Chapter 16

Multidimensional Family Therapy for Adolescent Drug Abuse: Making the Case for a Developmental-Contextual, Family-Based Intervention

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INTRODUCTION

   Much of family therapy's past has been estranged, intentionally so, from mainstream individual and group psychotherapy, from which it evolved. Family therapy's genuine and self-proclaimed differentness helped to sequester it from the influences of the mental health establishment. Although this position was functional and developmentally useful in its day, this separatist position is no longer viable (Coyne and Liddle 1992). There is a developing spirit of integration of methods in family therapy, and in group psychotherapy as well, to deal with pragmatic, clinical problems and population-specific treatment packages, using integrated treatment models.
   Family therapy's roots in group therapy are clear, with similarities between the two approaches (Nichols and Schwartz 1998). In fact, early family therapists approached families as small groups with equality among their members (e.g., John Bell). First, family and group therapy are both very concerned with process at the level of etiology and intervention. Both assume that interactional and interpersonal processes and functioning are interconnected, with clinical implications. Modern family therapy approaches do not limit their boundaries to family process but extend diagnostic and intervention targets to include processes within the family, within individual fam-

ily members, and among family members and extrafamilial sources of input and influence. Second, in both family and group therapy, the interactional process is the main target of change, using the interpersonal processes in group and in the family. Third, family and group therapy both utilize developmental aspects of group dynamics, understanding that groups and families in therapy go through natural, predictable developmental stages. Finally, both approaches focus on the roles members play in the family or group.

However, important differences exist among families and other groups, which explains why family therapists developed unique techniques and approaches (Nichols and Schwartz 1998). Families are not random groups of people, but instead family members share common histories and maintain long-term commitments to one another. Families are not democratic groups in which members can have equal power and status, nor is the family therapy environment always safe, supportive, and nonthreatening, as is often the case in group therapy. Family therapists must employ creative techniques to promote openness and honesty and generate new ways of relating that will break long-standing, ineffective interactional patterns. Family therapists regard the family as the core, and in certain developmental periods the most important, unit of socialization.

Family therapists may use aspects of group therapy; two major family therapy approaches maintained their group therapy roots: multiple family therapy (Laqueur 1972) and network therapy (Speck and Attneave 1972; Rueveni 1979). Multiple family therapy, as the name suggests, brings several families together as one supportive and often challenging group to deal with their problems jointly. The multiple family therapy approach was widely used by Murray Bowen (Nichols and Schwartz 1998) and has demonstrated efficacy with families of schizophrenics (Goldstein and Miklowitz 1995). Network therapy (Chapter 11) brings together everyone who is significantly involved with the family and/or individual who presents for treatment, including friends, extended family, neighbors, and members of external systems. The therapy network is directed by a team of two or three professionals whose primary goal is to "stimulate, reflect, and focus the potentials within the network to solve one another's problems" (Speck and Attneave 1972, p. 641). In both of these family therapy approaches, aspects of the therapeutic process parallel the dynamics of traditional group therapy.

This chapter presents an integrated intervention model that has broadened the scope of family therapy interventions, approaching adolescent substance abuse from a developmental-contextual, family-based perspective, using a working knowledge of the influence of group and family dynamics. This multidimensional approach places emphasis on the unique feelings, thoughts, and behaviors of the individuals within the system as well as the interactional patterns occurring within the system. Two questions organize this pursuit: (1) What is the role of the adolescent's family group in the development and maintenance of adolescent substance abuse? and (2) How are these developmental and contextual factors incorporated into and addressed within a multidimensional treatment for adolescent substance abuse?

Reviews of family therapy efficacy research articulate major advances in the field during the past two decades (Lebow and Gurman 1995; Liddle and Dakof 1995b). Manualized family-based approaches have been developed and tested in controlled trials with clinical populations of adolescent substance abusers by several research groups (e.g., Henggeler et al. 1991; Liddle and Dakof 1995b). Specific engagement strategies (Szapocznik et al. 1989) and therapist behaviors related to positive therapeutic alliance (Diamond and Liddle 1993, 1996) have been defined, clinically developed, and empirically tested to improve therapeutic alliances and cohesion and increase retention rates in family therapy with problem youth (Liddle et al. 1998). Family-based interventions have been tested against clinically viable treatment alternatives (e.g., Chamberlain and Reid 1991).

