CHAPTER

10

Multidimensional Family Therapy for Adolescent Substance Abuse: A Developmental Approach

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OUTLINE

Treating adolescent substance abuse is challenging. The clinical profile of referred adolescents is complex. It can include the secretive and illegal aspects of drug use; involvement in criminal activities with antisocial or drug-using peers; despairing, stressed and poorly functioning families; involvement in multiple social agencies and services that may but typically do not meet the youth's and family's needs; disengagement from school and other prosocial contexts of development; and lack of intrinsic motivation to change. Many contemporary developments in the drug abuse and delinquency specialties offer guidance for clinicians and hope for parents, adolescents, and families. The volume and, more critically, the quality of basic and treatment research in the adolescent treatment area have increased. At least until the recent economic downturn, an increased funding for specialized youth services could be noticed. And an expanded interest in the problems of youth from developmental psychopathology researchers, applied prevention and treatment scientists,

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policy makers, clinicians and prevention programmers, professional and scientific societies, mass media and the arts, and critically, from the public at large, can be documented without difficulty. Greater consensus exists today than ever before about preferred conceptualizations and intervention strategies for youth problems in general, and adolescent substance abuse and delinquency in particular. Leading figures in the field now conclude that drug abuse results from both intraindividual and environmental factors. And, as the reasoning goes, unidimensional models of drug abuse are inadequate; making the support and continued development of more complex, multicomponent, and integrated research and intervention approaches are all the more important.

This contribution summarizes multidimensional family therapy (MDFT), an empirically supported family-focused therapy specializing in the treatment of youth drug abuse and delinquency. A *developmental* perspective and the basic science knowledge base about adolescent and family development inform and organize all aspects of the treatment. The knowledge base teaches therapists about the course of individual adaptation and dysfunction through the lens and tasks of normative development. Youth and family developmental milestones are benchmarks that guide assessment and interventions in terms of their framing and form. The developmental psychopathology knowledge base moves beyond consideration of symptoms only to understand a youth's and family's ability to cope with the developmental tasks at hand. It specifies the implications of stressful experiences and developmental failures in one developmental period for adaptation or problems in future periods. Because multiple pathways of adjustment and problem development may unfold from any given life cycle point, emphasis is placed equally on understanding competence and resilience in the face of risk. Adolescent substance abuse is conceptualized as a problem of development – a complex, multifaceted deviation from the normal developmental pathway. Substance abuse involves difficulties in facing developmental challenges and it is a set of behaviors that compromises capacities to achieve future developmental milestones.

The *risk and protective factor* knowledge base teaches clinicians about the empirically derived determinants of problem formation. Perhaps more critically given the clinician's responsibility, specific knowledge of risk and protection in the multiple realms that have been filled in by longitudinal studies empowers clinicians with knowledge of the diverse *promotive* processes that might be located and facilitated to fight against risk and negatively cascading developmental slides. It identifies factors from diverse domains of functioning (psychological, social, biological, and neighborhood/community) relevant to positive adaptation and threats to development. Thinking in terms of risk and protection also helps therapists to identify key interactional or process terms about the intersecting and mutually influencing dimensions of the adolescent's and family's current life circumstances.

Another framework and body of knowledge, the *ecological or contextual perspective,* specify the interconnected web of influences forming the context of human development. Regarding the family as a principal developmental arena, ecological and contextual notions take a keen interest in how both intrapersonal and intrafamilial processes are affected by and affect extrafamilial systems (i.e. significant others involved with the youth and family, such as school, job, or juvenile justice personnel), and of course how these external to the family processes and events affect family development, parenting, and parent–adolescent relationships. Ecological and contextual ideas coincide with contemporary theorizing and empirical work about reciprocal effects (i.e. dynamic systems theory) in human relationships, and it underscores how, like all behavior, problems are manifest at different levels, and in different ways with different individuals, and how circumstances in one domain can affect other domains. Taken together, the ideas and still accumulating research about development, context, ecology, and risk and protection have had an enormous, transformative influence on the conceptualization of youth and family problems, the program theory in both treatment and prevention that is thought to be needed to impact multiple embedded problems, and the corresponding interventions that aim to resolve individual and family dysfunction and burden.

