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CHAPTER 7

Integrative Treatment Development: Multidimensional Family Therapy for Adolescent Substance Abuse

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HISTORY OF THE APPROACH

Multidimensional family therapy (MDFT) is an outpatient, family-based drug abuse treatment for adolescent substance abusers (Liddle, Dakof, & Diamond, 1991). It blends the clinical and theoretical traditions of developmental (Liddle, Rowe, Dakof, & Lyke, 1998; Liddle et al., 2000) and ecological psychology (Hogue & Liddle, 1999; Liddle & Hogue, 2001) and family therapy (Liddle, 1995, 1999). The approach is manualized (Liddle, 2001), comprising modules that organize the assessment and intervention into key areas of the teen's life: the adolescent as an individual and as a member of a family and peer group; the parent as an individual adult and mother or father; the family environment; and extrafamilial sources of positive and negative influence (see Liddle et al., 1991; Liddle, 2001, for an overview of the MDFT therapeutic model). MDFT has received national recognition as an "exemplary" empirically supported approach for treating adolescent drug abuse (Center for Substance Abuse Treatment [CSAT], 1999; National Institute on Drug Abuse [NIDA], 1999).

The model has evolved over its 16 years in response to the unique clinical needs of each population studied, empirical advances in our understanding of the clinical phenomenon of adolescent drug abuse, and treatment outcome and process research findings that guide our clinical approach (see Liddle & Hogue, 2001, for an overview of the MDFT research program and findings). Consistent with treatment development guidelines (Kazdin, 1994), the model has undergone tests of therapeutic process and outcome. We are interested in questions about child, parent, family, and environmental factors that influence treatment outcomes (e.g., Dakof, Tejeda, & Liddle, 2001). We also test the impact of systematic variations of MDFT. These different versions of the approach are designed to more effectively target the needs of different groups of adolescent drug abusers, such as

adolescent girls, adolescents from different cultural backgrounds, and adolescents with multiple problems. For instance, in applying the model with a largely African American urban sample, we examined the cultural themes being expressed in therapy, studied the literature on the risk and protective forces at work in the lives of urban African American teens, and created a new treatment module that integrates this content (Jackson-Gilfort, Liddle, Dakof, & Tejeda, in press). Empirical study of alliance-building interventions with adolescents who initially demonstrated poor therapeutic relationships enabled us to develop early-stage interventions necessary to succeed in engaging teens in MDFT (Diamond, Liddle, Hogue, & Dakof, 1999). Relatedly, Dakof (2000) has developed clinical guidelines for applying MDFT with adolescent girls and their families. Rowe, Liddle, and Dakof (2001) are pursuing a line of research to articulate a clinically informative typology of adolescent substance abusers.

In one current version of MDFT, the treatment intensity and dosage have been increased to create a "high-strength" version of the model that will respond to the needs of more severely impaired teens and families, including dually diagnosed adolescent drug abusers. Kazdin (1994) explains that "the high-strength model is not only an effort to maximize clinical change, but also a test of where the field is at a given point. Given the best available treatment(s), what can we expect from the maximum dose, regimen, or variation?" (p. 583). Given the existing empirical support for MDFT, can we effectively treat adolescent substance abusers with a higher level of dysfunction in multiple domains by changing the parameters (e.g., dose, intensity) and expanding the targets of change of the treatment? With this guiding question, we have sought to integrate intensive therapeutic work in important areas, including case management, school interventions, drug counseling methods (including the use of drug screens in therapy), the therapeutic use of multimedia, HIV/AIDS prevention, manualized interventions to work collaboratively with the juvenile justice system, and close management of psychiatric interventions. Each of these modules is an integral, systematically applied component of case conceptualization and intervention in the high-strength version of MDFT. The current chapter highlights relevant aspects of this approach, emphasizing efforts to integrate these modules into a coherent, comprehensive, clinically acceptable and viable high-strength version of MDFT.

THEORY OF CHANGE IN MDFT

Adolescent drug abuse is widely recognized as a multidimensional phenomenon. A variety of risk factors are present in each of the major domains of the adolescent's life (Hawkins, Catalano, & Miller, 1992). Accordingly, MDFT is organized around these functional domains, targeting change in each of the systems maintaining drug use and other problem behaviors. MDFT targets all of the processes implicated in the development and persistence of the adolescent's problems: intrapersonal factors (identity, self-competence, etc.); interpersonal factors (family and peer relationships); and contextual and environmental factors (school support, community influences). The risk and protective factors framework guides the therapist in assessment and intervention efforts. Drug abuse is seen as a deviation from healthy, adaptive development, and interventions aim to place the adolescent on a more functional trajectory (Liddle et al., 2000). Table 7.1 outlines the most important risk factors in the development of adolescent drug abuse and provides examples of corresponding MDFT interventions designed to reduce risk and bolster protective mechanisms.

Knowledge of risk and protective factors and the interactions between them that create conditions for negative behavioral cycles helps the therapist identify factors facilitating dysfunction. Yet, initiating change in these areas is

Table 7.1 Blueprint for MDFT interventions.

Domain	*Risk Factor*	*MDFT Intervention*
Adolescent	1. Alienation/isolation.	1. Adolescent engagement interventions (AEIs).
	2. School failure.	2. Work with school staff and other resources in academic planning, tutoring, vocational training.
	3. Alliance with deviant peers.	3. Individual work with parent to improve monitoring time and involvement with peers; direct work with adolescent and peer system.
	4. Lack of bonding to prosocial institutions and school.	4. Engage in prosocial recreational activities, clubs, afterschool programs.
	5. Behavioral problems and delinquency.	5. Work with court personnel on sanctions for criminal activity; work with parents on behavior management; work with adolescent on anger management and impulse control.
Parent	6. Parental disengagement.	6. Parental relationship interventions (PRIs).
	7. Parental substance abuse.	7. Encourage/facilitate AA/NA participation.
	8. Inadequate parenting practices.	8. Improve parental monitoring, discipline, limit setting, and appropriate reinforcement.
	9. Parental stress/lack of resources.	9. Link with community resources for parent and other family members.
Intrafamilial	10. Family conflict and disengagement.	10. Explore and work through past and present disappointments and conflicts.
	11. Poor communication.	11. Work with parent and adolescent individually on communication skills; guide interactions to improve communication in-session.
Extrafamilial	12. Drug availability.	12. Refusal skills.
	13. Poverty.	13. Financial assistance/job placement service.

complex and often overwhelming. These negative, destructive behaviors and adverse relational patterns are frequently long-standing and tend to be highly resistant to change (Loeber, 1991). Longitudinal studies of adolescent substance abuse show that problem behavior almost always precedes substance abuse problems; these youth demonstrate deficits at an early age and experience numerous emotional and behavioral problems during childhood and into adolescence (Bukstein, 1995; Shedler & Block, 1990). Thus, effective interventions with this population must be intense and comprehensive and must create lasting change in the multiple systems fostering problem behaviors (Kazdin, 1993).

Behavioral alternatives must be created, attempted, accepted, and adopted by both the adolescent and the significant influences in his or her life. Therapists must first attend to the important task of motivating the teen and family members to engage in treatment, an area of clinical work in which family therapy has had notable success (Diamond et al., 1999; Williams & Chang, 2000). When the adolescent, family

members, and extrafamilial influences are engaged in therapy, the next stage of work begins in each domain of the adolescent's life. Change in MDFT follows systematic, organized sequences in which small gains build on each other and become the foundation for more significant changes (Liddle, 1999). Just as normative development progresses along predictable stages of change, MDFT conceptualizes change as an epigenetic process in which early-stage developments enable more sophisticated processes to emerge. With adolescents and families, therapeutic change occurs along a trajectory of milestones. Establishing a therapeutic relationship with a teen or parent can be broken down into several components. These parts are organized sequentially, with accomplishments in one realm paving the way for movement into the next developmental therapeutic task.

THEORETICAL CONSTRUCTS

In offering frameworks that create an empirically based and stepwise treatment development process, Linehan (1997) and Kazdin (1994) emphasize the importance of articulating core operating principles. Therapy principles are defined as theory-grounded, fixed, and predetermined rules that guide clinical orientation and behavior. Principles guide what a therapist is to do in any given approach (i.e., prescribed behaviors) and imply what he or she is not supposed to do (i.e., proscribed behaviors). Integrative, multicomponent treatments have special challenges in this regard. Broadened treatment scope creates more complex treatments, which may be more difficult to teach and to implement. However, there are now many examples of empirically based, family-oriented treatments for which proponents have succeeded in articulating core principles as part of the model's development (Alexander & Barton, 1976; Fruzzetti, Waltz, & Linehan, 1997; Miklowitz & Goldstein, 1997). Here are the operating principles of MDFT:

1. *Adolescent drug abuse is a multidimensional phenomenon.* MDFT's conceptualization and treatment are guided by an ecological and developmental perspective. Developmental knowledge informs interventions: 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.* The current symptoms of the adolescent or other family members, as well as crises pertaining to the adolescent, provide not only critical assessment information but important intervention opportunities as well.
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 intervention give indications about the timing, routes, or kinds of change that are accessible and possibly 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.* It is not assumed 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. Resistance is understood as normative. "Resistant" behaviors are seen as 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 yet 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 idiosyncratic 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 beginning of treatment as well as ongoing treatment; formulations are revised on the basis of new information and in-treatment experiences. In collaboration with the family members and relevant extrafamilial others, therapists continually evaluate the results of all interventions. Using this feedback, they alter the intervention plan and modify particular interventions accordingly.
8. *Treatment and its multiple components are phasic.* MDFT is based on epigenetic principles specifying sequential patterns of change. Thus, theme development, intervention plans and implementation, and the overall therapy process are organized and executed in stages. Progress in certain areas lays the foundation for the next, frequently more difficult, therapeutic changes.
9. *Therapist responsibility is emphasized.* Therapists accept responsibility for promoting participation and enhancing motivation of all relevant 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 necessary.
10. *Therapist attitude is fundamental to success.* Therapists are advocates of 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 naïve 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 families.