Family therapy has emerged as a promising but not exclusive approach to treating adolescent drug abuse and related problems (Liddle and Dakof 1995a). Family therapy approaches for problem adolescents have been shown to have effects in multiple domains in addition to reducing drug use, including improving school performance, externalizing problems, and reducing internalized distress. *Structural strategic family therapy* has been shown to effectively engage Hispanic adolescents and their parents, reduce drug use and behavior problems, and improve family relations up to one year following treatment (Szapocznik et al. 1989). Among delinquent adolescents followed up to four years, *multisystemic family therapy* (Henggeler et al. 1991) was associated with fewer drug-related arrests and less drug use compared with juvenile delinquents treated in individual therapy and those who refused treatment (Mann et al. 1990). *Multidimen-*

sional family therapy (Liddle, Dakof, and Diamond 1991) is more effective than a family group education intervention, peer group counseling, and individual treatment in reducing drug use and externalizing problems up to one year following treatment. Thus, positive results with clinically referred adolescent drug abusers have shown that family therapy holds great promise in treating this difficult population (Liddle and Dakof 1995a).

The onset and progression of adolescent substance abuse is multiply determined by the interaction of individual, family, peer, and community variables. Therefore, interventions must occur at several levels of the adolescent's functioning. The family-based model described in this chapter was developed specifically to attend to the multiple forces impacting upon the adolescent, intervening within the adolescent, as well as parental, parent-adolescent, and extrafamilal subsystems. Critical changes within each of these subsystems must occur in order to stop the cycle of chronic problem behaviors and heavy substance involvement.

THE FAMILY AND ADOLESCENT DRUG ABUSE

Family risk factors for adolescent drug use and antisocial behavior include parent and sibling modeling of substance abuse, parental attitudes that minimize the child's drug use, poor relationships with parents, and inadequate child-rearing practices (Brook et al. 1990). The close association between adolescent problems and family variables, which often predate the initiation of adolescent problem behaviors (Baumrind 1991; Farrington 1995), establishes the critical influence of families in mediating and/or moderating the development and maintenance of adolescent drug and other problem behaviors. However, changes in parenting practices can impact adolescents' drug initiation as well as their frequency of drug taking after initiation has begun (Steinberg, Fletcher, and Darling 1994), and interventions have been shown to change parenting practices of drug-involved and delinquent youths (Schmidt, Liddle, and Dakof 1996). The family's role in adolescent substance abuse includes (1) ineffective child-rearing practices, (2) family discord, and (3) poor parent-child bonding.

Ineffective Child-Rearing Practices

Baumrind (1991) reports that parents who are nondirective and permissive have children with the highest level of drug use. Lack of both clear limit setting and rules against drug use have been correlated with relatively high levels of drug use among adolescents (Brook et al. 1990). Negative communication patterns (criticism, blaming, lack of praise), unrealistic parental expectations of children, and inconsistent or harsh discipline are strongly correlated with delinquency (Farrington 1995). Parents who do not monitor and structure their children's behaviors and activities place them at high risk for substance abuse and delinquency (Chilcoat, Dishion, and Anthony 1995). Children raised by "authoritative" parents, who are consistent and firm in disciplining the child but also warm, responsive, and respectful of the children's needs and ideas, are less likely to use substances (Steinberg, Fletcher, and Darling 1994). Coombs and Landsverk (1988) described the nonuser's parent as more likely to provide praise and encouragement, set down guidelines and rules about the adolescent's activities, and play an active role in the teenager's life than the user's parents, who are seen as emotionally distant, less helpful, and less likely to establish limits.

Family Discord

A second familial factor associated with adolescent problem behavior is family discord. It is not the disruption of the family due to divorce that contributes to adolescent problems, but the level and management of parental conflict (McCord 1979). Stanton et al. (1982) were among the first researchers to link drug abuse to families in which parental conflict prohibited a strong primary parental coalition. Marital instability both affects child development and makes an independent contribution to adolescent problem behavior and illicit drug use.

