding list indicates the core interventions according to target and domain of intervention and stage of treatment. The following list covers clinical skill and interventions that are used throughout treatment. While hardly MDFT-unique interventions, they are nonetheless fundamental to making therapy work.

1. Check in frequently about the client's understanding of what the therapist is talking about (e.g., "Do you know what I mean? Do you know what it means? Do you know why I am focusing on this right now? Is it clear to you where we're headed with this?")

2. Gently ask leading questions. Using a supportive tone, use the Socratic questioning technique. These might be questions that a therapist might know the answer to, but, as per the Socratic method, the point is to lead the client to an area of focus and to facilitate a process of inquiry and discovery. The destination might be to increase the amount of time a client spends focusing on an important topic or area of their functioning, or it might be more bottom-line-oriented—to make a point with the parent or teen. These can be simple questions; they can be posed not to obtain information necessarily, but to help the client realize something important.

3. Constantly check in about behavior in the different locales in which outcome is expected, and fundamentally, where problems have evidenced themselves (e.g., at home and school). Ask questions such as, "How is it going? Are the changes holding? Are there problems? What has to be done to keep the changes happening and to recapture the outcomes that have been slipping?"

4. Provide a solid, predictable, and consistent therapeutic relationship, and use clinical skills that encourage and enable the experience and expression of thoughts and feelings.

5. Work individual and relationship change with different people and different subsystems simultaneously. While therapy with individuals may work with a person in multiple realms of their functioning, the leap to working with potentially several people during the same treatment on multiple fronts, some of which are common between family members and some of which are more individual in nature, can be daunting. So, therapists stay organized by remembering that there are four "corners" of each case that they must work. Within those four corners—adolescent, parent, family interaction, and the extrafamilial—there may be multiple topics and issues, and the strategies and methods may be diverse, but the most complex and challenging work involves the intersection of work in one of those corners with work in the others. The next guideline outlines some practical examples of this therapeutic intention—an intention having to do with therapeutic multiplicity—within MDFT.

6. Prepare participants individually for upcoming, likely-to-be-difficult, conversations. This overall guideline relates to the MDFT approach that emphasizes

how work on different issues and with different people is woven together like a tapestry that over time shows more emotional and behavioral complexity, as well as better relationship and behavioral outcomes. Work with the adolescent has focus and intended outcome unto itself, but it also represents the elucidation of content, issues, or sometimes proof of change that is brought to the parent in joint sessions ("See how well he is doing? Now that he is thinking so clearly about things, and more able to express himself constructively, it is important for your son to talk to you about these things that have been going wrong in his life.") Similarly, individual meetings with the parent(s) are useful to provide support and to address parental stress and burden. These meetings also serve as a place in which issues and methods for relating to their child in new ways can be contemplated, discussed, and rehearsed. This work prepares the parents to bring their new changes and insights to the next conversations with their son or daughter.

7. Setting up and working enactment in sessions is one of the more difficult skills to master in all of family therapy. At the same time, it remains a critical clinical skill to acquire, since enactment provides a unique opportunity to learn about family relationships, understand different aspects of individuals, and promote direct and immediate changes in family relationships. This is accomplished by facilitating, monitoring, guiding, encouraging, and shaping the small transactions between parents and teens as they occur in sessions.

8. Use the phone frequently between sessions with the parent, youth, and extrafamilial members. Once thought of as primarily an appointment reminder procedure, the telephone is now an indispensable part of our work. More than reminding clients about upcoming appointments, phone work builds continuity between sessions, reminds clients about important things that have happened in face-to-face sessions, and allows therapists to check in about process. Additionally, the phone provides an opportunity for ongoing intervention assessment, feedback retrieval and recalibrations, and new input on the therapist's part. We aim for change efforts to be as continuous as possible. A weekly (single session/contact) approach to therapy can handicap one's efforts to promote continuous effort and change attempts. The telephone provides another way for a therapist to get information, on a daily basis if needed, about change attempts, reactions to change attempts, and new developments in the case. Since MDFT works closely with school and juvenile justice professionals, and since events can break quickly in each system of influence in the teen's natural ecology, having access to information about events in the everyday social environment and the events themselves is instrumental to the MDFT way of working. The goal is to bring new or revised interventions vis-à-vis these connected and important ecologies into treatment as quickly as possible.

9. Use current events, particularly crises of any proportion, to resuscitate motivation, renew focus, and mobilize action. Therapists remain calm through crises—but not unconcerned or unfeeling. They teach family members about the importance of responding directly and quickly to crises, particularly those that pertain to outside sources of influence or input, such as court violations, school suspensions, relapses in drug use, or affiliation with former drug-using or delinquent peers. It is in relation to these events that significant progress to change can be

made. They provide real-life forums for new behaviors to be exercised. Although what a therapist defines as productive sessions week after week may be foundational to, or even predict ultimate changes, when changes that were planned in sessions are actualized in everyday life a new stage in the change process has occurred. The crises and ups and downs that come during the course of any given treatment episode are a normal part of the change process. More importantly, crises provide opportunity and context to work out, in real-world settings with real-world consequences, the intentions discussed in more formal therapy sessions.

10. Read client feedback and shift focus, when necessary, to respond to the client's needs and concerns.

11. Work in close emotional proximity.

12. Show warmth and compassion. Be friendly.

13. Help youth and parents talk about (i.e., stay with or go to) emotions of sadness, pain, and sensitivity, instead of focusing on anger and acting out.

14. Be supportive and nonjudgmental (e.g., "I understand what you are going through."). Communicate unconditional positive regard.