METHODS OF ASSESSMENT AND INTERVENTION IN INTENSIVE MDFT

Multidimensional Assessment

Assessment in MDFT is the basis for the therapeutic "map," directing therapists where to intervene in the multiple domains of the adolescent's life. A comprehensive, multidimensional assessment process involves identifying risk and protective factors in all relevant domains, and then targeting these identified factors for change. Mainly through a series of individual and family interviews and observations of directed family interactions, the therapist seeks to answer critical questions that fill in information about each MDFT module. The core modules are the adolescent, parent, family interaction, and extrafamilial social systems. Questions are based on empirically derived knowledge of the deficits of adolescent substance abusers and their life context. The

therapist attends equally to areas of strength, so as to provide a complete clinical picture of the unique combination of assets and weaknesses that the adolescent, family, and ecosystem bring to therapy. Assessment is an ongoing process, continually being integrated with interventions as a way of calibrating treatment planning and execution.

The assessment process typically begins with a meeting that includes the entire family, allowing the therapist to observe family dynamics and to begin to identify the roles that different individuals play in the adolescent's life and current circumstances. The therapist then meets individually with the adolescent, the parent(s), and other members of the family in the first session or two. Siblings and other members of the household are generally included as part of initial assessments and continue to participate in sessions as needed. 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. Individual sessions highlight the unique perspective of individual family members, their different views of the presenting problems, family relationships, and what they would like to see change in the family.

Therapists attempt to elicit the adolescent's unique life story, an important assessment and intervention strategy, during early individual sessions. By sharing their life experiences, the teens begin the joining process and provide a detailed picture of the severity and nature of their drug abuse, family history, peer relationships, school and legal problems, and important life events. In addition to clinical interviews, the therapist may use such techniques as asking adolescents to draw a map of their neighborhood, indicating where they go to buy drugs or to use. Therapists also inquire about the adolescent's health and lifestyle issues, including sexual behavior. The existence and severity of comorbid psychiatric conditions is determined through the review of previous records and reports, clinical interviews, and psychiatric evaluations.

Assessment with the parents is focused on their functioning as parents and as individual adults with their own unique history and current interests, goals, and concerns, apart from their parenting role. MDFT therapists assess the parents' strengths and weaknesses in terms of parenting skills, general parenting style, and parenting beliefs and commitment. In assessing parenting skills, the therapist both asks parents about their parenting practices and observes their limit-setting and communication skills when interacting with the adolescent in session. In discussing parenting style and beliefs, the therapist may ask parents about their own experiences growing up. Considerable attention must be paid to the parents' level of commitment to the adolescent: Have they abdicated their parenting responsibilities? Can the therapist find and rekindle even a small hope of helping to get the teen back on track? What is the parents' capacity to understand what needs to change in their family and their child, and are they responsive to having a role in facilitating the needed changes? Individual parental psychopathology and substance abuse are also evaluated as potential obstacles to parenting in a functional and developmentally appropriate manner (see Liddle et al., 1998).

Finally, assessment of extrafamilial influences involves gathering information from all relevant sources and combining this information with the adolescent's and family's reports to compile a complete picture of each individual's functioning in relation to external systems. All of this work is done with the overarching aim of fostering protective factors and reducing risk. Thus, the adolescent's educational/vocational placement is assessed and alternatives are generated to build bridges to a productive lifestyle. Establishing these concrete alternatives is fundamental to the therapy's success. Therapists collect information from probation officers and the juvenile court

regarding legal charges and level of risk for future problems. We translate this information about charges and possible outcomes in ways that both teen and parents can understand, and we use it integrally in the overall treatment strategy. The likely consequences of court involvement are used to create and increase a workable focus in treatment, to rally parents relative to the potential harm of negative outcomes, and to help focus the teen into a reality mode regarding the need to change. Finally, assessment of peer networks involves encouraging adolescents to talk about their peers, school, and neighborhood contexts in an honest and detailed manner; this is used to craft areas of work in treatment.

Overall, assessment in MDFT is consistent with current recommendations on assessment for this population: It is comprehensive, multidimensional, and relies on information from a variety of sources. With a complete picture of the adolescent and family, interventions are targeted toward decreasing risk and enhancing protection in the most accessible and malleable domains. This individualized approach, based on a thorough examination of each corner of the adolescent's world, is fundamental to the successful implementation of MDFT.

Facilitating Development: Interventions of the MDFT Model

A multidimensional perspective suggests that symptom reduction and enhancement of prosocial and appropriate developmental functions occur by facilitating adaptive, risk-combating processes in functional domains. We target behaviors, emotions, and thinking patterns implicated in substance use and abuse (Hawkins et al., 1992), as well as the complementary aspects of behaviors, emotions, and thought patterns associated with development-enhancing intrapersonal and familial processes (Holmbeck & Updegrove, 1995). Intervention targets have intrapersonal (i.e., feeling and thinking processes) and interpersonal (i.e., transactional patterns among family members or between family member and extrafamilial persons) aspects (Liddle, 1994). Targets for change are prioritized, so that the focus for change begins in certain areas, and these are used as departure points for the next, usually more difficult working areas for change. Five domains of functioning organize assessment and intervention.

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 et al., 1999). Sequentially applied alliance-building techniques called adolescent engagement interventions (AEIs) are used to present therapy as a collaborative process, define therapeutic goals that are meaningful to the adolescent, generate hope, and attend to the adolescent's experience of his or her life. Moreover, systematic incorporation of certain cultural themes (e.g., journey from boyhood to manhood) with teens also enhances engagement (Jackson-Gilfort et al., in press).

The initial stage articulates the 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 et al., 1991). A systematic elaboration of the youth's view of his or her 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, and (4) enhance social competence. Considerable work is done in individual sessions with parents and teens to prepare them to come together to talk about salient issues. Individual sessions with teens assess their peer network and friendship patterns and develop alternatives to impulsive and destructive coping

behaviors, such as drug and alcohol use. Detailed drug use histories and interventions to address attitudes and beliefs about drugs, or developing a connection about drug use and distress are examples of individual work with teens.

Interventions with Parents

MDFT focuses on reaching parents both as adults with their own needs and issues, and as parents who may have lost motivation or faith in their ability to influence the adolescent. Parental reconnection interventions (PRI's; Liddle et al., 1998), such as enhancing feelings of parental love and commitment, validating parents' past efforts, acknowledging difficult past and present circumstances, and generating hope, are used to increase parents' emotional and behavioral commitment to the adolescent. These interventions facilitate the parents' motivation and willingness to address relationship issues and parenting strategies. Once a foundation is set by increasing parental involvement with the adolescent (e.g., showing an interest, initiating conversations), therapists then foster parenting competency by teaching and coaching about consistent and age-appropriate limit-setting, monitoring, and support functions.

Interventions to Change the Parent-Adolescent Interaction

Family therapy articulated a theory and technology about changing particular dysfunctional interactions that develop and maintain problem behaviors (Minuchin, 1974). Following in this tradition, MDFT interventions also change dysfunction-maintaining transactions (Diamond & Liddle, 1999). Direct changes in the parent-adolescent relationship usually are made through the structural family therapy technique of enactment (Minuchin, 1974), which involves preparing family members to relate in new ways, and then actively guiding, coaching, and shaping more positive interactions. For discussions between parent and adolescent to involve problem solving or healing, they must be able to communicate without excessive blame, defensiveness, or recrimination (Diamond & Liddle, 1996). Therapists help teens and parents to avoid extreme, inflexible stances that lead to stalemates. The clinician creates a context for such discussion by directing and focusing in-session conversations on important topics in a patient, sensitive way.

Interventions with Other Family Members

Although individual and interaction work with adolescents and parents are central to our approach, 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, when indicated, sessions are held with them alone. Cooperation is achieved by emphasizing the serious, often life-threatening circumstances of the youth's life, and establishing a connection between their involvement in treatment and the creation of behavioral and relational alternatives for the adolescent.

Interventions with Social Systems External to the Family

MDFT also facilitates major changes in the ways 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 long-lasting therapeutic change. For an overwhelmed parent, help in dealing with complex bureaucracies or in obtaining needed adjunct services not only increases engagement but also improves his or her ability to parent effectively by reducing stress and burden. In MDFT, these activities are delivered within the

therapeutic context by a therapist assistant (see next section).