Poor Parent-Adolescent Relations

Numerous studies have found that a lack of parental warmth and involvement are positively correlated with drug use (Jessor and Jessor 1977; Brook et al. 1990). Poor relationships among family

members may be more important than parental drug use or parental control in determining adolescent drug use. Parental warmth, support, and interest in the children protects adolescents from drug abuse problems and delinquency (Brook et al. 1990).

The family-based model described in this chapter places primary emphasis on reestablishing the critical connection that is frequently damaged in families of drug-abusing youth. Family members must feel respected and trust that their side of the story will be heard. Individual work with both parents and adolescents addresses the unique issues and concerns of each family member, and prepares the adolescent and parents to come together for the work of repairing strained and often disconnected relationships. The next section presents some clinical interventions describing the role of the family during adolescence and the factors that place adolescents at risk for continued problems, using examples of interventions prescribed in each of the modules of this family therapy approach to correct disruptions in the development of the adolescent.

CLINICAL IMPLICATIONS

This final section offers guidelines for the practical translation of some of the previously outlined research findings within a family treatment approach (MDFT) for adolescent drug abuse (Liddle, Dakof, and Diamond 1991). The interventions described were developed and refined according to empirical findings within the domains of adolescent development, drug abuse risk and protection, as well as adolescent treatment research. Examples of interactions from actual therapy sessions with drug-abusing adolescents and their parents are provided in order to illuminate specific points.

Contemporary thinking endorses interventions that are comprehensive (targeting multiple levels or areas of problem behavior), coherent, and intensive, finding ways to enhance existing treatment models, sometimes by combining various components of existing, empirically based approaches. A multidimensional perspective suggests that change can occur via *multiple pathways or mechanisms* (e.g., cognitive restructuring, affective clarification and expression), *in different contexts* (individual, familial, and extrafamilial), and *through different mechanisms* (e.g., development of a new cognitive framework and acquisition of new skills). The format used an inter-

connected series of sessions/interactions between therapist-adolescent, therapist-parent(s), therapist-extrafamilial systems (e.g., probation officers, school personnel), which gives access to these multiple domains.

Specific Therapeutic Guidelines

Working with families as small groups does not mean abandoning individual therapeutic work. Individual sessions, in which the adolescent and parents are seen separately, comprise up to 40 percent of the total treatment protocol. The therapist organizes therapy by introducing several generic themes (Liddle, Dakof, and Diamond 1991). These are different for the parents (e.g., feeling abused and incapable of finding a way to influence their child) and the adolescent (e.g., feeling disconnected and angry with parents). The therapist uses the generic themes of parent-adolescent conflict as assessment tools and as a way of developing workable content in sessions. Sometimes, interactions with the teenagers or parents are intended to prepare them for a conversation that they will have with the other family member ("what do you need to talk with them about?" and "what can we do now to plan it out?"). Individual work with family members is conducted in accordance with assumptions about mechanisms of change: adolescents and parents will change if they have the motivation, opportunity, skills, and practice to interact in new ways.

Individual Work with the Adolescent

Engaging adolescents in the therapy process is extremely challenging, particularly with adolescent drug abusers, who frequently have been coerced into therapy, do not believe that they have a problem, and are not necessarily motivated to make any significant changes in their lives. It is important to attend to interventions designed to engage the adolescent during the critical first phase of therapy (Diamond and Liddle 1997). Specific therapist behaviors have been identified that relate to the quality of the adolescent-therapist alliance, or therapeutic relationship. Therapists who are able to establish a positive therapeutic alliance with the adolescent present themselves as an ally, help the adolescent to formulate personally meaningful goals, and attend to the adolescent experience (Diamond and Liddle 1997). These techniques

may be helpful in improving therapeutic relationships with unengaged adolescents.