15. Initiate change in the most accessible focal area, since building motivation about and concrete encouragement to change is vital. A positive set of expectations, and beginning results of renewed effort to address current problems, helps family members consider that all of their hard work will be worth it.

16. Without overdoing it and while keeping encouragement linked to real positive outcomes, change attempts, or even attitudinal or perceptual shifts (intentions to change), reinforce small steps, changes, and accomplishments.

SPECIAL CONSIDERATIONS IN THE TREATMENT OF ADOLESCENT SUBSTANCE ABUSE

The Use of Drug Screens in MDFT

MDFT has a protocol that integrates the drug urine screening procedure and the results of the drug screen directly into the therapeutic context of parent-teen sessions (see Liddle, 2002b). Results from weekly urinalyses are shared overtly with both the adolescent and the family, creating an atmosphere of openness and honesty about drug use from the beginning of therapy. Using the results of the drug screen is a therapeutic procedure or method, but at the same time, its use is designed to be therapeutic—facilitative of an interpersonal and intrapersonal process that addresses drugs and the context of drugs, including individual perceptions and family reactions and interactions around drug taking.

The MDFT therapist, as a part of the ongoing relationship with the teen, will often say, "So, tell me what the (drug screen) results are going to be . . ." prior to conducting the urine screen. This interaction is significant because it offers the adolescent a chance to be honest about his or her drug use and builds a relationship based on openness and integrity, rather than secrecy and dishonesty. This context shift sets the stage for a teen's honest communication with parents and others. When the teen produces a drug-free urinalysis, this outcome creates a context for adolescents and parents to begin to communicate differently. Parents may

rediscover hope and believe that their lives may begin to be less disrupted by drug use and its consequences. With the therapist's help, family agreements about restrictions and privileges, as well as shifts in emotional interactions, occur. Utilizing the urinalysis in this family session reduces negativity in family relationships, a core target in family-based work, and facilitates trust and agreements between family members.

When teens do not want to complete the drug test, it may be a sign that their drug use persists. The therapist may ask, "Are you afraid of what the results might be?" With a positive urinalysis, the therapist will discuss the consequences from a nonpunitive framework: "What we're doing isn't working and we're not helping you enough. What do we have to do to avoid continued use?" This process begins by eliciting the critical details of the social context of use, as well as the teen's intrapersonal functioning prior to and after drug use. Dirty urine tests facilitate the functional analysis of drug use and abuse. Important questions are asked, such as what happened; when did the teen use; what time and place; how much and what did the teen use; how many times; what were his or her thoughts and feelings before, during, and after using; which friends were present; and, most importantly, how could the use episode have been prevented? These details help the therapist determine next steps. Typically, new parental monitoring structures need to be put in place, and the therapist and teen should refocus on their work as well (i.e., triggers and urges to use, skills, peers, alternatives to drug-using lifestyle, taking care of oneself). Brief residential stabilization is used if the drug use reaches dangerous levels or has become so stable as to be unalterable in the current therapeutic attempts. Using drug screens with teens in strong denial is a powerful tool, as it provides concrete grounds for discussing restrictions and promotes the adolescent's understanding of the consequences of use.

The therapist arranges opportunities for the teen to tell his or her parents themselves that he or she has used drugs and have produced a dirty urine test. In keeping with the agreement made early in therapy that secrets are not a part of the drug recovery process, the adolescent is reminded that the parents will be told the urinalysis results, and that this is an opportunity to be honest with them. When the adolescent tells the parent that the urine test was dirty, this honesty creates openings for new relationships with the parents and with him- or herself. Parents are frequently focused on drugs as the only cause of their adolescent's problems, and see abstinence as equivalent to a return to a normal life for themselves. A clean urinalysis resuscitates hope and relieves some of the intense fear surrounding drug use. While parents frequently want the problem fixed, therapists help parents to understand that, given the nature of the adolescent's problems, recovery from serious drug use can be a rollercoaster ride, not a problem-free steady state once progress occurs. When an adolescent stops or drastically reduces his or her drug use and then relapses, parents' hopelessness is ignited again. The parents worry that history will endlessly repeat itself. The therapist's work is to shift the parents' fear to a developmental perspective of their adolescent, where they understand that the teen has several areas of impairment that need attention, and that the development of a drug-free, more-adaptive lifestyle takes time, and is dependent on a number of areas of progress coming together (individual outcomes, parent outcomes, fam-

ily changes, school improvement, juvenile justice involvement decreased or stabilized). Therapists help the family to not panic in response to crises or relapses; the events of the crisis are always used as information about what has to happen next and as opportunities to rework the changes that have already begun.

Using the results of the urinalysis in sessions can be significant in the life of the teen and the parents. It allows for new and honest interactions, emotional reconnections, trust-building, and a focus on the mobilization of the family system as a whole to address and combat continued drug use. Consistent with our ecological-developmental focus, clinicians use the drug screen results with parents and teens to build toward the overall improvement of individual and family functioning and extrafamilial relationships.

