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ADOLESCENT

SUBSTANCE

ABUSE

Etiology, Treatment, and Prevention

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The Adolescent Module in Multidimensional Family Therapy

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Michelle Holt, Jacqueline Aroyo, and Michael Watson

Basic clinical research has clarified the family's role in the formation, maintenance, and treatment of adolescent drug abuse (e.g., Baumrind, 1989; Baumrind & Moselle, 1985; Bernal & Flores-Ortiz, 1991; Brook, Whiteman, Nomura, Gordon, & Cohen, 1988; Coombs & Landsverk, 1988; Dishion, Patterson, & Reid, 1988; Dishion, Reid, & Patterson, 1988; Pandina & Schuele, 1983). Although a review of family intervention programs indicates that family treatment is a promising approach for adolescent drug abuse (Bry, 1988; Davidge & Forman, 1988; Liddle & Schmidt, 1991; Todd & Selekman, 1991), only carefully constructed, empirically based clinical models will fulfill the promise of family systems interventions (Liddle, 1991b).

In the mid-1980s, the National Institute on Drug Abuse (NIDA) launched an initiative to address the possibilities of constructing family therapy models to treat adolescent drug abuse. Because several clinical research teams had empirically established successful family therapy approaches for drug abuse (e.g., Stanton & Todd, 1982; Szapocznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1983), the NIDA was interested in determining whether effective family therapy treatment models could be developed with adolescents (Joanning, Lewis, & Liddle, 1990; National Institutes of Health, 1983; Todd & Selekman, 1991). The NIDA's

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interest in this area has continued with its funding of the first treatment evaluation research center to study family therapy approaches for adolescent drug abuse—the Center for Research on Adolescent Drug Abuse. The first approach developed in a NIDA-funded study, the Adolescents and Families Project, continues to be tested and refined in the Center. The Adolescents and Families Project began in 1985 at the University of California, San Francisco and moved to Temple University in April of 1990.

MULTIDIMENSIONAL FAMILY THERAPY

A multisystemic treatment approach for adolescent substance abuse and its correlated behavior problems (Liddle, 1991a, 1991c), multidimensional family therapy has its roots in the integrative structural-strategic family therapy tradition (Fraser, 1986; Stanton, 1981; Todd, 1986). It incorporates additional notions about the targets, mechanisms, and methods of change, however. The multidimensional family therapy approach developed for the Adolescents and Families Project, for instance, (1) does not use paradoxical interventions, (2) does not employ a function of the symptom concept, (3) does not draw primarily from other schools of family therapy for its tenets and methods, (4) is not ahistorical in its focus, (5) uses adolescent development research to guide its assessments and interventions, (6) requires working with individuals in the course of treatment more than the structural-strategic models, and (7) employs knowledge and methods from the skills-based intervention approaches with adolescents.

The clinical research program's mandate to construct a specialized treatment model for adolescent substance abuse led to the model's refinement. This activity, tailoring an existing integrative approach, was also influenced by two contemporary trends in drug abuse treatment (Liddle & Schmidt, 1991; National Institutes of Health, 1983) and psychotherapy (Miller & Prinz, 1991)—treatment development (i.e., greater particularization of treatment models, population-specific treatment manuals, theory-specific outcome, therapy process specification) and model enhancement (i.e., the reconstruction of treatment packages for specific purposes).

Conceptually, multidimensional family therapy reflects the growing, perhaps standard, trend to conceive of adolescent problems such as drug use and delinquency as correlated behaviors (Elliott, Huizinga, & Ageton, 1985; Kazdin, 1987). Dishion, Reid, and Patterson (1988) argued that drug abuse and delinquency are "somewhat different aspects of a unified behavioral process" (p. 189). This perspective typifies the contemporary work in this area, which is beginning to clarify the strong relationship of adolescent substance abuse to conduct disorder (Bukstein, Brent, & Kaminer, 1989). Investigators and clinicians alike have reached a consensus on the importance of understanding adolescent problems in

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a multivariate, multisystemic, nonreductionistic fashion (Dishion & Loeber, 1985; Fishman, 1986; Henggeler et al., 1986; Jessor & Jessor, 1977; Pandina & Schuele, 1983). Newcomb and Bentler (1989) summarized the treatment implications of this empirically derived perspective:

Substance use and abuse during adolescence are 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. (p. 243)

Multidimensional Family Therapy in the Context of Other Family Therapy Approaches

The multidimensional family therapy approach has several features that distinguish it from contemporary family therapy models. First, it is a research-based approach. Although there are several well articulated, empirically based family treatment models for adolescent problems of drug abuse and conduct disorder (e.g., Alexander, Klein, & Parsons, 1977; Alexander & Parsons, 1973; Barton, Alexander, Waldron, Turner, & Warburton, 1985; Henggeler et al., 1986; Lewis, Piercy, Sprenkle, & Trepper, 1990a; Robin & Foster, 1989; Szapocznik et al., 1988), others fall outside the context of systematic evaluation and research (Fishman, 1986; Jurich, 1990). Family therapy, however, is now in an era that is less tolerant of approaches that lag behind in evaluation, regardless of their logical or intuitive appeal (Erickson, 1988; Liddle, 1990b).

Second, developed in a specific context for particular purposes, multidimensional family therapy is a specialized model designed to treat the problem behavior syndrome (Jessor & Jessor, 1977) or cluster (Kazdin, 1987) of adolescent problems of substance abuse and conduct problems. Philosophically, it is consistent with calls for specialization in therapy model construction (Achenbach, 1986; Goldfried & Wolfe, 1988; Gurman, 1988; Liddle, 1990a; Pinsof, 1989).

Third, this approach takes into account the problems associated with the tendency of some family therapy models to endorse family reductionism—the crediting or blaming of health and pathology on the family. Accordingly, multidimensional family therapy emphasizes individuals as systems and subsystems more than do many other contemporary family therapy approaches.

Its multidimensional focus is a fourth distinguishing feature of this model. For example, integrating assessment dimensions such as cognitive attributions, affective states, and recollections of the past with communication and social skills training is not the usual fare for family therapy models. Another aspect of multi-

dimensionality is the import of extrafamilial factors in maintaining and treating adolescent problems. Peer, educational, and juvenile justice systems, in addition to individual and family domains, are principal areas of assessment and intervention in any multisystemic, multidimensional model.

A fifth factor concerns the integrative nature of the model. Although still lagging behind that in the psychotherapy field, the integrative tradition in family therapy is beginning to take hold (Lebow, 1987). Still, most family therapy integrative models, particularly those designed for the treatment of adolescent drug abuse, have relied on other models of family therapy for their sources of integration. For instance, approaches for adolescent substance abusers, such as those outlined by Ellis (1986), Lewis, Piercy, Sprenkle, and Trepper (1990b), and Todd and Selekman (1991), rely primarily on structural, strategic, brief therapy, behavioral, and systemic schools of family therapy, while the approach developed by Joanning (1991) represents the radical constructivist wing of family therapy. Existing within a family psychology framework (Kaslow, 1987; Liddle, 1987a, 1987b), multidimensional family therapy is more comprehensive than are most contemporary family therapy models and makes it possible to avoid the problems of some integrative family therapy models that underutilize basic knowledge of psychological principles and content (Liddle, Schmidt, & Ettinger, in press).

A sixth distinguishing characteristic of multidimensional family therapy concerns its emphasis on the adolescent in the context of family therapy for adolescent problems. The adolescent is a prominent figure in the successful conduct of this therapy, and treatment is seen as disadvantaged if he or she does not participate fully. Therefore, engagement is a primary emphasis of the clinician's early work. The adolescent should feel that therapy can be a context in which his or her individual concerns can be met.

Finally, the incorporation of empirical findings of developmental and adolescent psychology into the clinical model is a core characteristic of multidimensional family therapy (Liddle, Schmidt, & Ettinger, in press). Too few have appreciated the need for this activity in family therapy. Many family therapists (1) make incorrect assumptions about adolescent development (e.g., Pittman, 1987); (2) urge mobilization a priori to counter anticipated adolescent resistance (Jurich, 1990); and (3) ignore or minimize individual adolescent development issues (Berg & Gallagher, 1991; Durrant & Coles, 1991; Fisch, 1989; Heath & Ayers, 1991), while overfocusing on parental power and authority (Fox, 1991; Haley, 1981) and correction of "incongruous hierarchies" (Madanes, 1981, 1985). Multidimensional family therapy, in contrast, uses existing knowledge of the ways in which families serve as buffering or protective mechanisms against the influence of deviant peer and societal influences (e.g., Burke & Weir, 1978, 1979; Greenberg, Siegel, & Leitch, 1983; Larson, 1983; Steinberg & Silverberg, 1986; Wills, 1990), as well as empirical work on the ways in which positive fam-