In the first several sessions, the therapist spends a significant amount of time with the adolescent alone in order to hear the adolescent's story, and to provide the adolescent with the opportunity to share things with the therapist privately. Alliance-building techniques are the main focus of early interactions with the adolescent. In the following example of a first session with a drug-abusing adolescent, the therapist notes that the parent has offered most of the information about why the adolescent and she are coming to therapy, and the adolescent has been withdrawn and seemingly frustrated with being forced to come for therapy. The therapist uses time alone with the adolescent to hear about the things that upset him most about his current situation, and the adolescent explains to the therapist that whenever he tries to talk to his mom about his problems, they end up arguing. The therapist offers the following statement to the adolescent in an attempt to show him that there is something in this therapy for him:

> One of the things that we do here, and that I'm going to try to help you to do, is to try to have these kinds of conversations without arguing, to find a way to sort of negotiate so that you feel that you get your story out. This isn't just about what your mom or your probation officer have to say—you have a story to tell. You have a perspective. You started to say some of that today, and that's going to be really important. I want to help you say some of those things in a way that your mom and your probation officer and the people at school can hear. I hear you saying some important things, like "I want to build Mom's trust back," and "I want to be able to talk to Mom about some of these things that are important to me and feel like I'm being heard." I hope that I can help you do that in here.

The adolescent responds to this intervention by sharing more about his frustration with being treated like a child, and the therapist is able to offer the suggestion that therapy can be about negotiating with his mother to gain back some of his privileges.

Drug abuse derails adolescent development (Kandel and Davies 1996). Adolescent drug abusers have profound feelings of meaninglessness, low self-efficacy, and tend to lack commitment to and involvement in normative, prosocial activities and bonds. The individ-

ual subsystem sessions focus on important tasks of development, such as decision making, developing effective communication skills, and problem-solving. Drug use is discussed from a perspective of the negative ways in which it impacts one's health and one's perceptions of the world. Drug use is seen as an ineffective solution for bad feelings about oneself and the world, and the therapist helps the adolescents to identify the ways in which their drug use fails in meeting their needs. The therapist takes advantages of opportunities throughout the therapy process to explore with the adolescent how drug use makes these short-term gains difficult or impossible, reminding the adolescent of the "big picture."

The overall themes of individual work with the adolescent pertain to identity formation issues, self-efficacy, and the development of the adolescent as an individual and as a participant in multiple other interpersonal contexts. Change for the adolescent and the parent is both intrapersonal and interpersonal, and neither is more important. Helping the adolescent prepare for a conversation with parents increases self-efficacy and feelings of competence. Exploration of new ways of communicating thoughts and feelings is also critical because it increases the likelihood of more positive responses from the parent. In many cases, parents have given up hope of being able to talk honestly with the adolescent, or feel that they have no way of reaching the adolescent in any meaningful way. When adolescents act in new ways, the parents' feelings and beliefs about them change, and their commitment and involvement can be resuscitated, which is critical to treatment success (Dishion, Patterson, and Reid 1988). Parents who can experience the new behaviors and attitudes of their adolescent are then more likely to develop the attitudinal set necessary to renegotiate the parent-adolescent transition (Schmidt, Liddle, and Dakof 1996).

Individual Work with Parents

Running parallel to these adolescent subsystem sessions are sessions or parts of sessions with the parental subsystem. Parenting styles are directly related to adolescent drug abuse (Baumrind 1991; Brook et al. 1990), and thus are a direct intervention target. Parental belief systems pertaining to adolescents are addressed in order to propose fresh perspective skills for parenting adolescents. Parents are helped to examine the consistency between their parental philosophy

(policy) and the implementation of this policy (in the form of their parenting styles), examining parental influence that is appropriate for adolescence. Parents learn to decide more appropriately which "battles" to choose, and engage the adolescent in more effective interactions.

The alliance between the therapist and parents is critical in promoting change during therapy. Interventions designed to bring parents into collaboration with the therapist are called "Parental Reconnection Interventions" (PRI). The ultimate aim of PRI is to have the parent reconnect on an affective level with the adolescent, and hence recommit to trying to help him or her (i.e., reclaim their parenting role and functions). The following techniques comprise the PRI:

1. *Focusing on parents' stress and burden*, acknowledging the difficult circumstances that impede parenting, as well as acknowledging that the parent has individual issues and problems.
2. *Identifying and supporting previous or current parenting efforts*, confirming examples of successful parenting behaviors and abilities.
3. *Enhancing feelings of love and commitment*, including therapist behaviors that facilitate a parent's experience and feelings of love, caring, and commitment toward the adolescent.
4. *Addressing important events, core issues, or themes* in the parent-adolescent relationship to bring issues of conflict and hurt out into the open.
5. *Enhancing beliefs in parental influence*, including planned discussions about the degree to which parents believe they can influence their adolescent's life for the better.
6. *Generating hope: Therapist as an ally*, involving interventions instilling hope that the therapist is willing to work with, stand by, and support the parents in their attempts to influence the adolescent. These interventions are critical in changing parenting behaviors.