Decision-Making for Individual or Joint Sessions

MDFT is a therapy of subsystems. Treatment consists of working with parts (subsystems) to larger wholes (systems) and then from wholes (family unit) back down to smaller units (individuals). Working in this way requires guidelines for how to constitute any given session or piece of therapeutic work. Session composition is not random or at the discretion of the family or extrafamilial others, although sometimes this is the case. When therapists are new to MDFT, one of their main questions is, "When is it appropriate to meet with the adolescent alone, the parent alone, or with the parent and the adolescent together?" Clinicians want to know about the inclusion of extrafamilial people in treatment as well. There is a broad-level answer to these many questions that is always the same—composition of sessions depends on the goals of that particular piece of therapeutic work, the stage of treatment, and the goals of that particular session. Goals may exist in one or more categories. For example, there may be strategic goals at any given point that dictate or suggest who should be present for all or part of a session. The first session, for example, from a strategic and information-gathering point of view, suggests that all family members and even important people outside of the family be present, at least for a large part of the session. Later in treatment, individual meetings with parents and the teen may be needed because of estrangement or high conflict. The individual sessions are information-acquiring but are also preparation for joint sessions (working parts to a larger whole). Session composition (i.e., who attends) may be dictated by therapeutic needs pertaining to certain kinds of therapeutically essential information. Individual sessions are often required to uncover aspects of relationships or circumstances that may be impossible to learn about in joint interviews. Therapeutic goals about working a particular relationship theme in vivo, via enactment for instance, may be another compelling rationale for decisions about session composition.

If decisions about session composition flow from therapeutic goals, it should be emphasized that not all goals are set a priori. For instance, some goals are at smaller operational levels than an objective such as *increase of parental competence.* Some therapeutic goals are set and existing goals are adjusted on the basis of feedback that one reads from the family and extrafamilial others. Therapeutic feedback from any and all parts of the therapeutic system and environment is sought and used constantly to answer the following core questions: How is this

therapy going? What have I accomplished in terms of addressing and successfully attending to MDFT's core areas of work—the four domains of focus? (For example, do I know the teen's hopes and dreams? Do I know the parents' burdens? What am I working on extrafamilially—in the natural environment of the teen and family?) What are we working on and is this content and focus meaningful? Are we getting results? Progressing reasonably?

Thus, while core pieces of work in MDFT, such as engagement of the teen and working on parent issues (e.g., parenting practices, the shaping of the parent-teen relationship through the interpersonally and behaviorally oriented technique of enactment) may dictate session composition and participation because of the obvious nature of their work; other aspects of therapy, such as working a given therapy theme, for example, may require feedback to be read before session composition can be determined or decided. Having a clear sense about the core aspects of what one has to focus on in MDFT, working in the four domains of adolescent, parent, the teen-parent relationship, and the extrafamilial, largely, but not completely, indicates who will be involved in any given session. A therapist's realization that his relationship with the adolescent is slipping after a rough session or negative outside-of-therapy event (e.g., a tense court hearing where a decision went against the adolescent), must use this insight (i.e., reading of feedback) to right the therapeutic course. An individual meeting, in the clinic, in the home, at school, or at a fast food restaurant is needed, and it is in the therapist's best interest to act quickly in relation to feedback of this type. Decisions about session composition are important and they can be confusing. However, once one readjusts the decision-making lens to put therapeutic goals first, and to determine those goals on the basis of the generic aspects of the MDFT therapy, as well as the reading of idiosyncratic and temporal feedback, session composition decision making becomes much easier. The therapist's assessments of multiple domains of functioning provide the answer to where he or she needs to go and what needs to be focused on. From these questions derive the more simple questions—who do I work with, and when.

Therapist Assistant Duties

Some versions of MDFT have included a therapist assistant or case manager as part of the therapeutic system. The therapist assistant (TA) works closely with the therapist to ensure that the assessment of case management needs and the delivery of services coordinate with the clinical work. The therapist and therapist assistant assess families for social service needs, the nonfulfillment of which creates therapeutic barriers. A case management plan is developed and the therapist assistant, in close collaboration with the therapist, attempts to meet its objectives.

Therapist assistants work with systems outside the family. For an overwhelmed parent, help in negotiating complex bureaucracies or in obtaining needed adjunct services is therapeutic. Clients often need help to obtain services (e.g., housing, medical care, and coverage) or transportation to job training or self-help programs. TAs are involved in all of the extrafamilial systems, including school, where they (1) monitor the client's attendance and parental receipt and signatures on all school reports and forms, (2) compile monthly attendance and in-school behav-

ior records, and (3) attend school meetings and conferences and team meetings. TAs also maintain active contacts with schools and/or alternative education programs and monitor contact and progress with tutors. With regard to job placements, TAs make referrals to appropriate agencies and are also responsible for assisting the client (parent or adolescent) with his or her appointments at job agencies, vocational rehabilitation, and/or interviews. Prosocial activities is another area where TAs contribute by (1) taking clients to 12-Step meetings, (2) facilitating parental access to support groups/12-Step meetings, (3) evaluating the appropriateness of recreational activities in terms of content, staff competence, cost, and attendance requirements for activities, and (4) accompanying the client to activities as necessary. If a family is in need of core social services, like health/ mental health care, food banks, and financial services, the TA will facilitate access to all services available, make referrals to and appointments with appropriate services, take clients to apply for and obtain services, and follow-up with service providers regularly. The TAs are used extensively when working with the court system. They make referrals to appropriate programs, maintain contact with the juvenile probation officer, conduct daily check-ins with clients regarding the conditions of probation, attend court hearings, and visit the clients in detention as necessary. For the duration of treatment there is ongoing contact (i.e., nightly and weekend check-ins by phone) between the TA and clients to monitor progress.