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ily relations in the adolescent years foster competence, such as self-confidence (Ryan & Lynch, 1989), self-regulation and exploratory behavior (Hartrup, 1979; Hill, 1980; Hill & Holmbeck, 1986), autonomy (Steinberg, 1987, 1990), and ego development of both the teen-ager (Hauser et al., 1984) and the parent (Hauser, Borman, Jacobson, Powers, & Noam, 1991).

Clinical Use of Adolescent Development Research

The history of adolescent psychology has been dominated by the theoretically derived belief that separation/individuation constitutes the central task of adolescence. Modern day developmental research challenges this position. Empirical evidence demonstrates, for example, that positive parent-child relationships foster and predict healthy adolescent development (Hauser et al., 1985; Hill, 1980; Montemayor, 1983, 1986) and that families serve as a primary context of adolescent development (Grotevant & Cooper, 1983; Hauser et al., 1984). Research in this area also indicates that emotional support from the family has a protective or buffering effect against substance abuse (Burke & Weir, 1978; Greenberg, Siegel, & Leitch, 1983; Larson, 1983). Wills and Vaughn (1989) found that, when there is a high level of substance abuse in the peer network, family, but not peer, support had protective effects. Wills (1990) concluded:

Many parents believe that they are powerless in the face of peer pressures toward adolescent deviance. To the contrary, my findings indicate that parents, through the support they provide to teens, can have considerable favorable influence . . . parents protect their teens by being interested in and available to talk about problems. (p. 91)

Research findings such as these have helped to depose separation/individuation as the goal of adolescence. Parent-child interdependence has come to be seen as the optimal developmental condition. As Steinberg (1990) noted,

Transformations in family relations at adolescence reflect the adolescent's growing understanding of his or her *interdependence* within the family and the parents' willingness to engage in a process through which close ties are maintained but the young person's individuality is not threatened. (p. 265)

Youniss and Smollar (1985) stated,

Both parent and adolescent actively participate in the mutual and reciprocal process of redefining the relationship. Transformation of the rela-

tionship from one of unilateral authority to one of cooperative negotiation is necessary for the adolescent's social and psychological development to proceed on course; a severing of the parent-child bond jeopardizes this process. (p. 265)

When the parent-child relationship falters or remains poor over time, an adolescent's psychosocial growth deviates from normative parameters (Baumrind & Moselle, 1985; Kellam, Brown, Rubin, & Ensminger, 1983; Newcomb & Bentler, 1988a, 1988b; Shedler & Block, 1990).

The two primary dimensions of family relations, organization and cohesion, have important clinical implications. Given the degree of disengagement and lack of cohesion in the families of adolescent drug abusers, interventions that rely primarily on parental hierarchy and power (organization) can further alienate an already estranged teen-ager. Therefore, increasing cohesion (i.e., developmentally appropriate attachment) among the family members becomes an essential goal. Rather than unilateral closeness, cohesion between adolescents and parents involves, as indicated, the negotiation of new modes of interdependence (Silverberg & Steinberg, 1987; Steinberg, *in press*)—a relationship definition that coincides with the developmental needs of teen-agers.

Reformulated to fit the developmental period of the second decade of life, attachment has been an important concept in multidimensional family therapy (Greenberg et al., 1983). Youniss and Smollar (1985) reached a conclusion that is representative of those reached by a wide array of adolescent development researchers.