TEN GUIDING PRINCIPLES

1. *Adolescent drug abuse is a multidimensional phenomenon.* Individual biological, social, cognitive, personality, interpersonal, familial, developmental, and social ecological aspects can all contribute to the development, continuation, worsening, and chronicity of drug problems.
2. *Family functioning is instrumental in creating new, developmentally adaptive lifestyle alternatives for adolescents.* The youth's relationships with parents, siblings, and other family members are fundamental areas of assessment and change. The adolescent's day-to-day family environment offers numerous, indeed essential opportunities to re-track developmental functioning.
3. *Problem situations provide information and opportunity.* Symptoms and problem situations provide assessment information as well as essential intervention opportunities.

4. *Change is multifaceted, multidetermined, and stage-oriented.* Behavioral change emerges from interaction among systems and levels of systems, people, domains of functioning, and intrapersonal and interpersonal processes. A multivariate conception of change commits the clinician to a coordinated, sequential use of multiple change methods, and working multiple change pathways.
5. *Motivation is malleable but it is not assumed.* Motivation to enter treatment or to change will not always be present with adolescents or their parents. Treatment receptivity and motivation vary in individual family members and relevant extrafamilial others. Treatment reluctance is not pathologized. Motivating teens and family members about treatment participation and change is a fundamental therapeutic task.
6. *Multiple therapeutic alliances are required and they create a foundation for change.* Therapists create individual working relationships with the adolescent, individual parent(s) or caregiver(s), and individuals outside of the family who are or should be involved with the youth.
7. *Individualized interventions foster developmental competencies.* Interventions have generic or universal aspects. For instance, one always wants to create opportunities to build teen and parental competence during and between sessions, but all interventions must be personalized, tailored, or individualized to each person and situation. Interventions are customized according to the family's background, history, interactional style, culture, and experiences. Structure and flexibility are two sides of the same therapeutic coin.
8. *Treatment occurs in stages: continuity is stressed.* Core operations (e.g. adolescent or parent treatment engagement and theme formation), parts of a session, whole sessions, stages of therapy, and therapy overall, are conceived and organized in stages. Continuity – linking pieces of therapeutic work together – is critical. A session's components and the parts of treatment overall are woven together – continuity across sessions creates change enabling circumstances.
9. *Therapist responsibility is emphasized.* Therapists (1) promote participation and enhance motivation of all relevant persons, (2) create a workable agenda and clinical focus, (3) provide thematic focus and consistency throughout treatment, (4) prompt behavior change, (5) evaluate, with the family and extrafamilial others, the ongoing success of interventions, and (6) per this feedback, collaboratively, revise interventions as needed.
10. *Therapist attitude is fundamental to success.* They are neither "child savers" nor unidimensional "tough love" proponents; they advocate for adolescents and parents. Therapists are optimistic but not naïve or Pollyannaish about change. Their sensitivity to contextual or societal influences stimulates intervention possibilities rather than reasons for how problems began or excuses for why change is not occurring. As instruments of change, a clinician's personal functioning enhances or handicaps one's work.