RESEARCH EVIDENCE SUPPORTING THE EFFECTIVENESS OF MDFT

Multidimensional Family Therapy has been developed and tested in federally funded research projects since 1985. This research program has provided evidence for the efficacy and effectiveness of MDFT for adolescent substance abuse. The studies have been conducted at sites across the United States (including Philadelphia, Miami, St. Louis, Bloomington, Illinois, and several communities in the San Francisco Bay area), among diverse samples of adolescents (African American, Hispanic/Latino, and White youth between the ages of 11 and 18) in urban, suburban, and rural settings, with various socioeconomic backgrounds. International studies of MDFT, including a European multisite trial of MDFT in five countries, are funded and currently underway. In MDFT studies, all research participants met diagnostic criteria for adolescent substance abuse disorder as well as other serious problems (e.g., delinquency and depression). The following section will review the significant findings from four types of studies: (1) randomized controlled trials, (2) process or mechanisms of action studies, (3) economic analyses, and (4) transportation or technology transfer studies.

Randomized Controlled Trials

Six randomized controlled trials have tested MDFT against a variety of comparison treatments for adolescent drug abuse. MDFT has demonstrated more favorable outcomes than several other state-of-the-art interventions, including family group therapy, peer group treatment, individual cognitive-behavioral therapy (CBT), and comprehensive residential treatment (Liddle et al., 2001; Liddle, 2002a; Liddle

& Dakof, 2002; Liddle, Rowe, Dakof, Ungaro, & Henderson, 2004; Rowe, Liddle, Dakof, & Henderson, 2004). MDFT studies have included samples of teens with serious drug abuse (i.e., heavy marijuana users, with alcohol, cocaine, and other drug use) and delinquency problems. Here is a summary of some noteworthy findings from the MDFT clinical trials:

Substance use is significantly reduced in MDFT to a greater extent than all comparison treatments investigated in five controlled clinical trials (between 41 percent and 82 percent reduction from intake to discharge) (Liddle et al., 2001; Liddle, 2002b; Liddle, Dakof et al., 2004; Rowe, Liddle, Dakof, & Henderson, 2004; Rowe, Liddle, Dakof, Henderson, Gonzalez et al., 2004). Additionally, substance-abuse-related problems (e.g., antisocial, delinquent, externalizing behaviors) are significantly reduced in MDFT to a greater extent than comparison treatments (Liddle, 2002b; Rowe, Liddle, Dakof, & Henderson, 2004; Hogue, Liddle, Becker, & Johnson-Leckrone, 2002; Liddle et al., 2001; Liddle, Rowe et al., 2004).

Youth receiving MDFT often abstain from drug use. During the treatment process and at the 12-month follow-up, youth receiving MDFT had higher rates of abstinence from substance use than comparison treatment. MDFT studies (Liddle, 2002b; Rowe, Liddle, Dakof, & Henderson, 2004) have indicated the majority of youth receiving MDFT report abstinence from all illegal substances at 12 months post-intake (64 percent and 93 percent respectively). MDFT demonstrated durability of obtained change (Liddle et al., 2001; Liddle, Rowe et al., 2004) whereas comparison treatments reported lower abstinence rates (44 percent for CBT and 67 percent for peer group treatment).

Treatment gains are enhanced in MDFT after treatment discharge; MDFT clients continue to decrease substance use after discharge up to 12-month follow-up (58 percent reduction of marijuana use at 12 months; 56 percent abstinent of all substances and 64 percent abstinent or using only once per month; Liddle, 2002a; Liddle & Dakof, 2002; Rowe, Liddle, Dakof, Henderson, Gonzalez et al., 2004).

School functioning improves more dramatically in MDFT than comparison treatments. For example, MDFT clients return to school and receive passing grades at higher rates (43 percent in MDFT versus 17 percent in family group therapy and 7 percent in peer group therapy; Liddle et al., 2001; Rowe, Liddle, Dakof, & Henderson, 2004). Overall, MDFT improves school bonding and school performance, including grades improvements and decreases in disruptive behaviors (Hogue et al., 2002; Liddle et al., 2001; Liddle, Rowe et al., 2004).

Family functioning and interaction improves to a greater extent in MDFT than family group therapy or peer group therapy using observational measures, and these improvements are maintained up to 12-month follow-up (Liddle et al., 2001; Liddle, Rowe et al., 2004). MDFT improves family functioning, including reductions of family conflict and increases in family cohesion (Diamond & Liddle, 1996; Hogue et al., 2002; Liddle et al., 2001; Liddle, Rowe et al., 2004).

Preventive effects. In addition to successfully treating adolescents drug abuse, MDFT has worked effectively as a community-based drug prevention program (Hogue et al., 2002) and has successfully treated younger adolescents who are initiating drug use (Liddle, Rowe et al., 2004; Rowe, Liddle, Dakof, & Henderson, 2004).

Psychiatric symptoms show greater reductions during treatment in MDFT than

comparison treatments (Liddle et al., 2001; Liddle, 2002a; Rowe, Liddle, Dakof, & Henderson, 2004; Rowe, Liddle, Dakof, Henderson, Gonzalez et al., 2004). MDFT demonstrated 30 to 85 percent within-treatment reductions in behavior problems, including delinquent acts and other mental health problems such as anxiety and depression (Liddle, Rowe et al., 2004).

Effectiveness with comorbidity. In comparison with individual CBT treatment, MDFT had superior outcomes for drug-abusing teens with co-occurring problems (i.e., externalizing symptoms and family conflict; Henderson, Greenbaum, Dakof, Rowe, & Liddle, 2004).

MDFT decreases externalizing and internalizing symptoms. Youth receiving MDFT decrease their externalizing behaviors more rapidly from intake to discharge according to both self- and parent reports. These gains are maintained through the 12-month follow-up. Youth decrease their internalizing symptoms (e.g., general mental distress) more rapidly through the 12-month follow-up.