In healthy families, adolescents remain responsive to parental authority and continue to seek parents' advice, but they do so in a context of greater freedom. The parents, at the same time, retain their authority through giving more freedom to adolescents by recognizing their personal needs and capabilities. . . . It is clear that parental relationships have not been discarded nor have they lost their binding power. In fact, the adolescents said that the transformation helped to bring them and their parents closer. (pp. 162-163)

Conceptual Framework

Multidimensional family therapy draws from contemporary work that emphasizes the continuous interplay and reciprocally determining relationship between cognition, affect, behavior, and environmental input and feedback (e.g., Bandura,

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temporary work that emphasizes strengthening relationship between parent and adolescent and feedback (e.g., Bandura,

1978; Greenberg & Safran, 1987; Mahoney, 1984; Wachtel, 1977). In the words of Bandura (1986),

Conceptions of human behavior in terms of unidirectional personal determinism are just as unsatisfying as those espousing unidirectional environmental determinism. (pp. 22-23)

Rather, human functioning is explained in terms of a model of triadic reciprocity in which behavior, cognitive and other personal factors, and environmental events all operate as interacting determinants of each other. (p. 18)

Fundamental to the treatment model as well are the ecological (Bronfenbrenner, 1983), dynamic-interactional (Lerner, 1978), and interactional (Magnusson, 1988) perspectives on human development. This holistic conception of development underscores "the organization and integration of capacities in various developmental domains" (Reider & Cicchetti, 1990, p. 382). Also influential has been developmental psychopathology with its roots in a thorough understanding of problems in their developmental context (Achenbach, 1990; Cicchetti, 1984; Kazdin, 1989; Rutter & Sroufe, 1984).

The key assumptions of multidimensional family therapy, which have been drawn in large part from the theories that have been briefly mentioned, include the following:

- complexity of human functioning. The premise that people function simultaneously in numerous domains of human existence (e.g., affective, cognitive, behavioral, temporal, moral/ethical, spiritual, interpersonal) is hardly a new revelation. For more than 20 years, for example, the social cognition area has contributed substantially to the understanding of the links between cognition, emotion, and behavior (Shantz, 1983).
- interconnectedness across domains. Although the domains of human existence are interconnected, the mechanisms that govern these relationships are not always apparent.
- practical implications of this perspective. In therapy, problems can be accessed through these related domains of human functioning. By implication, solutions to these problems can be generated within any one (or more) of these domains. Work in the domain of emotion, for example, is related to the belief systems and behavioral repertoires. The therapist must maintain access to these interrelated areas and must understand the accessing and potentiating aspects of one domain upon another.
- potential pitfalls of a univariate or narrow perspective. Therapists are handicapped if they work only in one domain or consider one domain more impor-

tant than another. Multidimensional family therapy avoids a univariate focus at both assessment and intervention levels.

- clinical advantages. At a practical, clinical, decision-making level, a clinician who uses multidimensional family therapy has available multiple targets for change.

WHITHER INTERVENTIONS: THE CASE FOR MODULES

Because the term *intervention* infers a single technique or method, the term *modules* better organizes and defines the content domains of the multidimensional family therapy model. Modules indicate the "territories" in which the therapist needs to operate. Cognitive psychologists may refer to the module notion as a therapist's schemata. Just as "chunking" allows chess masters to think of several moves and countermoves at once, in a series of interconnected "chunks," modules allow therapists to think in larger units.

A vignette from live supervision may help to illustrate the usefulness of this thinking device. Live supervision is a training method in which a supervisor observes a session as it occurs. It allows the supervisor to offer suggestions to the therapist-trainee through a telephone connection between the observation and therapy room. As Haley (1976) said in describing this method, live supervision provides help to a therapist when he or she needs it most—during the conduct of an actual session. At its worst, live supervision can be disorienting and therapeutically harmful (Liddle & Schwartz, 1983; Montalvo, 1973), particularly when there is poor case planning, difficulty in formulating overall working themes, and/or a therapist with a low skill. If, for example, a therapist repeats a phrase phoned in by a supervisor, but does not have a broader theme in which the phrase or single intervention fits, the therapist has no broader direction to follow after the single intervention has run its course. Left without a theme to play, the therapist sits in the session waiting for the supervisor to call with the next (decontextualized) "intervention."

Rather than relying on single interventions per se, therapists who follow the multidimensional family therapy model operate according to essential modules or units of treatment. These modules include territories to be covered, agenda items to be developed, and generic themes to be explored. They are inextricably connected to the treatment model within which they were developed.

There are different levels of modules as well. At one level, modules are broadly defined as themes or foci. These basic building blocks of the content of therapy become actualized in a majority of cases. Such modules include engaging the adolescent, working with the parental subsystem, establishing and working with themes with parental and adolescent subsystems together, and including extrafamilial influences in treatment.