In-Home Family Therapy

In-home therapy is recognized as a powerful format for families who face complex, multiple problems (Boyd-Franklin & Bry, 2000; Cottrell, 1994), and randomized clinical trials have demonstrated efficacy for multisystemic, home-based approaches to adolescent and other clinical problems (Henggeler, 1999; Olds et al., 1998). In MDFT, the provision of in-home services has become an integral part of the treatment, due to the many benefits of conducting therapy in the home. In-home therapy is convenient for families: Many families presenting for therapy have great difficulty attending office-based therapy due to time or travel constraints or the sheer chaos present in their home lives; conducting sessions in the family's home eliminates many of these barriers. A second benefit of in-home therapy is that the therapist is able to observe the family in their natural environment; family members may feel more comfortable discussing sensitive issues in their own home than in an office setting, and the therapist is able to observe the family interacting in their natural environment. The therapist is also able to view the adolescent's extrafamilial environment firsthand, particularly the neighborhood ecology (e.g., availability of drugs around the home, gang activity, safety issues). Access to the adolescent's peer network is also more likely in in-home therapy; the therapist may meet peers in the home and occasionally bring them into sessions. It has been found that meeting in the family's home increases therapeutic engagement and may facilitate a more personal connection to the therapist than in an office-based approach. The intensive involvement that we seek in the MDFT model is enhanced through the trusting, personal relationships achieved through home visiting.

There are significant challenges to in-home therapy, and our clinicians are creative in attempting to overcome them. Therapists must devote attention and energy to establishing an appropriate atmosphere for therapy with sufficient privacy and limited distractions. The therapist may decide to conduct individual or family sessions in the office when appropriate. For instance, the office setting is used for holding teen-focused NA meetings, plugging teens into resources such as the Internet that they may not have at home or school, and viewing and discussing movies in a quiet place. There is no mandate to do all sessions or a particular number of sessions in the home. We do in-home therapy because it provides more options for access to the teens and their families, enabling us to increase the therapeutic dose. It is critical to strike a balance between utilizing home visits as opportunities to develop a more personal relationship with the family, and maintaining a therapeutic focus and tone during sessions. In working with families who show the range of difficulties common among adolescent substance abusers, the integration of in-home sessions has expanded our range of possible interventions.

The Role of the Therapist Assistant

Just as in-home therapy has increased our access into important life domains and the potency of the MDFT model, more systematic and programmatic attention to extrafamilial interventions has also expanded the therapist's repertoire. Adolescent substance abusers offer many clinical challenges: academic failure, juvenile justice involvement, health and mental health problems, and limited vocational skills. These adolescents come from families with compromised resources, significant stress, and limited skills in accessing services, and frequently live in communities lacking adequate social services. Therapists cannot do all of the important therapeutic work that must be done to create

change for these families, yet referring the family for case management services in the community leaves critical outcomes to chance. Thus, in working systemically with this population, we have integrated case management as a fundamental aspect of the model. The therapist assistant (TA) has been built in as part of the MDFT clinical team, enabling the therapist to devote more time and energy to within-session intrapersonal and family processes, therapeutic planning, and case conceptualization. TAs assist therapists in handling a variety of extrafamilial interventions in our high-strength version of MDFT.

TAs have become invaluable members of the team. They are essential in integrating therapeutic case management activities into the overall intervention plan. In close collaboration with and guided by the lead clinician, the TA provides a range of important services and frequently helps to stabilize a family in crisis. Yet, integrating the TA's activities into the daily management of the case presents a formidable challenge, particularly with adolescents and families who experience frequent crises and have a range of needs. The tasks in Table 7.2 define the scope of the TA's duties; later sections of this chapter provide more details about the TA's specific activities.

Table 7.2 Therapist assistant duties.

Schools

1. Daily monitoring of attendance of those clients who attend school.
2. Compile monthly attendance and in-school behavior records.
3. Pick up school records.
4. Monitor parental receipt and signatures on all school reports and forms.
5. Attend school meetings/conferences, team meetings.
6. Maintain active contacts with schools/ alternative education programs.
7. Monitor contact and progress with tutor.

Jobs

1. Make referrals to appropriate agencies.
2. Take client (parent or adolescent) to appointments at job agencies, vocational rehabilitation, or interviews.

Prosocial Activities

1. Take clients to 12-Step meetings and record all meetings.
2. Facilitate parental access to support groups/12-Step meetings.
3. Evaluate appropriateness of recreational activities in terms of content, staff competence, and rapport.
4. Determine cost, hours, attendance requirements for activities.
5. Take client to meet staff and enroll in activities.
6. Accompany to activities as necessary.
7. Facilitate mentor contact and monitor contact.
8. Conduct nightly and weekend checkins by phone.

Financial Services

1. Facilitate access to all economic services available.
2. Take clients to apply for and obtain services as necessary.
3. Maintain updated contacts with providers.

Court

1. Make referrals to appropriate programs.
2. Maintain contact with juvenile probation officer.
3. Conduct daily checkins with client regarding conditions of probation.
4. Attend court hearings as needed.
5. Visit client in detention as necessary.

Health/Mental Health

1. Facilitate health and mental health care service access.
2. Make referrals/appointments to/with appropriate services.
3. Take family members to appointments with providers.
4. Obtain reports/results from providers as necessary.
5. Visit family members at inpatient facilities when appropriate.

INTERVENTIONS TO IMPROVE ACADEMIC AND VOCATIONAL FUNCTIONING

In the extrafamilial module of MDFT, a primary focus is on the adolescent's functioning in the academic or vocational realm. Adolescents with drug abuse and associated behavioral problems typically experience little academic success and tend to have low commitment and bonding to school (Chatlos, 1997; Hawkins et al., 1992). They may have already dropped out or might be on the brink of dropping out of school by the time they reach treatment. A parent's endorsement of the importance of academic success is a

strong predictor of positive outcome in MDFT (Dakof et al., 2001). School success and reconnection are among the most important areas of work in MDFT because they are critical components in the process of creating a prosocial, productive trajectory for the teen. Work in this realm is one of the most direct ways to bolster protective factors for teens because it gives them a sense of accomplishment, a powerful success experience, a tangible product (either a GED or high school diploma) to set them on a positive life path, and new relationships with healthy peers and positive adults. The therapist and TA work closely with school personnel to institute changes in this realm, including integration of special programs, tutoring, and vocational training.

Several interventions are integrated into the overall treatment plan to address school problems. First, a staffing with all relevant school personnel is arranged as soon as the adolescent begins treatment to determine if the teen is in the most appropriate educational placement. The therapist and TA gather as much information as possible from all relevant sources and then use all available school resources (e.g., dropout-prevention programs, vocational rehabilitation, alternative school programs) to provide informed feedback to the school and family regarding the most appropriate placement for the adolescent. Relationships with teachers, counselors, and administrators are developed and fostered throughout treatment, and therapists encourage parents to reconnect with the school as well.

The following vignette illustrates some difficulties the therapist may encounter and the proactive stance that is necessary to facilitate positive, adolescent-focused activation of extrafamilial systems.

> Edward is a learning disabled student in middle school, who at age 14 was two years behind his age-mates and reading at the third-grade level. When he entered the program, he had recently been transferred from juvenile detention into a mainstream high school classroom serving emotionally handicapped students with high levels of reading ability. However, his educational records had not been transferred from the middle school. He "hated" school and was failing, but did attend despite his deep frustrations. Edward understood that something was wrong with his academic placement. He knew that although he was failing his classes, the school was also failing him. Because of this understanding and the strong relationship he had with his therapist, Edward accepted her advocacy in regard to school. The therapist began by requesting a meeting with school personnel. Her goal was to set up a school staffing meeting, communicate to the school staff that Edward was in fact functionally illiterate, and obtain his school records from all past schools to corroborate his difficulties. Present at the meeting was the head of the Exceptional Student Education (ESE) program for the school, one of his teachers, and the behavior modification specialist. Unfortunately, the school meeting went poorly. The school personnel did not have Edward's records, offered only negative feedback about his behavior in class and lack of responsibility with his assignments, had minimal information about his reading and writing level, and gave pessimistic, abdicating responses to the therapist's requests for changes in his educational plan.
>
> Because the school had clearly not met Edward's educational needs and did not appear willing to do so, the therapist contacted the executive director of the ESE program for the district, who recommended that she contact the regional director for the emotionally handicapped and learning disabled students program. In response to the therapist's systemic activation attempt, the regional director convened a multidisciplinary team (M-Team) meeting, including all of the school, county, and regional personnel mentioned, as well as Edward's therapist, to assess Edward's needs. The regional director ordered a psychological assessment, a complete Vocational Interest Inventory, a reading tutor, and a private reading program to meet Edward's educational needs. His individualized education plan (IEP)

was reviewed as part of the M-Team meeting, and the therapist pointed out that all of the goals on this document pertained to the student's behavior. None of the goals addressed how the school would meet his academic needs, as required by the Individuals with Disabilities Education Act. Several changes were made to the IEP, and the outcome of the meeting was the decision to enroll Edward in a half-day remedial program at the high school, with a half-day of vocational training to prepare him for work after graduation.