Delinquent behavior and association with delinquent peers decreases with youth receiving MDFT, whereas youth receiving peer group treatment reported increases in delinquency and affiliation with delinquent peers; these changes are maintained through a 12-month follow-up (Hogue et al., 2002; Liddle et al., 2001; Liddle, Rowe et al., 2004). Additionally, objective records obtained from youths' Department of Juvenile Justice records indicate that youth receiving MDFT are less likely to be arrested or placed on probation, as well as having fewer findings of wrongdoing during the study period (Rowe, Liddle, Dakof, & Henderson, 2004). MDFT transportation studies have also shown that association with delinquent peers decreases more rapidly after therapists have received training in MDFT (Liddle, Rowe et al., 2004; Rowe, Liddle, Dakof, & Henderson, 2004; Rowe, Liddle, Dakof, Henderson, Gonzalez et al., 2004).

Studies on the Therapeutic Process and Mechanisms of Change in MDFT

Studies have specified the within-treatment process of improving family interactions (Diamond & Liddle, 1996; Diamond et al., 1999), demonstrated how therapists successfully build therapeutic relationships with teens and parents (Diamond et al., 1999; Shelef, Diamond G. M., Diamond G. S., & Liddle, in press), and showed that adolescents are more likely to complete treatment when therapists have stronger relationships with their parents, and that stronger therapeutic relationships with adolescents predict greater decreases in their drug use (Shelef et al., in press). MDFT process studies have shown that parents' skills are improved during therapy and that these changes are linked to reductions in adolescents' symptoms (Schmidt, Liddle, & Dakof, 1996), and that a connection exists between systematically addressing important cultural themes and increasing teens' participation in treatment (Jackson-Gilfort, Liddle, Tejeda, & Dakof, 2001). The approach is exploring adaptations of MDFT to the needs and issues of adolescent girls (Dakof, 2000). Finally, MDFT interventions that focused on changing the family produced changes in drug use and emotional and behavioral problems (Hogue, Liddle, Dauber, & Samuolis, 2004), and in a related study of mechanisms of action, the quality of the therapeutic alliances between therapist and adolescent and thera-

pist and parent was found to predict treatment completion or dropout (Robbins et al., in press).

Economic Analyses

The average weekly costs of treatment are significantly less for MDFT ($164) than community-based outpatient treatment ($365; French et al., 2003). An intensive version of MDFT designed as an alternative to residential treatment provides superior clinical outcomes at significantly less cost (average weekly costs of $384 versus $1,068; Liddle & Dakof, 2002). More extensive cost benefit studies are underway.

Transportation or Technology Transfer Studies

MDFT transported successfully into a representative hospital-based day treatment program for adolescent drug abusers (Liddle et al., 2002). There were several important outcomes, including the following: (1) *Clients' outcomes were significantly better after staff were trained in MDFT*—clients showed a 25 percent decrease in drug use during treatment prior to MDFT training, compared to an average of 50 percent improvement in reduction following the MDFT training (Liddle et al., 2002; Rowe, Liddle, Dakof, Henderson, Gonzalez et al., 2004); (2) *treatment gains were sustained;* following withdrawal of all MDFT clinical and research staff, clients improved at similar rates to those achieved while therapists were closely monitored by MDFT trainers (Rowe, Liddle, Dakof, Henderson, Gonzalez et al., 2004); (3) *therapists successfully delivered the MDFT according to protocol* following training, with a 36 percent increase in the number of weekly individual therapy sessions, a 150 percent increase in the number of weekly family sessions, a 390 percent increase in contact with juvenile probation officers, and a 1,400 percent increase in school contacts following training (Liddle et al., 2002; Rowe, Liddle, Dakof, Henderson, Gonzalez et al., 2004); (4) *therapists broadened their treatment focus* after MDFT training, addressing more MDFT content themes and focusing more on the adolescents' thoughts and feelings about themselves and important extrafamilial systems (Rowe, Liddle, Dakof, Henderson, Gonzalez et al., 2004); (5) *after training in MDFT and withdrawal of all MDFT clinical and research staff, therapists continued to deliver MDFT according to protocol* (Rowe, Liddle, Dakof, Henderson, Gonzalez et al., 2004); and (6) *program or treatment system level factors improved dramatically,* including adolescents' perceptions of increased program organization and clarity in program expectations.

Case Study

Willie is a 15-year-old Caucasian male who was referred to treatment by his 52-year-old single mother, Marge, due to his polydrug abuse and repeated school failures. Upon entry into treatment, Willie was using, alternately, cannabis, cocaine, Xanax, and Ecstasy on a daily basis. He expressed no motivation to stop doing drugs ("I love getting high, it calms me down") and had no desire to be in treatment. At 11 Willie began to use drugs. He smoked cannabis on a weekly basis. At 12 and 13 he began to take prescription drugs (Xanax), lacing the cannabis with cocaine, and

increasing his drug use to two to three times a week. By age 14 to 15 he had progressed to daily drug use, using either cocaine alone or cannabis laced with cocaine (three to four times per week), and Xanax or Ecstasy with alcohol on occasion.

Willie had been using drugs steadily for several years, and although his mother believed he was using more than just cannabis, she was in denial and did not want to confront him about his drug problems. Although she was not pleased with Willie's marijuana use, given her own substantial substance abuse history, initially she was not concerned. It was only when she realized the magnitude and frequency of Willie's drug use, including the associated problem behaviors, that she became alarmed and sought help.