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FOR MODULES

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Modules at a more narrow level are "subroutines" or conceptual content units that help operationalize therapeutic strategy and research-based knowledge. At this more prescriptive level, modules are suggested "lines" or minispeeches that the therapist is prepared to deliver when the occasion arises. Modules also assist in establishing certain content domains over others. They give therapists a practical way of creating certain content themes within the session. In this therapy, not all content is created equal, and some conversations are judged more important than are others.

Modules are advantageous for other reasons as well. They prepare the therapist for several common situations. They also provide a shorthand or code that allows the therapist and supervisor to communicate expeditiously about volumes of content with a single phrase. Most important, however, modules are meant to be "worked," interactionally, in conversation with the family members. They are vehicles by which to establish content themes in sessions. Finally, in addition to establishing a content territory in a session, modules develop the therapist's position about that content territory.

CLINICAL APPLICATIONS

The overall goal of multidimensional family therapy is the improvement of family relationships so that the family can act as a buffering mechanism against the deviant and destructive behavior of its youth (e.g., Wills, 1990). Care is taken to avoid the excesses of approaches with teen-agers that overemphasize parental control functions, because such approaches can exacerbate the alienation and disengagement of the teen-ager. Therapy not only helps to renegotiate the parent-adolescent transition, but also addresses and heals prior relationship hurts.

A new developmentally appropriate relationship evolves between parent and adolescent. This relationship allows a parent to begin anew, offering guidance and influence within new, developmentally guided parameters. The parent is available to the teen-ager for support, yet is not afraid to make demands. Parents learn to balance the two principal aspects of their parenting practices—guidance and support. Therapy helps them to rekindle their commitment, hopes, and dreams for their adolescent, despite the problems that he or she has caused.

At the same time, the teen-ager in this relationship is not in a reactive or avoidant stance vis-à-vis the parents. Adolescents in a developmentally appropriate relationship with their parents are able to discuss certain aspects, although certainly not all of their life with their parent(s), and they remain connected to a healthy, vital peer network and sphere of activities. The therapist connects and at times translates the parent's and adolescent's experience of the other. Seeing the adolescent and parents separately throughout therapy accentuates this intermediary function. When a crisis has occurred or the affect regulation ability of parents

and teen-ager is low, separate sessions buy time until each can adopt a less extreme stance and can constructively address and communicate the strong emotions aroused by the other.

The instigation of these processes is challenging, given the degree of (often longstanding) emotional distance, disenchantment, and hostility evident in these families (Burke & Weir, 1978, 1979; Mann, Borduin, Henggeler, & Blaske, 1990). Participation in environments such as these extracts a severe psychological price (Rook, 1984). A critical step in reconnecting the parent and adolescent occurs at therapy's outset. Without success in this area, therapeutic efforts to repair the relationship often remain incomplete.

Defining Therapy with the Adolescent

Adolescents who abuse drugs commonly feel disrespected, abused, and believe themselves to be hardly worth listening to—mostly, they are told to listen and be quiet. Many people (e.g., family members, school personnel, and probation officers) have agreed the teen-ager's behavior and/or personality is undesirable. The therapist should aim to create a new experience for the adolescent, one that is in keeping with some the most basic elements of any counseling relationship. Alliance building is not simply a strategy to obtain the adolescent's cooperation; it represents a genuine interest in and commitment to the adolescent's well-being. Presenting the possibility of a relationship in which the adolescent will be cared about, respected, and listened to is a basic first step of engagement.

Therapist: So what do you think of this?

Larry: It's cool.

Therapist: You've never been in therapy like this have you?

Larry: No, not like this.

Therapist: Do you feel nervous, do you feel . . .

Larry: No. It's just another counseling?

Therapist: I don't think it's going to be another counseling. That's not the way I work. I think we could do a lot here. But, I guess one thing I want to know is whether you're going to work with me. You know what I mean by that?

[Larry nods.]

Therapist: You see, I'm really interested in who you are, and I really want to know more about you. I want to know who you are in this family, and who you want to be, as your own person, Larry.

The therapist tries to make this therapy different from other attempts at therapy by clearly inviting the teen-ager's full participation. Great care is taken to help the

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adolescent feel that he or she will be an inherent part of the treatment. New expectations are offered. The therapist tries to enable and challenge the teen-ager to assume a proactive stance toward therapy—to use each therapy session as a place to clarify thoughts, feelings, and future dreams. Anchored in the therapeutic alliance, this activity creates a laboratory in which to address some of the normal developmental challenges of adolescence, as well as to solve some of the current areas of stress for the adolescent.