Parents of problem youth present with both strengths and weaknesses (Schmidt, Liddle, and Dakof 1996). Parental strengths, or positive parenting practices, are identified early in therapy, and the therapist utilizes these behaviors during sessions and makes suggestions for building these behaviors outside of sessions. These behaviors in-

clude positive discipline and communication, monitoring and limit setting, positive affect and commitment, and interparent consistency. Negative parenting behaviors fall into categories defined by power, assertive discipline, problems in monitoring and limit setting, inconsistency between parents, negative affect and disengagement, and cognitive inflexibility. It is easier to replace negative parenting practices by introducing new, positive parenting behaviors than it is to focus solely on getting rid of negative behaviors. Most parents show significant improvements over the course of MDFT, including an increase in positive parenting behaviors and a decrease in less effective parenting practices. These improvements have been linked to reductions in adolescents' drug use and externalizing problems (Schmidt, Liddle, and Dakof 1996).

This vignette shows how parenting behaviors are frequently closely tied to the emotional climate of the parent-adolescent relationship. Parenting style, or the emotional context in which parenting practices are delivered, largely determines the impact and effectiveness of parenting behaviors upon the adolescent (Darling and Steinberg 1993). The father's "preaching" is examined as the father's basic parenting tool as well as the main way that the father interacts with his son. The therapist suggests that a different, more fulfilling, and more effective way of communicating with his son might exist.

T: I'm really interested in two things you just said. You feel like you've been doing a lot of preaching. Let me ask you—what kind of response do you get when you preach?

D: I get the sense that most of the time it's going in one ear and out the other. But I resolved myself a long, long time ago that I don't care if it does or not—I'm going to do it anyway. You know? At least he's going to hear how I feel about this—my principles and what I expect. It's up to him if he wants to take it and go with it or not, but at least I'm going to let him know. Maybe it's preaching, but we interact.

T: When you're preaching about important things like his future plans, or how he's dealing with his life now, you say he doesn't really get a chance to talk.

D: Right. He doesn't say much. He doesn't give much input back.

T: Is that something you're interested in? Would you like to hear his thoughts?

D: Oh yeah! 'Cause I'd like to help him along in what he wants to do. But up until this point I always felt that he didn't know what he wants to do.

T: Preaching doesn't lead to the kinds of conversations you want to have with him. I think you're right—it goes in one ear and out the other. But there is a different way of having a conversation with Jim. It would be more satisfying for you, because you'd be heard. He's not going to do everything you say, but I think he's going to consider what you say in a different way.

D: Right—that's the important thing—I just want to know that I have tried to tell him what I think about the things he's doing. But I know when it comes out, it's not coming out in that way—that loving, caring way. I don't know how it comes out, but I know it doesn't come out the way I think it comes out. . . . I want to help him, but I must come off like I'm yelling at him. He gets afraid. . . . The next thing I know, he's got tears in his eyes. I start out trying to help him, and I'm hurting the kid.

T: It sounds to me like you're an involved, caring father. I think that's a great thing and I want to help you reach out in a way where you don't feel frustrated. We're going to have to think about that together—how to do that. I think there's a way for you to be there for Jim and help him grapple with these things, without doing it all for him.

Bringing Parents and Adolescents Together

Facilitating new methods of relating and opening lines of communication that have been shut down due to years of disappointment and conflict are important goals of work with parents and adolescents. Once the therapist has joined with each family member and has helped the parent and adolescent individually to "sign on" to the therapeutic process, significant work in the parent-adolescent relational domain can begin.