CHARACTERISTICS OF THE TREATMENT PROGRAM

Multidimensional Assessment

Assessment yields a dynamic and evolving therapeutic blueprint – an indication about where and how to intervene across multiple domains and settings of the teen's life. A comprehensive, multidimensional assessment process identifies risk and protective factors in relevant areas, and prioritizes and targets specific areas for change. Information about functioning in each target area comes from referral source information and dynamics, individual and family interviews, observations of spontaneous and instigated family interactions, and interchanges with influential others outside of the family. There are four overall targets: (1) adolescent, (2) parent, (3) family interaction, and (4) community social systems. Attending to deficits and hidden areas of strength, we obtain a clinical "moving" picture (transactional perspective) of the unique combination of weaknesses and assets in the adolescent, family, and social system. This contextualized portrait includes a multisystem formulation of how the current situation and behaviors are understandable, given the youth's and family's developmental history and current risk and resilience profile. Interventions decrease risk processes known to be related to dysfunction development or progression (e.g. disengaged or conflict heavy family relationships, parenting problems, strong and patterned affiliation with drug-using peers, disengagement from and poor outcomes in school), and enhance protection and develop problem solving, first within what the therapist finds to be the most accessible and malleable areas. An ongoing process rather than a single event, assessment continues throughout treatment as new information emerges and experience accumulates. Assessments and therapeutic planning overall are revised according to feedback from our interventions.

A home-based or clinic-based family session generally launches treatment. But before this meeting, clinicians try to have brief telephone conversations with a parent, and sometimes the youth. These talks can be important

to relationship formation, ascertaining roadblocks to participation, and current crises. They begin the process of defining the treatment program, making it personal, and targeted to getting help to what can be a distressing set of immediate circumstances, given what can come with youth drug use and delinquent behavior. Motivation enhancement and assessment of the various corners of the youth's and family's life begins here. Even in the first session, therapists stimulate family interaction on important topics, noting to themselves how individuals contribute to the adolescent's life and current circumstances. We also meet alone with the youth, the parent(s), and other family members within the first session or two. These meetings reveal the unique perspective of each family member, how events have transpired (e.g. legal and drug problems, neighborhood and negative peer influences, and school and family relationship difficulties), what family members have done to address the problems, what they believe needs to change with the youth and family, as well as their own concerns and problems, perhaps unrelated to the adolescent.

Therapists elicit the adolescent's telling of his or her life story during early individual sessions. Sharing one's life experiences facilitates engagement. It also provides a necessarily detailed picture of the nature and severity of the youth's circumstances and drug use, individual beliefs and attitude about drugs, trajectory of drug use over time, family history, peer relationships, school and legal problems, any other social context factors, and important life events. Adolescents sketch out literally and in conversation an eco-map, a representation of one's current life space. This includes the neighborhood, indicating where the youth hangs out or buys and uses drugs, where friends live, and school or work locales. Per protocols, therapists inquire about health and lifestyle issues, including sexual behavior. Comorbid mental health problems are assessed by reviewing records and reports, the clinical interview process, and psychiatric evaluations. Adolescent substance abuse screening devices, including urine drug screens (used extensively in therapy), are invaluable in obtaining a comprehensive picture of the teen's and family's circumstances.

Parent(s)' assessment includes their functioning both as parents and as adults, with individual, unique histories and concerns. We assess strengths and weaknesses in terms of parenting knowledge, skills and parenting style, parenting attitudes and beliefs, and emotional connection to one's child. Inquiring in detail about parenting practices is essential, and this includes asking about available support for the parent, child care, other adults who help out or might be available for relationship or parenting help. Clinicians promote parent–adolescent discussions, and in this process watch for relationship indicators such as supportiveness, autonomy giving, problem solving, or the triggering of relationship conflict or emotional disengagement. Parents discuss their experiences of family life when they were growing up since these may be used to motivate or shape needed changes in current parenting style and beliefs, or the parent–adolescent relationship generally. Nothing is more vital to ascertain and facilitate than the parent's emotional connection to and investment in their child. Parent's mental health status and substance use are also appraised as potential challenges to improved parenting. On occasion we make referrals for a parent's adjunctive treatment of drug or alcohol abuse or serious mental health problems.