Developing a Collaborative Set

The adolescent's conception of therapy must be discussed. This discussion is an opportunity for the therapist to define the work as different from that which may have taken place in the past. The therapist works quickly to define some concrete areas that can be the focus of therapy. These areas, of course, must have salience for the teen-ager.

Therapist: But, I'm going to need your help. Do you think you can help me with it?

Larry: I can try.

Therapist: Yeah? You think it's going to be hard?

Larry: Yeah.

Therapist: What do you think it'll mean?

Larry: I don't know, man. I don't think counseling does any good. If you want to get in trouble, you get in trouble no matter who tells you not to. If you don't wanna get in trouble you won't get in trouble no matter who tells you to get in trouble. So I don't really think counseling does anything.

Therapist: Hm. Well, . . .

Larry: But I could be wrong.

Therapist: Well, you told me last week when the big fight happened with your father, that you don't like dealing with your anger that way.

Larry: I don't, man, but that doesn't mean any of you are gonna make me change. . . . Maybe I'm wrong, I'm not saying I'm not.

Therapist: Would you be interested in learning how to deal with things better?

Larry: Yeah. I would.

Therapist: That's something we could do here.

In this case, the adolescent initially resists the therapist's requests. His disbelief in counseling indicates a pessimistic attitude and an inability to imagine a meaningful future. Themes of meaninglessness have been common in the identities of

adolescents involved with drugs (Bentler, Harlow, & Newcomb 1986; Newcomb & Harlow, 1986). Furthermore, drug-using adolescents are at high risk for what has been called identity diffusion—a failure to develop the skills necessary to take hold of their own lives and, as a result, consolidation of their identities around a negative self-image (Baumrind, 1985). The therapist resuscitates or creates the adolescent's natural desires for growth and health. The individual sessions with the teen-ager often focus on the development of an expanded repertoire of interpersonal skills, which have frequently been found to be in need of work with troubled adolescents (Dodge, 1980; Dodge, Murphy, & Buchsbaum, 1984; Hansen, Watson-Perczel, & Christopher, 1989).

Understanding the Adolescent's Affect

Teen-agers frequently present themselves with an aura of impermeability (e.g., "I'm tough," "I'm hip," "I don't care"). Professional and public perceptions of adolescents further these stereotypes (Offer, Ostrov, & Howard, 1981). Therapists must not be taken in by these false and misleading characterizations. Multidimensional family therapy facilitates therapist-adolescent engagement by accessing different aspects of the teen-ager's emotional world that, too often, go unexplored. Feelings of vulnerability, sadness, and tenderness, for example, are frequently assumed to be therapeutically inaccessible with teen-agers. Yet, with skill and an appreciation of these sensitive themes, the therapist can facilitate engagement and develop substantive content by working with these underappreciated and sometimes avoided domains of a teen-ager's existence.

The adolescent's ability to process and constructively express emotions is often weak. In fact, emotion regulation and the management of aggressive impulses have been found to be significant deficit areas in clinical populations (Aber, Allen, Carlson, & Cicchetti, in press). Many teen-agers become overwhelmed and cognitively disorganized when dealing with their emotions in the early stage of treatment. This domain of work has benefits for engagement and substantively for the therapy as well, however. For example, the therapist may use an event that he or she witnessed (e.g., the fight between Larry and his dad) to connect with the affective domain of the teen-ager and offer alternatives that therapy can address.

Therapist: You know, you didn't look so happy when you were hitting your dad. You told me you hate when you get mad at him. I didn't think you looked too happy. Tonight you didn't look happy. Maybe you didn't like what they were saying, or you feel they don't understand you. Maybe you feel like you get caught between them when they argue. You know, it's a hard situation, your parents being separated. They're still working out their own problems. It's going to affect you. I know that's

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rough. So, I want to help you work through some of this in a way that
 would make things better for you.

Larry: [Indifferently]: Yeah.

Therapist: Would you like to see things change?

Larry: Sure.