Formulation. We see drug abuse as developmental derailment. In this MDFT case both mother and son were struggling with their destructive substance abuse. Marge's own substance use was critical and affected her son profoundly. Although no longer using illicit drugs, Marge's extensive alcohol abuse prevented her from properly supervising Willie. He made his own decisions, had no guidance or responsibilities, and considered himself an adult. Due to Marge's lack of monitoring, Willie was taking care of himself in some ways but was using drugs and was involved with drug-using friends. When he experienced difficulties in school, there was no one to help, so he had given up and started skipping classes, which led to two consecutive school year failures. At home, the mother's absences disrupted family life and made parenting attempts impossible. There was no other significant adult figure in the client's life to care for him or be a positive role model. Since the mother-son relationship was so poor, they never discussed meaningful issues related to past hurts. Marge's own history of sexual abuse and drug use made it difficult for her to function to the best of her abilities. She had never processed her traumatic experiences, never been properly parented herself, and never received any kind of social or financial support. In working with Willie, the therapist (Elda Kanzki) was able to identify two major themes that seemed to have negatively impacted his dreams and hopes for a better life: (1) Feelings of failure associated with academics and (2) the conflict and anger he harbored towards his mother. His resentment of Marge was obvious; the adolescent repeatedly told the therapist how his mother "always talks crap" and how "she'll say things and make promises, but she doesn't follow through."

Goals. A crucial goal in therapy was to help Willie and Marge improve their relationship to facilitate open communication about salient issues (i.e., substance abuse, parental neglect, and academic failure)—an important part of the relationship transformation and healing process. One of the primary goals in working with the adolescent was to transform his drug-using lifestyle into a more developmentally normal one. Other goals included teaching Willie anger management skills, changing his involvement with drug-using peer groups, improving school functioning, providing a safe environment for him to express himself, generating hope, and facilitating self-examination. In working with Marge individually, one major goal was to motivate her to seek treatment for her alcohol abuse and psychiatric problems. Since she was not monitoring Willie, interventions to improve her parenting skills and help her to view herself as her son's medicine (an important positive source of influence) were vital.

MDFT Interventions

Adolescent Domain

During the first session, Willie was difficult to engage and angry for having been forced to undergo the program by his mother. As part of a typical initial assessment procedure, the therapist asked Willie to write down three goals he had for his future. Although reticent, he did specify goals, stating that he wanted (1) to begin playing football again, (2) to help his mother around the house, and (3) to improve in school. The therapist generated hope by having the adolescent express his aspirations and dreams.

For the next session Elda went to Willie's school, where she met with him for lunch, thus engaging him in his own environment. She observed first-hand the difficulties he was facing. She immediately noticed how being the oldest kid in his class bothered him. When Elda inquired about his classmates, Willie responded with, "Oh, these stupid bunch of stupid kids"—he was embarrassed and angry about being in a class with younger teens. Observing something that was so troubling for Willie and also being in the environment in which Willie revealed and spoke about this problem was a great advantage. Thus, improving his school situation became a therapeutic goal and facilitated the therapeutic alliance. Elda related that from this conversation forward she was able to broach other sensitive topics, such as his drug use and the relationship with his mother.

In individual sessions Elda facilitated discussions about anger and Willie was taught new ways to manage his emotions. She also prepared him for sessions with his mom. The therapist coached Willie on how to express his angry feelings in a constructive way, and Marge was asked to understand the reasons (i.e., Willie's experiences and conclusions about them) for Willie's angry mode. By continuing to explore school difficulties and his peer network, Elda sought to help Marge understand the world her son lived in.

In exploring Willie's relationship with his mother, core relational themes of neglect and abandonment were discussed, as Elda helped Willie process strong feelings of disappointment and frustration. In one poignant exchange, Willie tearfully shared his disappointment with the lack of trustworthiness shown by the people in his life (friends and especially his mother). As the therapist continued to gently probe, Willie expressed how much his mother's drinking bothered him. The therapist instilled hope by stating that they would focus on this together in therapy and that she would help him relay his feelings to his mother.

Reaching this point (i.e., discussion of hopes and dreams, the painful issues of abandonment, and his mother's alcohol and past drug use), involved a multifaceted process. This sequence, a typical one in MDFT, involved several steps whereby Elda guided the adolescent, creating links for him that fostered understanding into the reasons for his drug use and present situation. First, the therapist helped the adolescent to reflect on how having failed the eighth grade twice was a major disappointment for him, but that he suppressed it through drug use. Next, she addressed the subject of drugs, to talk about why he was using and then to connect his drug use to the chaos that his life had become. Progress on this front then allowed for a discussion about his relationship with his mother. Those discussions seemed to

elicit a loving response from Willie. He may have been angry with his mother, and justifiably so, but he concluded that he wanted and needed her in his life.

Parental Domain

The mother's own drug use and recovery, past traumas (sexual abuse and abandonment), guilt with regard to neglecting her son, her own stress and burden, the mother-son relationship, and parenting practices were explored in depth. In particular, psychoeducation with this mother regarding her parenting practices was important, given the manner in which her parents had abused her; she had never had proper parenting role models. During the initial evaluation Elda assessed parenting strengths and weaknesses. According to his mother, Willie disobeyed her rules, he was truant, and he exhibited emotional and at times violent outbursts. Despite her son's disconnection, Marge's attitudes about her son were generally positive ("He's got a good heart, he's fair and caring and only hurts himself . . . he's a good boy"), and this served as a protective factor and an important foundation to use in building relationships and creating change. However, Marge's overly permissive parenting style and lack of emotional connection diminished any positive parenting outcomes at the outset.