These major steps in changing Edward's educational plan would not have been accomplished without the therapist's strongly advocating on his behalf. Foundational to that intervention, however, was the therapist's knowledge of how the school system works and her experience in advocating for the teen. We define these therapist behaviors as clinical skills in the same way that therapists' work with the teen or parent constitutes therapeutic expertise; these skills are no less important than any others in MDFT. This case illustrates the profound impact of advocacy on combating the hopelessness and helplessness that permeates these families' lives. The responses of the school system to our advocacy engendered a sense of optimism that empowered this family to believe they could have effective interactions with school and other systems leading to changes in Edward's life.

The clinical team also explores the option of tutoring for adolescents struggling in certain classes. Success here can have positive effects by reconnecting the teen to the school, providing a sense of pride and accomplishment in schoolwork well done, providing contact and interaction with a prosocial adult, and maintaining structure during the critical afterschool hours when the teen might otherwise be engaging in problematic behavior. This individualized attention to basic skills is consistent with the types of remedial academic programs that are recommended for high-risk adolescents (Dryfoos, 1991). We do this intensive work because school disconnection and failure are consistent predictors of chronic antisocial behaviors and substance abuse (Flannery, Vazsonyi, & Rowe, 1996). The following vignette illustrates the use of tutoring in MDFT.

> Sarah was an intelligent teen who failed a grade in school due to involvement with drugs. She was held back and became very concerned about completing high school, passing her state competency tests, and keeping up with her coursework. She very much wanted academic help. Sarah, her therapist, and her family discussed her options, and all parties agreed on tutoring. The therapist then spoke with the tutor, describing the situation and explaining Sarah's needs, and the tutor agreed to work with the teen. The therapist and tutor went to Sarah's house, met the family, and the tutor quickly developed a bond with the family.
>
> Sarah and her tutor began meeting twice a week for three months to prepare for her competency tests, and the tutor checked in weekly by phone with Sarah's therapist. The tutor responded well to Sarah; she was sensitive with her but firm about her work. The tutor's continual affirmation enabled Sarah to achieve a sense of competency. By the end of the semester, after 12 weeks of work, Sarah not only passed the competency tests, but received her highest grades since elementary school.

In addition to assessing and focusing attention on progress in academic skills and functioning, job skills and vocational training are also explored early in therapy. The therapist might encourage the teen's pursuit of appropriate part-time employment (while closely monitoring school performance), both to structure the adolescent's time productively and to provide a source of legal income. On occasion, therapist, teen, and family decide together (given the results of a comprehensive academic/vocational assessment) that the teen would benefit from a vocationally oriented track rather than a traditional academic approach. The adolescent may have had excessive absences or failed grades, may have lost motivation and interest in school, or may have experienced such severe

failure in the academic realm that his or her confidence is depleted. Adolescents may desire to simply drop out of school altogether, yet there are a variety of other options. Therapists and TAs link school and community services to promote more productive vocational planning and training. Knowledge about effective services and establishing relationships with community contacts are complementary and important skills.

Intervening with the Juvenile Justice System

Intervening successfully with multiple problem, drug-abusing youth involves intensive, collaborative work with representatives from the juvenile justice system. In working productively with juvenile justice personnel, relationships with both the adolescent's probation officer (PO) and judge are critical. Therapists contact POs at the very outset of a case, asking about their experience with and knowledge of the teenager and any opinions or insights into what has happened with the teen and his or her family. Exactly in the same way that we operate with teens and families, this work rests on building relationships and establishing multiple alliances based on respect and mutual accountability for the adolescent's outcome. The therapist clarifies how the PO wants to proceed with the teen in terms of a monitoring protocol (e.g., weekly drug screens, meetings) and takes steps with the adolescent and family to abide by the PO's requests. The core principle of collaboration is emphasized throughout the process. Therapists focus on what they can and will do, and only secondarily on what the PO may have to offer. The therapist explains the philosophy and parameters of treatment. As is the case when therapists join with a teen and family, they look for common ground and points of connection with the PO. They offer an analysis of the teen and family that provides hope for change, helping the PO understand that the focus on family relationship dynamics will pay off in practical terms: in better parental monitoring and compliance with the terms of probation.

MDFT therapists, TAs, and supervisors must integrate effective interventions for enlisting the court's involvement. Our ecological focus dictates that therapists inform and educate judges about the model, which influences outcomes by helping keep the teen in MDFT. A judge's prior awareness of how the treatment works, what is required of the adolescent, and the effectiveness of MDFT are critical for success. The judge must have adequate information on treatment to make informed decisions on the disposition of adolescent cases—not only an understanding of the theory and the science supporting MDFT's efficacy, but also the basic structure of therapy. We have found that judges are extremely responsive to this type of input, but even more enthusiastic about the actual results we have with the adolescents presenting in their courtroom. In the end, judges act on their experience with our therapists and their success with the teens. The following vignette illustrates this process, and its multiple aspects.

> Carlos is a 14-year-old Hispanic male referred for drug abuse treatment who had been removed from his mother's custody at age 3 by the Department of Children and Families due to chronic physical and sexual abuse. He was taken into custody by his father and a stepmother. Carlos exhibited multiple problems throughout childhood, was placed in special education classes, and demonstrated serious anger management problems associated with his severe childhood abuse. He also had significant attachment problems, failing to bond with any adults. He experienced chronic conflict with his stepmother and his biological father, which became so severe that he asked his therapist to place him in residential treatment. The therapist understood that Carlos wanted to get out of the home, but felt there was greater potential for him in helping his family to work through the long-standing conflict. The stepmother also wanted Carlos to be placed in

residential treatment. She resented him for the problems she felt he created and the attention he received from his father. Carlos's family asked for a hearing with the judge to request residential treatment for their son. His therapist and the therapist's supervisor felt very strongly that Carlos's problems could be addressed in the MDFT outpatient program.

Carlos's therapist went to court with the family. The stepmother spoke for her husband, as was a typical pattern in the family, requesting that Carlos be removed from the home because there was too much temptation to use in the neighborhood. Carlos's therapist stated that she understood the interests of the family, but believed there were relational difficulties in the home that would best be addressed in family therapy. In this situation, both the therapist and the supervisor had built strong working relationships with the judge in prior cases. The judge understood the fundamental principles behind MDFT and had seen positive results with other teens. In responding to the family, the judge spoke from his experience with the MDFT model. He told Carlos's family that they all needed help, that they shared Carlos's problem jointly, and that it was this outpatient family therapy approach that could best help Carlos.

In this case and others, effective integration of juvenile justice system work is integral to success. Decisions about their legal status profoundly impact the trajectory of teens' lives. Chronic legal problems predict ongoing difficulties into adulthood (Farrington, 1995). We have found that although it is time-consuming, careful coordination between the clinical team and juvenile justice personnel makes therapeutically sound decisions possible. Close collaboration with POs and judges also enhances therapeutic work by offering the adolescent a second or sometimes a third chance to remain in our program (and thus not incarcerated or advanced to adult offender status) when faced with new or, in some cases, existing charges. Finally, coordinated involvement with the legal system gives us leverage to motivate both adolescent and parent to work hard in therapy toward attainable goals, such as avoiding a more restrictive placement, getting off probation, and eventually escaping the system altogether. It is up to the therapist to make this coordination occur and to present the work required as part of therapy and the mandates of the court in an integrated way to teens and parents. When adolescents and parents have evidence that their therapist has an impact on outcomes in court and they see their therapist fight for them, hope is resuscitated and family members are willing to work harder in therapy. The following case illustrates the therapist's powerful influence in such cases.

Jordan was a 17-year-old adolescent who came to treatment on the brink of being "direct-filed" into adult court. This means that his charges were extensive and severe enough for the court to consider advancing his case into the adult system. The therapist participated in a juvenile justice commitment hearing immediately after receiving the case, in which all involved parties discuss the adolescent's situation and make recommendations to the court. Due to the fact that Jordan had multiple cocaine possession charges, the state's attorney was pushing for the direct file and was not at all open to the idea of Jordan's being placed in an intensive in-home therapy program. The therapist involved in the case fought to keep Jordan in our program on the grounds that he hadn't received any new charges since his release from detention that month, that he had given clean urine screens every week, and that he and his father wanted help. The therapist assured the court authorities that Jordan would comply with weekly urine screens, follow a court-mandated curfew, attend a hearing every month to monitor progress, and would wear an electronic monitor to track his whereabouts. She also explained that our program was not a standard outpatient program, but that the entire family is involved and responsible for helping the teen change, and that as his therapist, she would have daily contact with him to monitor his progress. After an hour-long discussion among the

therapist, the public defender, the state's attorney, the PO, and the case manager, they agreed with the therapist's recommendations and Jordan was court-ordered to our program.

The therapist reported that both Jordan and his father were very happy, indeed moved, following the hearing. They told their therapist that they would do whatever she asked of them, that they were willing to do whatever it took to keep Jordan out of jail. They trusted her implicitly after seeing how effectively she went to bat for them. The therapist thus had great leverage with both Jordan and his father, and they began to address issues in therapy that they had never discussed, including their past disappointments in each other and their mutual desire to have a closer relationship. Jordan called his therapist everyday (part of our protocol, which emphasizes daily focus and effort from each family member) and started to make concrete changes, such as attending school regularly and helping around the house. Dad and Jordan were both pleased with the progress they were making, and enjoyed the time they were spending together.