The therapist has specified some salient emotional themes (e.g., anger, marital conflict, parents' separation) that are rarely acknowledged in this teen-ager's life. By communicating therapy's possibilities for addressing the significant issues of this teen-ager's life, the therapist makes the sessions an arena for a teen-ager's developmental growth. Adolescents learn to manage difficult emotions; take another's perspective; cope with life's disappointments; and make mature claims for attention, respect, and love.

Meeting Developmental Challenges

For adolescents who abuse drugs, cognitive sophistication often lags behind developmental expectations. Teen-agers should be acquiring the skills in formal operational thinking, self-reflection, and the ability to make choices based on abstract ideas rather than on concrete experience. Amotivational syndrome, which is characterized by apathy, mental laziness, and withdrawal from demanding social stimuli (Baumrind & Moselle, 1985) and is thought to be exacerbated by drug use, particularly extensive marijuana use, may contribute to inhibitions in this area.

At its best, therapy stimulates the growth of these skills. The therapist asks the adolescents to reflect on their behavior; to confront avoided interpersonal problem situations (with new attributions and skills); and to wrestle with ideas about what they want from therapy, from the family, and from life.

Therapist: It sounds like Dad would like to be closer to you. Is that something you share also?

Larry: I don't know.

Therapist: You don't know? Hm . . . Well, . . . it's perfect that you say that, because that's exactly the kind of thing I'm going to ask you *not* to do. I'm going to ask you to struggle with things in here, and say "Yeah, this is what I hate" or "This isn't what I want." Even when it's difficult. Because I know you've got a voice in there that wants things. But, sometimes they're hard to say. You're afraid you're going to hurt somebody, or get angry with them, or you might not get what you want. But I want to help you discover that things can be different. That you can be different.

Throughout treatment, the therapist requests mature, active, responsible behavior from the adolescent, who usually welcomes this challenge. Furthermore, these requests convey the message that the therapist believes the teen-ager is capable of mature behavior. This is a radical departure from the environment of criticism and neglect that the adolescent often experiences in the family and social environment.

Making the Strange Familiar

Therapy is a strange and foreign environment for many teen-agers. The therapist must succinctly, yet deftly, sketch in this landscape, always stressing core themes of collaboration, compassion, experimentation, communication, and responsibility.

Therapist: There are times I will ask you to talk to your folks, and be straight with them. There are times I will ask you to do things in here or at home and try out new things. There will be times when we meet alone, and I'll want you to be straight with me and say what's on your mind so that you can get some of your own needs met. Because I feel like you're not getting what you want right now. [Pausing] What does that all sound like? Do you want to give it a try?

In the early stages of therapy, the therapist often uses such "speeches" in an attempt to establish an agenda and a direction for the treatment. They define expectations and set forth propositions to be considered by the teen-ager and the family.

Calibrating Expectations

Although the therapist must avoid becoming overorganized and pessimistic because of a therapy-disinclined teen-ager, it is essential to respect to the adolescent's caution and distrust. He or she must be given the opportunity to work out a way to participate in the treatment. Therefore, the therapist must be careful to pace the presentation of the treatment program and requests for participation and commitment.

WALKING THE TIGHTROPE: A GUIDING METAPHOR

When working with adolescents and their families, clinicians must learn to "walk the tightrope." They must establish and maintain alliances with both the

ature, active, responsible behavior; this challenge. Furthermore, the therapist believes the teen-ager is a product of the environment of experiences in the family and

for many teen-agers. The therapist's focus, always stressing core relationships, communication, and

talk to your folks, and be sure you do things in here or there. There are times when we meet and say what's on your mind. Your needs met. Because I feel down. [Pausing] What does it mean?

The therapist uses such "speeches" in an effort to define the treatment. They are defined by the teen-ager and the

overorganized and pessimistic adolescent. The opportunity to work out a plan with the therapist must be careful to respond to requests for participation and

METAPHOR

In these cases, clinicians must learn to maintain alliances with both the

adolescent and the parents. Thus, at one time, they must be the voice of the adolescent; at other times, the voice of the parent(s). To support and speak for both teen-agers and parents, while also taking into account extrafamilial systems (e.g., juvenile justice and school), is a daunting task. Yet, maintaining multiple alliances is not only possible, but also essential, for successful therapy with drug-abusing adolescents and their families.