The therapist explored ways for Marge to improve existing parenting skills and adopt new parenting behaviors. New parental skill acquisition was accomplished via the use of Parent Reconnection Interventions (PRI) (Liddle et al., 1998), which facilitated in bridging the emotional distance between Marge and Willie. The following PRIs were used extensively by the therapist: (1) Enhancing feelings of parental commitment and love, (2) validating parents' past efforts, (3) acknowledging parents' stress and burden, (4) generating hope via the therapist as an ally, and (5) by helping parents understand that their influence is crucial. Elda began by allowing Marge to discuss her own issues—she acknowledged her stress and burden by validating her personal struggles with drugs and life's difficulties.

The therapist then moved into another significant area; that of enhancing feelings of parental commitment and love. With Elda's guidance Marge was able to remember how things had been between her and her son—she felt the desire to recapture some of the "good times" they once shared as mother and son. Marge realized, with Elda's help, that it was important to have realistic expectations about some of this optimism; however, the positive expectations were cast in developmentally appropriate terms. The next step was to help Marge understand how necessary it was to (1) express her fears and concerns regarding his drug use, (2) inform him about her commitment and love for him, and (3) understand that she was the medicine for Willie. We address these themes in all parental domain work—the notion that the parent must develop a sense of potential personal efficacy and influence about their teen. Parents are told that they have a position of unique and special influence and the treatment program will help them regain that position and the positive outcomes that go with it.

Parents are not maximally effective if their own personal functioning is compromised in any way. Thus, Elda focused on Marge's recovery as well. Marge was asked to reflect on the reasons for her drinking, and how it affected her and her family. Treatment for alcoholism was discussed, and she was strongly encouraged

to seek help. By the end of therapy, Marge had been attending daily Alcoholics Anonymous (AA) meetings and had remained abstinent for 8 days. She began to see a psychiatrist for treatment of depression, anxiety, and her past trauma. Her actions were meaningful and demonstrated to Willie her sincerity and commitment to dealing with their problems. Elda strongly supported Marge's efforts to help her understand the importance of what she was doing and of the message she was sending her son: "I think the bigger message with you stopping drinking is that you're saying to Willie, 'Not only do I want to save you and make you stop doing these things, but I'm willing to realize my *own* part in how you're turning out.' That's powerful, Marge!" With Elda's help, Marge concluded that if she was going to ask her son not to use drugs (and this is a critical task/outcome in every case), then she would have to remain abstinent and monitor him. It was at this point that Marge was able to commit to the reality that her son was not doing well emotionally or developmentally, was in pain, and needed her support. Thus, helping Marge face Willie's emotional turmoil was a first step. Next, Marge had to address how her lack of self-care was a factor in Willie's outcomes. Furthermore, in order to improve her parenting and thus have a chance of influencing Willie's downward spiral, she would need to take care of herself, and specifically change her drinking behaviors—then she would be in a position to help Willie. As stated earlier, Marge began attending AA meetings daily, committed to a sponsor, began short-term psychiatric treatment, and became more attentive to personal self-care needs (she lost 19 pounds over the course of treatment).

In addition to practicing self-care, Marge's parenting practices changed radically. She began to seriously monitor her son, constantly questioning him about his comings and goings, calling his teachers every single day to check on his attendance, and visiting the school on several occasions to meet with his teachers. This was tremendous for Willie because he had *never* seen his mother care about him like this before. During a family session he told his mother, "You know, I can't believe you're going to the school, that you're doing all that." For the first time in his life he was convinced that his mother was changing. Consequently, Willie began attending school again, but it took drastic measures—from the mother first, her apology and acknowledgment of past mistakes, and her regular involvement with his school and persistent effort in supervising him.

Family Domain

Here the crux of work in therapy was to help Willie and his mom reconnect. Marge's relationship with her son was worked on extensively—how she would like it to improve and what her hopes and dreams were for him. This change in the family interaction was accomplished via enactment (wherein the adolescent and his mother, facilitated by the therapist, were able to talk about past hurts and recommit to their relationship), and the work done in individual sessions with Willie and Marge. Willie and his mother were coached on how to express their feelings to one another so they could communicate how they wanted things to be different. With the therapist's help, Marge was able to tell her son that she would do anything to help make things better for him and them as a family. She also shared with him the reasons she was so adamant that he not use drugs (i.e., be-

cause of her love for him and because of the destructive force drugs had been in her life). Similarly, Willie was coached in talking to his mom about difficult subjects: Willie's reasons for using drugs and associating with drug-using friends, and his mother's drinking.

Once the mother opened up to her son, the therapist was able to gradually coach her in tackling even more delicate issues (feelings of guilt and neglect of her son). The therapist worked with the mother to prepare her for the apology—a powerful moment in therapy in which Marge expressed her remorse for actions in the past and all the pain she had caused her son. With the therapist's guidance she was able to reaffirm her love, investment, and commitment to her son, and effectively communicate her strong desire to consistently be there for him.

At the midway point of treatment, the therapist conducted an appraisal of what they had accomplished thus far and the work that still needed to be done. It was noted that after just a few sessions, the mother-son relationship had begun to show positive change. Marge and Willie were starting to communicate in new ways, and their experience of the other had changed as well. Marge recounted an incident where they had both initially responded in their typical hostile way, but then decided, together and quite deliberately, to utilize the new methods of communication they had learned. The result was that mother and son apologized to each other. Later they told Elda, individually and then in a joint session, how each had felt encouraged by this event and its new kind of outcome. At the same time, however, there were still areas needing significant improvement. The mother reported that immediately after this progress, and similar episodes in other interactions, she realized that Willie had stolen money from her. The therapist reminded her that it would not be easy for Willie, but to remember they made great strides in a short period of time. The therapist stressed the importance of discussing this incident with him in the forthcoming joint session.