The case went very smoothly until two months into treatment, when Jordan was arrested for a battery-and-assault charge against a security guard at the train station. Jordan's father called the therapist very upset, to tell her about the incident, in which a security guard identified Jordan as having hit him in the back of the head with a weapon. The therapist tried to comfort Jordan's father, who was despondent, and promised to be at court the next morning with him. When she arrived at court, Jordan's friends explained the story and assured her that he had had nothing to do with it, which was corroborated by other witnesses and by Jordan. When the proceedings started, the state's attorney stated that Jordan should be direct-filed, that he had been given a chance to do therapy and that it had failed. Jordan's therapist interrupted, once again fighting for his case. She first questioned the validity of the current charge given that nothing had been proven in court. Second, she made a thorough report to the judge concerning Jordan's significant progress during the past two months in therapy, including his perfect attendance record and conduct report in school, his clean urine screens, and his and his father's considerable effort in family therapy. The therapist told the judge, "I've been working with these kids for a long time and to see a kid change his life *so* much in two months, it's *rare*—we don't usually see that. Usually in the beginning, the kid's not doing really well, and then we work really hard to help them, but Jordan started off *knowing* that he had no chance if he didn't make this work, *knowing* that his case was in the air, and he really made a decision to work at this. I think when you have a kid like this you have to show him that we *see* his progress. So, at least until he goes to trial on this case, I want to work with Jordan and I want to help him out." Again, the therapist was able to sway the court's decision and Jordan was allowed to go home with an electronic monitor and to continue in the program until the trial for the most recent charge.

The therapist was able to show Jordan and his father that by sticking together and talking to each other, they were able to accomplish a lot. She supported Dad for hanging in there with Jordan despite all the stress and trouble, and helped him not to lose hope. She pointed out that through all the difficult times, they had gotten to know each other in a new way, had successfully renegotiated their relationship, and that sometimes hardships can bring families together. Both Dad and Jordan became very worried before the next commitment hearing, when the court authorities would review Jordan's placement in light of his current charge. The therapist instilled hope and helped them to turn to each other for support.

When Jordan's case was reviewed, the therapist was able to convince the judge to let him remain in our program until the trial. Following the hearing, the therapist was extremely grateful to the judge and personally thanked him for his faith in the program and in Jordan. Because Jordan's case had been assigned to the judge's drug court and the therapist had been seeing him at weekly case review meetings, they had developed a very productive working relationship. The judge even began to seek the therapist's opinion on other cases that weren't being seen in

our program. The judge respected and sought the therapist's opinion not only because of the obvious commitment and personal investment she had in our teens, but because he could see positive results in the adolescents and parents. All therapists are taught this lesson in their MDFT training, but it is powerful when they see it firsthand with a case. Therapeutic results are very influential.

On a personal level, the therapist reflected that the experience had a profound impact on Jordan. She believed that when he faced the very real prospect of going to adult jail, he saw that it wasn't a joke and that that might have been it for him. Hearing the state's attorney describe him as a "danger to society" woke him up to how people saw him, which was quite different from his image of himself. For the first time, he understood that he was giving his life over to the drugs and the streets, and that he had no power in a courtroom or in a jail. He saw very clearly in those hearings that the only person who could help him was his therapist, and even she could do only so much if he continued the way he was going. At the same time, he started to want better things for himself and to see that his life could be different. Before he got back in school and reconnected with his father, he felt that he had no future, that nothing mattered. Then he started to do well in school, and his father came back into his life, came to court, and fought for him and supported him. Jordan now believed that his life didn't have to keep going downhill. His therapist reflects, "He started to think, 'It's not that bad. People believe in me. Maybe there's a chance, maybe I *do* have hope. I can't believe the *judge* let me go, I can't believe a *judge* did that for me!' You know, those are the words he uses. Jordan started to believe in himself when he saw that other people believed in him."

INTEGRATING MEDIA MATERIALS TO REACH ADOLESCENTS IN MDFT

Integrative aspects of the MDFT model are exemplified in direct interventions with systems such as the school or court, as well as less traditional means such as the use of multimedia materials. In attempting to gain access to the adolescent's world, the therapist employs certain materials as props or aids to involvement. Psychoeducational videos, popular films, music, and written or Internet materials are used to facilitate discussion of the teen's personal experiences. During the first stage of therapy, the use of multimedia resources assists the therapist in broaching sensitive topics with adolescents, generating interest in therapeutic issues, and providing a nonthreatening atmosphere for talking with the therapist about their lives. Once the therapy progresses, and the adolescent-therapist relationship is stronger, these materials help teens express themselves in a creative, productive manner. The therapist encourages adolescents to bring in their own music or to identify movies they like in order to discuss their personal meaning. The multimedia resources become catalysts for emotional exploration and expression as well as facilitators of discussion regarding the medium's content.

MDFT therapists use a variety of videotape materials during treatment's beginning stages, both to generate discussion about different topic areas (e.g., drug involvement, consequences for criminal behavior), and to encourage adolescents to share their experiences relevant to the films. A number of psychoeducational videos are available that target high-risk adolescents, ranging from young adults describing their experiences in prison to teens sharing their past drug use experiences and ensuing consequences in great detail (e.g., *Straight Talk;* Substance Abuse Mental Health Services Administration [SAMHSA], 1993). Adolescents tend to tune out information presented as a lecture or perceived to be irrelevant to their own life, but they are captivated by characters who are sincere and realistic. Therapists also use popular movies to facilitate discussions in therapy, a procedure that has gained increasing support in recent years (e.g., Hesley & Hesley, 1998).

Therapists also encourage adolescents to share their music in therapy, as important aspects of

themselves. An adolescent's choice in music, and the discussion that may accompany reviewing the lyrics, can be intensely personal. Music provides another window into the teen's psychosocial world, as illustrated in the following vignette.

> Frank was 14 when his brother was referred for drug treatment. In individual sessions with Frank, the therapist noticed that Frank had difficulty, as many teens do, with the traditional, face-to-face therapy session. When he and the therapist were engaged in another activity (e.g., playing a game, eating lunch), he became much more talkative and comfortable. One week, Frank was suspended from school and spent considerable time at the therapist's office. He asked if he could bring in some favorite CDs, and he and the therapist printed out the lyrics from an Internet site. They listened to a few songs, then began talking about two songs in particular, both of which had a spiritual theme. One was entitled "Damien" (DMX, 1998), and described some of the temptations of street life. Frank identified with the song because he felt it was a picture of his own life, which he described as "hellish." The next song on the album, "Prayer" (DMX, 1998), talked about the rapper's conflicting pulls between right and wrong and his confusion about which path to follow. This song captivated Frank, who experienced ambivalence about religion and faith. Though his parents encouraged him to seek spiritual answers to his problems, he struggled with his religious beliefs and felt unsure about the concept of God. He also had difficulty seeing the point of following the straight-and-narrow path, because he felt his past efforts had gone unnoticed and unrewarded by his family. Some of the song's lyrics described his ambivalence. Focusing on them enabled Frank to clarify his experiences in a less threatening way. By discussing these songs in detail, the therapeutic conversation addressed material that the adolescent had not shared before. As the therapist described it, the music provided a window into the adolescent's world.

MDFT therapists also experiment with a variety of creative and expressive outlets for the adolescent, including writing or journaling; the use of teen-centered books, magazines, or Web sites; and audio- or videotaping. Therapists encourage adolescents to tell their story in any medium that is comfortable for them; this storytelling can be facilitated by reading or hearing about the experiences of other teens. We help the adolescent to access clinically relevant resources through the Internet. A National Public Radio series entitled "Teenage Diaries" (Richman, 2000) has been useful. Clinicians encourage teens to record their daily experiences using a diary format, and we use these devices to explore their thoughts and experiences in sessions. Therapists also use videotaping with adolescents, encouraging them to tell their stories as if they were a TV producer presenting a documentary of their own life. They watch the tape together, with the teen providing commentary and adding more details.

These materials and resources, when integrated in a nonpressured but clinically focused manner, create a different kind of atmosphere in therapy, parallel to the effect of play therapy with younger children. These techniques reduce adolescents' self-consciousness and anxiety, thereby opening them to new ways of sharing their story. We are clear that no progress can be made, indeed, no treatment can even occur unless the window to the adolescent's life is opened. The therapist's myriad activities, all carried out in the context of the strong therapeutic relationship, facilitate the opening of this window.

HIV/AIDS Prevention Interventions in MDFT

Although MDFT is primarily focused on elimination or reduction of drug use, integration of HIV/AIDS prevention has become necessary in virtually any therapeutic approach with high-risk adolescents. Furthermore, MDFT aims to promote the adolescent's healthy development

in all domains of functioning, including sexual relationships and behavior. Adolescents are encouraged to take responsibility for their sexual practices, particularly in terms of protecting themselves from contracting HIV and other sexually transmitted diseases. Early and risky sexual behaviors are common among adolescents with behavioral problems, and teen drug abusers appear to be particularly at risk (Deas-Nesmith, Brady, White, & Campbell, 1999). Our interventions addressing sexual behavior are delivered in a structured, educative manner through the use of an HIV prevention workshop, and in a less structured manner during the therapist's sessions with the adolescent and parents. Consistent with our formulation about how to reach teens, all content is presented in a relevant, stimulating way that blends state-of-the-science HIV prevention methods with core MDFT principles.