The initial challenge is to engage the adolescents in therapy. The majority of substance-abusing adolescents come to therapy only because their parents or the juvenile justice system has ordered them to do so. As the teen-ager's active participation in the therapeutic process increases chances for success, it is vital to help the adolescent formulate a personal therapeutic agenda. Without this viable agenda, engagement is compromised.

Establishing the adolescent's agenda is one of the primary therapeutic challenges. The adolescent must be persuaded that therapy can be personally worthwhile. To accomplish this goal, the therapist must prove to the teen-ager, through both words and actions, that therapy will be more than just helping the parents become more powerful and controlling. Engagement and alliance-building strategies must continue throughout the therapy.

In multidimensional family therapy, the clinician tries to facilitate both in-session and out-of-session change. Fostering in-session change through enactment is a core component of this approach. The therapist must be very careful to prepare the adolescent, the parent(s), and other family members adequately for these conversations to maximize the possibilities for success. Preparation consists of meeting with each family member alone to explore, highlight, question, and acknowledge personal beliefs, attitudes, opinions, and feelings about themselves, other family members, and the family as a whole. Family members often need help in ascertaining how they feel and what they think about the important themes that the therapist or other family members have brought to the therapy.

By working individually with each family member before the enactment, the therapist is able to (1) solidify alliances so that the therapist will be free to challenge in the upcoming enactment sequence, (2) help family members formulate the content and style of what they want to say to other members, and (3) elicit from the family members their most helpful statements. The definition of helpful statements, of course, varies from family to family, person to person, and issue to issue. For example, a parent's statement of willingness to listen to the adolescent's perspective, despite many previous disappointments and hurts, is a helpful statement.

Many substance-abusing adolescents have little control of their emotions, thoughts, behaviors, and daily life. Although they may not be able to articulate precisely how they experience the world, many adolescents have an unmistakable sense that something in their life is desperately wrong. Several interventions are used in this situation. First, the therapist should have high expectations for the

adolescent and should attempt to increase the adolescent's self-expectations by providing alternatives—holding up certain desirable behaviors and, in essence, saying, "This is what you can do, this is what you can be, this is how you can get along in the world, and this is how you can interact with your parents." For each family, the therapist may use different materials to sketch this portrait of higher expectations (e.g., attributions, emotions, the past), but the message is always the same: "You can do better, and I'm going to help you do better."

The therapist also presents to the adolescent high expectations of the parents and explains to the teen-ager the therapeutic goal of helping the parents be better parents—to be more fair, to listen and acknowledge the adolescent, and to be more responsive. By talking to the adolescent about the parents' parenting, the therapist counters the teen-ager's fear that the responsibility for change will lie solely with him or her. It is important not only to help parents understand that they will need to do some things differently for the adolescent to change, but also to help the teen-ager understand that he or she has a role (insofar as family atmosphere and relationships are concerned) in making things better as well. This serves to counter the adolescent's pessimism as well. It can be a difficult balance for the therapist to maintain, but the adolescent should feel *some degree* of responsibility to help alter the parents' behavior. The therapist creates a partnership with the teen-ager that, among other things, helps the adolescent deal with the parents and the way that they treat the adolescent. Teen-agers appreciate having and often need a spokesperson, even one who is not always completely on their side. They are accustomed to a world that does not respect them, expects them to be unreasonable, and in general perceives adolescence, incorrectly so, as a time of inevitable storm and stress (Offer et al., 1981).

In addition to increasing expectations, the therapist helps the adolescent, literally and figuratively, find a different language and, thus, a different way of being in the world. One teen-ager may need to learn to communicate unhappiness and frustration through words rather than through violence and self-destructive actions. Another may need to learn how to talk directly to the parent about past hurts and betrayals rather than continuing to punish the parent indirectly by repeated drug use and suicide attempts. The language that we aimed for is one in which the adolescents can, to the best of their ability, explain their subjective experiences, world views, hopes and dreams, complaints, and disappointments.

In conclusion, multidimensional family therapy accepts and uses the complexity of human existence and experience. It helps adolescents and their families work together in various realms to achieve multidimensional changes. Because families of teen-agers who are abusing drugs often have longstanding problems, comprehensive, developmentally rooted models are needed to address their problems. For therapeutic models to improve, the systems models of tomorrow must be empirically based and sufficiently intensive in design and execution. The families who come for help need and deserve no less than this.

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