Willie continued to test positive for drug use on his urinalysis screens. Although positive changes had been occurring at school (attending classes, improvement in grades), and in the mother-son relationship (better communication), he was still using drugs. With Elda's coaching, Marge expressed her concerns to Willie. In particular, Marge thought that Willie might not be able to stop using on his own. Marge decided that Willie needed to demonstrate to her that he could and would abstain. If not, they would come to a decision together that he would enter a hospital inpatient adolescent detoxification unit. Indeed, this is what occurred, Willie's drug use continued and they mutually agreed that he needed to be admitted. Several sessions took place while Willie was in a hospital inpatient adolescent detoxification unit. This service works in collaboration with the outpatient MDFT clinic, and in cases where the youth is not able to make significant enough progress in stopping or significantly diminishing his or her drug use, we employ this short-term (i.e., up to several weeks) program.

Extrafamilial Domain

In the extrafamilial realm the work focused primarily on Marge, as Elda guided her to gain knowledge about and then maneuver within different systems. Two areas were identified as primary focuses of assessment and intervention: (1) Un-

derstanding her adolescent's school situation, and (2) organizing prosocial community activities for him. The first step was encouraging the mother to take a proactive role in her son's school. The therapist coached her in how to navigate the often complex school system—its functioning, and ways she could become involved to help her son succeed. Her involvement in and of itself was therapeutic and important in that Willie finally saw his mother as his ally. Marge's intervention was consistent throughout the course of treatment and was effective, as Willie began attending classes regularly again. In one instance, with Elda's coaching, the mother single-handedly worked with the principal of the school and had her son transferred from a class he was having trouble in to a more appropriate one. This was powerful because for the first time ever this adolescent was seeing his mother clean and sober and advocating for him. Willie had doubted that his mother loved him, but through her actions she demonstrated to him her commitment to change. Another area focused on the extrafamilial domain was encouraging Marge to recognize the importance of enrolling her son in prosocial activities (e.g., Willie's interest in joining the football team).

By the end of treatment, both Marge and Willie had stopped using alcohol and drugs. During the final session—the launching of the family—mother and son were helped in negotiating house rules and establishing a contract regarding Marge's drinking. The therapist facilitated communication to help them recognize and express the many positive changes they had both made during the course of treatment. Marge told her son how proud she was of him regarding his improved performance in school (he earned his first "A"), and his staying clean and not wanting to use anymore. Willie expressed to his mother that he noticed how proud she was of him, of the choices he had been making, and acknowledged her abstinence and its positive effect on her health. By the end of the session, mother and son were learning to appreciate one another and committed themselves to building upon the positive changes they had made.

SUMMARY

Multidimensional family therapy is a family-focused, developmentally based substance abuse treatment for adolescents. MDFT operates from ten therapeutic principles designed to guide a therapist's overall mindset toward change. The therapist works to facilitate change at different system levels, in different domains of functioning, and with different people—inside and outside of the family—to end drug use and related problems, thus returning the youth and family to a normative developmental trajectory.

MDFT is administered in three stages. *Stage 1* includes a comprehensive assessment of problem areas and pockets of untapped or underutilized strength. Strong therapeutic relationships are established with all family members and influential persons such as school or juvenile justice personnel. The themes, focal areas, and goals of therapy are established in the first stage. *Stage 2* is the working phase of treatment, where significant change attempts are made within and across the interlocking subsystems (e.g., individual, family, peers, school) assessed

at the outset of treatment. *Stage 3* seals the changes that have been made and prepares the teen and family for their next stage of development, using the knowledge, experience, and skills gained in the treatment. Each stage includes work in each of the four MDFT assessment and intervention domains—the adolescent, parent, the family interaction system, and the extrafamilial social system.

MDFT is a research-supported treatment, having been developed and refined over 2 decades in federally funded research. MDFT studies have found this treatment approach to be an effective and flexible clinical approach. MDFT is a treatment system that has been tested in different versions, depending on the goals of the study, characteristics of the clinical sample (e.g., level of impairment, extent of co-occurring problems, level of juvenile justice involvement), and treatment setting (e.g., outpatient clinic, drug court, day treatment program). MDFT has achieved superior clinical outcomes in comparison to several state-of-the-art, widely used treatments. The treatment engages teens and families and motivates them to complete therapy. MDFT has a lower cost than standard outpatient or residential treatment, and it has demonstrated success in treating a range of teens and families (e.g., different ethnicities, gender, ages, and severity of problems). We have developed an extensive, empirically based knowledge about how MDFT works, and have been able to successfully adapt the MDFT protocol to existing non-research treatment programs. MDFT serves as one of the most promising interventions for adolescent drug abuse and related problem behaviors in a new generation of evidence-based, multicomponent, and theory-derived treatments. Given what we know now about how research-supported therapies can influence treatment systems, provider practice, and policies that govern such practices (Liddle & Frank, in press), the next set of developmental tasks for the evidence-based therapies in this volume offer steep challenges but many exciting research and clinical practice opportunities as well.

Additional background, clinical papers, the MDFT treatment manual, and the process and outcome articles of the MDFT approach can be downloaded at www.miami.edu/ctrada.

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