In accordance with this collaborative, ecologically oriented approach of drawing on existing community resources, we offer the educative portion of the adolescent HIV prevention module in cooperation with an existing community program. The educational material presented is appropriate for the adolescents' developmental level and consistent with the MDFT approach (e.g., fostering psychological and relationship competence). Workshops facilitated by peer leaders have been beneficial, and adolescents have become assistant leaders themselves (with therapists in attendance). Topics of this educational component include STDs, basic information about HIV/AIDS, decision-making skills regarding sexual behavior, communication skills, discussion of intimacy and relationships, peer pressure, and techniques for safer sex. The sessions are interactive and fun, keeping youth engaged in the education and skill-building process. Outreach activities, including making presentations about safe sex to other teens, are provided for adolescents who are at a more advanced stage of understanding about HIV/AIDS issues.

MDFT therapists also address HIV/AIDS prevention in individual sessions with the adolescent. Although our adolescents have grown up with the specter of AIDS, they still may demonstrate a tendency to feel invincible and to behave impulsively. Therapists conceptualize the focus on the adolescents' sexual practices as part of a movement toward health, including movement toward respect for self in both body and mind. A key component of the MDFT model is assisting the adolescent to move toward maturity, including an understanding and acceptance of the responsibility for self-care. The message that part of growing up is taking responsibility for one's health and life is consistent with our stance regarding drug use. The information learned during HIV workshops is cycled back through individual therapy sessions. Therapists reinforce and role-play how teens will put their new knowledge to use in new or difficult situations. Overall, the most important emphasis in terms of the adolescents' sexual behavior is that it is an issue of life and death, as is drug use. As one therapist explains:

> With the drugs, you say to the kid, "This is about the trajectory of your life, because your life is falling apart in so many areas." Or when you go to court, you say to them, "This is about your life. You've got to take this seriously because this gets to the outcome of your life." Sometimes they get that and sometimes they don't. Sometimes they can't see how those pieces all fit together and what the long-range outcomes might be. But when you talk to them about sex and AIDS, AIDS is so in your face, it has made everything about life and death for these kids. Here's an area where I can go to them and say, "This is life or death," and they know I'm not kidding. If I say that to an adolescent about the drug use, they might think I'm being dramatic. But with HIV/AIDS, when I develop the life and death possibility with them, they know it's true: "This is life or death. Use these condoms or you're going to get AIDS."

This type of realistic urgency tends to grab adolescents' attention. This work is linked to other aspects of the adolescent's move toward health and self-care, including a focus on drug use and

its consequences. This HIV prevention module attends specifically to the teen's sexual behavior but is organized within the guiding therapeutic plan, which involves the systematic exploration of personally meaningful life themes. Therapists orchestrate group, individual, and family sessions about high-risk behaviors and sexuality in a coherent way to facilitate a movement toward a healthier lifestyle. This represents another aspect of integration in MDFT. Coordination of these multiple, interdependent components takes thoughtfulness and skill.

The Use of Drug Screens in MDFT

Some first-generation family therapy models traditionally minimized the importance of drug use and other symptoms, focusing primarily on the family patterns maintaining them. MDFT focuses on drug use itself as an indicator of functioning and therapeutic progress. In response to the challenge to gain direct access to critical aspects of the youth's life, we have integrated a method used by drug counselors for decades: the use of urinalysis screens in therapy sessions. The first models that integrated family therapy and a systematic focus on drug abuse were developed by Stanton and Todd (1982) and Kaufman (1986). In our work, results from weekly urinalyses are shared openly with both the adolescent and the family, creating an atmosphere of openness and honesty about drug use from the beginning of therapy. Urinalysis serves as an index for the adolescent. A "clean urine" gives adolescents a sense of agency over their drug problem, whereas a "dirty urine" offers concrete evidence of continuing problems.

The MDFT therapist, as a part of the ongoing trusting relationship with the teen, will often say, "So, tell me what it's going to be" prior to conducting the screen. This interaction is significant, offering adolescents a chance to be honest about their drug use. It facilitates a relationship based on openness and integrity rather than the dishonesty characteristic of drug abusers. This shift is also significant because it sets the stage for honest communication with parents and others. When adolescents have a clean urinalysis, it can pave the way 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, can occur. The following vignette illustrates the use of drug screens in session:

> Jeff is a teen who, due to charges unrelated to drug use, was confined to his house after 6:00 P.M. unless in the company of one of his parents. Major themes of family therapy were trust and communication between Jeff and his parents. During a family session in the home, Jeff's therapist worked with the triad on communication, but Jeff became sullen and refused to speak. He then burst out angrily at his mother, upset because she believed he had been smoking marijuana the day before and obviously didn't trust him. Jeff's mother replied that she suspected his use because his eyes were red; she also admitted that she had little motivation to trust him after years of lies and disappointments. The therapist worked with mother and son on the affective level, then used the urinalysis as a way to reestablish trust. She suggested that Jeff take the test to demonstrate that he hadn't been using drugs. In this way, Jeff's therapist communicated to him that she believed him and wanted to help him to gain his parents' trust. She also helped his parents to establish acceptable guidelines for Jeff's afterschool activities. The therapist supported his parents in establishing guidelines and needing to know if Jeff was using. When Jeff returned and the urinalysis was negative, his mother kissed him on the cheek and expressed her relief that he was clean. Jeff's therapist also showed her pride in him for what he had accomplished, and the family was able to move forward and finalize the guidelines for his afterschool activities. Using the urinalysis in this family session

circumvented the negativity that had begun at the outset and facilitated trust and agreement.

When the adolescent does not want to complete the drug test, it may be a sign that he or she has been using. The therapist may ask, "Are you afraid of what the results might be?" With a dirty 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 needs to be put in place 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. 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 important, how could the use have been prevented. These details help the therapist determine intervention areas for future sessions. The structure to be put in place may include greater parental supervision and less free time or even brief residential stabilization if the use is reaching dangerous levels. Using screens with a teen in strong denial is a powerful tool. It provides concrete grounds for discussing restrictions and promoting the adolescent's understanding of the consequences of use.

The MDFT therapist will offer adolescents the opportunity to tell their parents themselves that they have used drugs and produced a dirty urine test. In keeping with the agreement made early in therapy that secrets are not a part of recovery, 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 adolescents choose to tell their parents that the test was dirty, this honesty paves the way for a new relationship with the parents and with themselves. 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. Parents frequently want the problem "fixed," and therapists help them to understand that given the nature of the adolescent's problems, recovery is usually a roller coaster ride, not a plateau leading to a steady incline of positive behavior. When an adolescent has been clean for some time and then relapses, parents' hopelessness increases; they worry that history will repeat itself endlessly. 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. The family can then be helped to use the crisis to renew and redirect their work in therapy. The following vignette illustrates this process:

Ray had been doing well in therapy and had been clean for several months when he came up with a urinalysis positive for marijuana. He initially denied using, telling his therapist that he came up positive because he was in a car where someone else was smoking pot. Ray's therapist took a nonblaming stance and offered to test him again several days later, at which point he gave another positive urine. The therapist used this as an opportunity to discuss the concept of relapse with Ray, his triggers for using, and the need to work even harder to help him continue to recover. Given this positive frame, Ray was able to admit to using, to ask for help, and to share the details of his use with his therapist. This nonpunitive, reality-based response by the therapist enabled Ray to begin a different kind of relationship with his therapist and deepened the trust between them.

Ray's therapist then offered him the opportunity to tell his mother about his relapse, and he agreed to do so. With encouragement from his therapist to be honest and take responsibility, Ray told his mother, "I came out dirty," and he began crying. His mother sighed but remained quiet. The therapist then helped both Ray and his mother to talk through the event in a positive way.

MOM: I had thought you weren't doing anything anymore.

RAY: I didn't want anyone in the family to know. You know, everybody thinks I'm doing good. Everybody, even Aunt Jackie. So in three weeks, they're gonna give me another drug test. To come out clean it takes three weeks to get out of my system.

MOM: You really have to want to stop smoking.

RAY: I know. I did. I was three months without smoking. Three whole months.

THERAPIST: Let me ask you this, Ray. When you were telling your mom, were you crying a little bit? (Ray nods yes.) Why? What were you crying about?

RAY: (Crying.) 'Cause I know she, like right now, she said I was doing good.

THERAPIST: So what are you feeling? Why are you crying about that?

RAY: 'Cause I was doing good.

THERAPIST: Okay, so why are you crying?

RAY: 'Cause now I know she don't trust me. She don't know if I'm gonna smoke again. (Sniffs.) Then I don't blame her 'cause she don't know. I don't even know.

THERAPIST: Okay, okay. So you made a really good point. And so she can't trust you and you don't even know yourself. Is that right?

RAY: Yeah, I don't even know. I know I don't want to smoke again. That's why I'm hanging around this guy that doesn't smoke. And he's nice. I . . . like, help him a lot. He don't smoke so I know that he won't tempt me to smoke. I just, I don't know . . . if, like, another girl will come around and make me smoke again.