Specific interventions can break impasses that frequently occur during individual and group sessions with adolescents and their parents and block in-session progress (Diamond and Liddle 1996). Therapists use three basic techniques in successful resolutions of in-session impasses: (1) actively blocking or diverting, or working through negative affect, blame, and resistance; (2) implanting, evok-

ing, and amplifying thoughts and feelings that promote constructive dialogue; and (3) crafting an emotional treaty using "shuttle diplomacy." These techniques have been found to be more difficult to utilize, and failure to resolve impasses has been shown to be more likely in families that were initially more conflicted and pessimistic. The process of resolving therapeutic impasses between the parent and adolescent involves several critical interventions. First, the therapist transforms parents' blaming and hopelessness by focusing on feelings of regret and loss, bringing the parents to a more vulnerable position in which they can be open to and listen to the adolescent. In order to engage the adolescent in this process, the therapist asks the adolescent if he or she believes that the parent is actually concerned. This provides the opportunity for the adolescent to share his or her experience. The therapist moves the conversation into the parent-adolescent relationship domain, asking the parent to listen and respond to the adolescent's belief and/or disbelief. Finally, the therapist amplifies the parent's empathy by offering support and admiration, which helps to facilitate further disclosure by the adolescent and an open dialogue between family members. The resolution of therapeutic impasses is one example of how therapists work in the relational domain.

The following segment offers an example of how the therapist works through an impasse, pulling for a different emotional tone and reaching a new level of openness between the parent and adolescent. In this session, the adolescent is angry and refuses to talk about a fight he and his mother had after she realized his girlfriend had spent the night in their home. The mother in this session insists that she is happy with how she handled the situation and feels that the issue is resolved. The adolescent, however, is clearly very angry about the argument. The therapist has the option of letting the issue die, but decides to push the mother to use this as an opportunity to find out more about her son's feelings and thoughts about intimacy and sexuality.

T: Let's go a little bit further and let's find out—I mean this is a big topic for a kid his age. He's starting to be sexually active and he's got to make decisions about this. Could you help him think through some of this? Does he want to be a father? Doesn't he? If he was a father, what would he do?

M: Do you want a child?

A: Not now.

M: If you keep having sex and someone comes to you and says they're pregnant, what would you do?

A: I would be there for her as the father . . . but I don't know . . .

T: Follow that up. Find out what he means.

M: What does it mean to be with someone?

A: To me to be with someone is to go places together, talk over the phone, do things together. Like that.

T: Have you ever had a relationship like that?

A: Just once—it was like five months.

T: [To mom] Did you know her? Did you like her?

M: Yeah—she was a sweet girl and she cared about him. He cried over her. Even this one now—I see that he really cares about her.

T: It sounds to me like you like being in a relationship. [Mom and adolescent both nod yes. Therapist turns to Mom.] You say yes. How do you know that? You think he enjoys being with someone?

M: He just likes having a girl he can talk with, laugh with, go places with. I see he gets real emotional about the girls he's with.

T: [To mom] You sound impressed about your son's sensitivity with women and relationships. It sounds like there's a lot more going on with him than just sleeping around and wanting his girlfriend to sleep over. I think he must have learned that sensitivity somewhere, and I'm thinking he has ideas and memories about what it was like for you to go through your relationships. Can you ask him what he remembers about you being in relationships?

The adolescent and his mother talk for the rest of the session about her relationship with his father, and how his father was not able to show him how to be in a stable, caring relationship. As they share their memories of this time in their lives, the adolescent talks more about what type of husband and father he would like to be. The adolescent and his mother have talked for the first time about the most important things in the adolescent's life, and they have opened lines of communication that were closed with hostility and resentment. The therapist moves the conversation into the realm of their relationship, and helps the adolescent and parent find a new way of talking about an issue that is and will continue to be central in each of their lives.

In summary, working in this way requires many conceptual and personal challenges for the therapist. A deep knowledge of the developmental issues of the adolescent period, family risk factors for adolescent substance abuse problems, and the transformations that typically occur in the parent-adolescent relationship, including changes in group cohesion in the family, provides a conceptual foundation for family-based interventions with adolescents. Comfort and knowledge in building and maintaining separate therapeutic alliances with the parent and the teenager is essential in this process. The ability to conceptualize family therapy and individual sessions in a stage-specific sense guides therapy in each domain.

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