THERAPIST: Okay, well let's go back to just what you're feeling right now. What is making you cry? I think you feel like you've let somebody down.

RAY: A lot of people. The whole family.

This opened the door to discuss the importance of honesty not only to Ray's recovery, but to having the kind of relationship Ray wanted to have with his mother. Ray shared that he wanted to be able to be a young man with his mom, not a little boy, and understood that this would mean "telling the truth like a man." To help Ray understand how his mother was feeling, the therapist asked Ray's mother to share how angry and hurt she felt when she knew he was lying to her, but that she was also scared that she was losing him to the drugs. Through conversations on this theme, the therapist helped Ray's mother reaffirm her love for him. Together, Ray and his mother thought of new ways for him to stay sober and learn from the situation. In wrapping up the session, the therapist and Ray's mother agreed to spend some time in individual sessions to focus on managing her frustrations. In this way, both Ray and his mother committed to making changes in their communication and coping styles.

Use of the urinalysis in session 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 system as a whole to deal with continued use. Therapists use the results of drug tests with parents and teens in a way that builds toward the overall improvement of individual and family functioning and extrafamilial relationships, in keeping with our ecological-developmental focus.

INTEGRATING PSYCHIATRIC INTERVENTIONS IN MDFT

In addition to extensive drug use and the consequences of this use, the majority of clinically referred adolescent drug abusers exhibit comorbid symptoms (Bukstein, 1995). We seek psychiatric consultation and consider psychotropic medication with every case. As with other components of MDFT, the therapist must ensure that medications are integrated into the adolescent's overall treatment plan in a way that is consistent with MDFT theory and principles, and that they are based on a comprehensive

evaluation of the adolescent's functioning. We work in collaboration with child/adolescent psychiatrists experienced with substance abuse and who share our clinical guidelines of close monitoring and integration of medication into the comprehensive treatment plan. The psychiatrist is integrated as an important member of the therapeutic team and works closely with the therapist, the adolescent, and the family to monitor the effectiveness of the medication for each teen. Medications are used to improve teens' functioning so that they are more receptive and responsive to the MDFT interventions.

Adolescents with symptoms of comorbid disorders receive a comprehensive psychiatric interview and medication evaluation. Specific medication guidelines and medication monitoring procedures for teens are developed by a team. Psychiatrist and therapist discuss diagnostic impressions, medications prescribed, and any obvious obstacles in implementing the medication plan. The therapist then reviews the psychiatrist's recommendations with the adolescent and the family, addressing issues of medication compliance. Parents vary in their opinions regarding their children's receiving medication and in their compliance with the medication regimen. Therapists can sometimes elicit parents' assistance in monitoring the adolescent's side effects and symptoms. On occasion, parents may resist medicating their child, as in the following example:

> Jennifer was 17 at intake to drug treatment and exhibited several depressive symptoms, such as hypersomnia, loss of appetite, dysphoric mood, and irritability. After a complete evaluation, the psychiatrist recommended that she begin taking Zoloft to alleviate these symptoms. The teen's father, however, was in recovery for his own addiction and adhered strictly to a philosophy that "drugs are drugs." He was concerned that his daughter would replace her reliance on illicit drugs with a dependency on psychotropics. The father had depressive symptoms but refused to take medication himself and was largely distrustful of therapy in general. Work with Jennifer's father focused on helping him to understand the impact of his intrapersonal and interpersonal problems on his daughter's functioning, and how his depression contributed to deficits in parenting. Over time, as the therapist built a strong alliance with the family, the father gradually began to trust her opinion. With continued progress in therapy and clear improvements in Jennifer's behavior and family relationships, Jennifer's father began to trust that therapy could work not only for his daughter and the family, but also for himself. He agreed to seek psychiatric treatment and devoted time to individual therapy sessions to deal with his depression. He began taking Wellbutrin, and his depression slowly lifted. The father's improvement in functioning impacted his daughter's well-being, and he also allowed Jennifer to begin taking medication for her own depression.

MAJOR SYNDROMES, SYMPTOMS, AND PROBLEMS TREATED

Adolescents targeted in MDFT are multiply impaired substance abusers with chronic problems in a range of functional domains. The majority come from families with substance abuse and/or mental health histories, family conflict, significant life stress, and few resources. Most clinically relevant is the fact that adolescent substance abuse is a heterogeneous disorder with important variations in trajectories and constellations of problems (Rowe et al., 2001). The concept of equifinality is particularly relevant for the youth we treat; there are many paths leading to substance abuse and a range of risk factors for adolescent problem behavior. We appreciate not only the multidimensionality of substance abuse problems but also the unique path each adolescent and family has taken to get to their current state. Most of these youth present with coexisting psychiatric disorders,

creating a more complex clinical challenge than either substance abuse or psychiatric problems alone do (Kaminer, 1999). Adolescent substance abusers with comorbid psychiatric disorders have earlier onset of substance use, greater frequency of use, and more chronic problems than those without comorbid disorders (Clark & Neighbors, 1996).

Given the challenge of treating substance-abusing youth with multiple impairments, including school failure, family dysfunction, relationships with antisocial, drug-using peers, coexisting psychiatric disorders, and other problems, there is general agreement that interventions for these youth must be comprehensive and integrated (Rounds-Bryant, Kristiansen, & Hubbard, 1999). Family-based approaches that target change in the multiple systems known to be associated with development and maintenance of these problems are among the most effective treatments for adolescent substance abusers (Williams & Chang, 2000). Family-based treatments for adolescent drug abusers have not only been shown to reduce drug use, but have also achieved reductions in comorbid psychiatric symptoms (Ozechowski & Liddle, 2000).

Adolescent substance abuse is a heterogeneous disorder. Drug-using teens present for treatment with diverse constellations of problems. They may be engaged in more of a *violence against others* type of delinquent behavior than drug use, or might be extensively involved in drug use and engage in only intermittent delinquent activities. Other substance-abusing adolescents experience primarily internalizing problems such as depression or anxiety, and their substance use may be a coping response or a means of "self-medicating" to deal with these emotions (Bukstein, Brent, & Kaminer, 1989). Because most adolescents seen in clinical studies are multiply impaired and have more than one diagnosis, broad descriptive terms such as delinquent or adolescent drug abuser, if not misleading, certainly must be considered insufficiently helpful for clinical work. Clinically, it is important to obtain a complex picture of the range of problem behaviors of the teenager and family, realizing that this presentation varies according to each individual case.

The following transcript illustrates some of the complexity involved in adolescent drug abuse cases. This case example demonstrates the multiple and interconnected problems manifested with drug abuse, the influence of early risk factors in the development of these problems, and the natural evolution of emotional, behavioral, and drug abuse problems over time. The therapist's intention was to help the adolescent clarify and articulate his life experiences.

THERAPIST: So, here's a little boy who's 7 years old, he doesn't speak English, he comes to this city, he doesn't know what's going on, he meets both his parents—never met them before—lives in a bunch of different neighborhoods, goes to live with strangers. Boy, that was a lot. Do you think that . . . How easy do you think that was for a little 7-year-old boy?

ADOLESCENT: To me it was, it was like easier than it should've been, because I didn't really know, like, the mother and father routine. All I knew was, I was somewhere, and they said "Oh go here, oh go here." You know what I'm saying, I didn't grow up with my mom, I didn't get taught no lessons or nothing. I see all these people living normal, and I'm, like, man . . .

THERAPIST: What is the mother and father routine? What is that?

ADOLESCENT: You know, like, you live, you grow up with your mother and father, and they teach you right from wrong and the do's and don'ts. You know, I didn't grow up like that. They ain't ever teach me no right and wrong. All I know is when I did some bad, I catched a whuppin, and when I did some good, I kept it to myself. You know what I'm saying?

THERAPIST: Nobody ever told you when you did something good?

ADOLESCENT: Nah . . . Nobody didn't care, I was a little kid, I mean . . .

THERAPIST: What about your aunt who died—she never told you that you did something good?

ADOLESCENT: No. She used to beat me when I did some bad too. Yeah, but you know that was sort of like to help me out, because that was like teaching me right and wrong: "Don't do that!"

THERAPIST: So tell me about the neighborhood where you lived, what was that like?

ADOLESCENT: Where I grew up, you know what I'm saying, you see guns fire, and you see drug dealers . . .

THERAPIST: It was in the projects.

ADOLESCENT: Yeah. I remember when I was a kid I used to be like, damn, they did drug dealing, you know, whoa, you know, that's real bad. . . . But then I started doing that when I was like 12 years old. You know what I'm saying. So that had an influence on me. . . . So I started, like, smoking cigarettes and stuff, and smoking weed, when I was in like the fifth grade. I was like 10 years old.

THERAPIST: How'd you get the weed?

ADOLESCENT: I had a cousin, you know, who lived in the Black part, and I lived in the Chico part . . . he's older than me. He was like 13, and I was like 9. And all the people he'd hang with was older than *him*. And all them smoke weed. And I was like, I wanted to be cool, so I started smoking weed, and I didn't used to tell nobody because I thought it was bad. And I started smoking cigarettes too, cause I used to always see my mom smoking. I used to pick up, like, the cigarette butts and stuff, trying to look cool, you know what I'm saying, and then get sick in the stomach. And then I started smoking weed. Now I used to, like, way back, like when I was little, my stepmom, I used to, like, I be seeing them drink, and my brother, he would sneak a beer. And he'd be like, "Oh let's sip some of this." I didn't know what it was, *glug glug*, and it didn't really get me drunk back then. So I'd drink and they'd say, "Oh, don't drink that" and they'd take it away. And I'd be like, "Why'd you take it from me?"

THERAPIST: Mm hmm. And how old were you then?

ADOLESCENT: I was like 8.

MDFT theory emphasizes the interconnected nature of adolescent problems. Frequently, problems with early adolescents may start gradually and appear to be mild or transient, but they can escalate rapidly, particularly when events involving external systems initiate a cycle that spirals out of control quickly (e.g., school expulsion, arrests). In our conceptualization of cases, we hone in on actual and potential escalating processes—events or impairments that amplify other problems—and establish immediate change in these areas. This case and the others presented in this chapter capture the multidimensionality of adolescent substance abuse and the need for an intensive, integrative, multisystemic intervention for these teens and their families.

MDFT OUTCOME AND PROCESS RESEARCH

Results of three completed randomized clinical trials demonstrate the efficacy of MDFT with drug-abusing adolescents. The first clinical trial of MDFT examined its efficacy in treating 144 substance-abusing adolescents in comparison to two alternative treatments, adolescent group therapy (AGT) and multifamily educational intervention (MFEI). All treatments provided weekly office-based therapy lasting between five and six months. Adolescents in MDFT showed the most significant improvement in drug use, grades, and observations of family functioning at discharge and up to the 12-month follow-up. For instance, 45% of MDFT youth, compared to 32% of youth in AGT and 25% of

youth in MFEI, showed clinically significant reductions in their drug use at the 12-month follow-up. At that time, 76% of youth in MDFT had passing grades in school (only 25% passing at intake), compared to 60% of adolescents treated in AGT and 40% in MFEI. The results indicate an overall improvement among youth in all three treatments, with the greatest and most consistent improvement in drug use, family functioning, and school functioning in MDFT (Liddle et al., 2001).

The second clinical trial examined the efficacy of MDFT in comparison to individual adolescent treatment: cognitive-behavior therapy (CBT). This study is noteworthy because it is the first adolescent drug abuse study comparing family therapy to a commonly practiced, state-of-the-art, empirically supported therapeutic modality. Participants in the study sample were 224 juvenile-justice-involved, drug-using adolescents randomly assigned to treatment. Adolescent drug use and externalizing and internalizing symptomatology were assessed at intake, discharge, and 6 and 12 months following treatment termination. At the 12-month follow-up, 70% of youth in MDFT were abstinent, compared to 55% of youth in CBT. Using hierarchical linear models, analyses revealed that both treatments produced a significant decrease in drug use, externalizing problems, and internalizing problems from intake to termination. However, only MDFT was able to maintain the symptomatic gain after termination of treatment. MDFT showed a significantly different slope from CBT, suggesting that youth who received family therapy continued to evidence treatment improvement after termination. The advantage of MDFT in comparison to CBT, then, concerns its ability to retain its gains up to one year after termination (Liddle, in press).

A third clinical trial is a multisite study designed to examine the effectiveness of five interventions, including MDFT, at reducing marijuana use and associated problems in adolescents. The Cannabis Youth Treatment (CYT) study was designed to adapt five promising adolescent treatments for use in clinical practice, and then to field-test their effectiveness in the largest randomized experiment ever conducted with adolescent marijuana users seeking outpatient treatment. Preliminary results suggest that all five treatments (MDFT, motivational enhancement/CBT, CBT, family support network, and adolescent community reinforcement approach) are more effective than current practice and that treatment gains were maintained at the 6-month follow-up (Dennis et al., 2001). Specifically, youth in MDFT went from 4% abstinent in the prior month at intake to 42% abstinent at the 6-month follow-up. At the 6-month follow-up assessment, 65% of youth in MDFT reported no substance use disorder symptoms in the prior month. Moreover, MDFT and the other CYT treatments cost less than both the mean and median cost reported by clinic directors of adolescent outpatient treatment.

MDFT principles were adapted in a controlled prevention trial with adolescents at high risk for substance abuse and conduct disorder. A randomized study ($N = 124$) tested the postintervention efficacy of an indicated, family-based prevention model, multidimensional family prevention (MDFP; Hogue & Liddle, 1999) with a sample of inner-city African American youth (ages 11 to 14) living in high-risk neighborhoods and attending schools well below average in academics. Key risk and protective factors associated with the development of drug use and antisocial behavior were targeted in four domains: self-competence, family functioning, school involvement, and peer associations. Compared to a school-based intervention, participants in MDFP showed gains in self-worth, family cohesion, and bonding to school, and decreases in peer antisocial behavior (Hogue, Liddle, & Becker, in press).

An exploratory pilot study investigated dose-response relationships in MDFT (Liddle, Ozechowski, Dakof, Rowe, & Tejeda, 2001). Specifically, the study explored whether pre- to

posttreatment changes in adolescent, parent, and family functioning were related to overall dosage levels of MDFT, as well as dosage levels in particular phases of treatment. The sample included 14 Black and Hispanic male adolescent drug abusers with high levels of comorbid symptomatology and juvenile justice involvement. Adolescents and parents completed an average of nine sessions of MDFT (*sd* = 5.5). Results indicate that changes in adolescent, parent, and family functioning were associated with overall MDFT dosage levels as well as phase- and stage-specific dosages of MDFT. A key finding was that adolescent drug taking decreased in relation to the amount of time therapists spent working with the teen alone. The more time a therapist spent with the adolescent alone during the engagement stage of MDFT (sessions 1 to 3), the more the teen decreased his drug use. Adolescent drug use also decreased in relation to the amount of time spent in conjoint family therapy during the change stage of MDFT (session 4 to termination). The total amount of time spent in conjoint family therapy was also related to improvements in parent reports of adolescent conduct problems, parental involvement, and discipline. Finally, overall dosage levels of MDFT were related to improvements in adolescent reports of internalizing problems and parent reports of positive parenting practices and family control.

The MDFT research program has also investigated mechanisms and nature of change questions (Liddle & Hogue, 2001). One study of MDFT mechanisms revealed a significant relationship between improvement in parenting and reduction of adolescent symptomatology (Schmidt, Liddle, & Dakof, 1996). A second therapy process study identified therapist behaviors and family interactions necessary to resolve therapeutic resistance (Diamond & Liddle, 1996). A third study examined the impact of MDFT adolescent engagement interventions on improving an initially poor therapist-adolescent alliance (Diamond et al., 1999). A fourth study found that focusing on certain culturally relevant themes can facilitate the adolescent's participation in MDFT (Jackson-Gilfort et al., in press). Finally, an examination of factors predicting engagement in adolescent drug treatment demonstrated that both adolescent and parent perceptions of problems are instrumental in determining whether youth and families stay in treatment; thus, engagement interventions must be geared to both teens and their parents (Dakof et al., 2001).

SUMMARY

The flexibility of the MDFT model has enabled developers to expand and contract the approach for application with a variety of drug-abusing populations. The MDFT outcome evidence is promising, and we continue to be motivated by both our successes and failures to find new ways to work effectively with drug-abusing teens and their families. This chapter introduced our high-strength version of MDFT, which is currently being tested as an alternative to residential treatment for severe drug-abusing youth with co-occurring disorders. With these youth, we have been challenged to apply new techniques and integrate new modules in a systematic way.

We have tried to convey some of the lessons we have learned in attempting to integrate new and existing components while maintaining the theoretical and clinical coherence of the MDFT model. Consistent with MDFT's roots in both structural and strategic family therapy, all of the interventions discussed are based on the negotiation of relationships and establishing healthy interconnections among family members and with resources in multiple systems. Therapists and TAs delivering each of these treatment components, whether it involves work with the school system or court or integrating HIV prevention in sessions, understand that change occurs in the context of new relational

opportunities. The families we see are frequently overwhelmed by the complexities of dealing with multiple systems; thus, our work is aimed at empowering families to deal effectively and confidently with influential social systems. Just as we have found with families, systems involved with these youth can lose perspective and move to extreme negative action quickly, thus making it imperative that therapists continually gauge the outlook of extrafamilial contacts to maintain optimism with the client. The consequences of losing the support of any of these systems can have an irrevocable impact on the teen; therapists are constantly recalibrating efforts to engage these supports. We have found that this work is not easy. It requires dedication, a considerable amount of therapeutic skill, and extensive training in the model by experts in MDFT. The strength and cohesion of the therapeutic team, which rests on excellent supervision, is integral to the success of the model.

Future treatment development efforts are aimed at examining the boundary conditions of this approach with different subsets of this population. For instance, are there certain individual or family characteristics that predict positive and negative responses to the intensive MDFT approach? Does dosage of one or all modules determine treatment response? Are therapist or TA characteristics predictive of treatment outcomes? Finally, we are conscious of and interested in the limits of this high-strength version of MDFT and what needs to be improved to establish the most effective treatment possible for these youth.

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