Information on extrafamilial influences is integrated with the adolescent's and family's reports to yield a comprehensive picture of individual and family functioning relative to external (to the family) systems, events, and circumstances. A new component of our approach provides on-site educational academic tutoring that meshes with core MDFT work. We assess school- and job-related issues thoroughly, and well-planned parent–youth meetings with school personnel are frequent. Therapists cultivate relationships and work closely with juvenile court personnel, including probation officers who help to sort out the youth's charges and legal requirements. Facing juvenile justice and legal issues can be a complex and emotional matter for the entire family. Clinicians help parents understand the potential harm of continued negative or deepening legal outcomes. Using a nonpunitive tone, we help teens face and take needed compliance actions regarding their legal situation. Friendship network assessment encourages adolescents to talk forthrightly and in detail about peers, school, and neighborhoods. Friends may be asked to be a part of sessions. Frequently, they are met and included during sessions in the family's home. A driving force in MDFT is the creation of concrete alternatives that use family, community, or other resources to provide prosocial, development-enhancing day-to-day activities that become acceptable substitutes for drug and illegal activity involvement.

Adolescent Focus

Clinicians build a firm therapeutic foundation by establishing a working alliance with the teenager, a relationship that is distinct from, but related to, a working relationship with the parent. We present the program as a team process, following through on this proposition by collaboratively establishing therapeutic goals that are practical and personally meaningful to the adolescent. Goals become apparent as teens express their experience and evaluation of their life so far. Treatment attends to these "big picture" dimensions. Problem solving,

creating practical and reachable alternatives to a drug-using and delinquent lifestyle – all of these remediation efforts exist within an approach that addresses an adolescent's conception of his or her own life, values, life's direction, and meaning. Success in one's alliance with the teenager is noticed by parents. Parents expect and appreciate how clinicians reach out to and form a distinct relationship and therapeutic focus with their child. Individual sessions are indispensable and their purpose is defined in "both/and" terms. These sessions access and focus on individual and parent–teen and other relationship issues through methods that might be construed as an individual therapy (versus multiple systems) approach. Individual parent and teen meetings also prepare (i.e. motivate, coach, and rehearse) for joint sessions.

Parent Focus

A vital therapeutic task is to reach the parent or caregiver(s) as an adult with individual issues and needs, as well as a parent who may have declining motivation or faith in her or his ability to influence their child. Objectives with parents in every case include enhancing feelings of parental love and emotional connection, underscoring parents' past efforts, acknowledging difficult past and present circumstances, including the particular difficulties that their child brings them, generating hope, changing the parent–adolescent relationship, and of course, improving parenting practices. When parents enter into, think about, discuss and experience these processes, their emotional and behavioral investment in their adolescent deepens. This process, the expansion of parents' commitment to their child's welfare, has internal cognitive, emotional, and behavioral aspects is fundamental to the change model. Achieving these therapeutic tasks is instrumental to and sets the stage for later changes. Taking this first step in a parent's change, these interventions grow parents' motivation and, gradually, parents' willingness and capacity to address caring, reaching out (again), understanding the youth's point of view, and overall improvements in the parent–youth relationship and parenting strategies. Increasing positive parental involvement with one's adolescent (e.g. showing an interest, initiating conversations, creating a new interpersonal environment in day-to-day transactions) creates a new context for attitudinal shifts, enhanced behavioral and emotional repertoire, and behavioral changes in parenting. Parental competence is fostered by teaching and behavioral coaching about normative characteristics of parent–adolescent relationships, consistent and age-appropriate limit setting, monitoring, improved communication, and listening to one's child, and overt emotional support – all research-established parental behaviors that enhance relationships, individual, and family development.

Cooperation is achieved and motivation is grown by discussing the serious, often life-threatening circumstances of the youth's life, and establishing an overt, discussable connection (i.e. a logic model) between that caregiver's involvement and creating, with the therapist's help, behavioral and relational alternatives for the adolescent. This follows the general procedure used with parents – promoting caring and connection through several means. First, through an intense focusing and detailing of the youth's difficult and sometimes dire circumstances, making sure that these realities are faced, discussed, and experienced deeply by the parent (although there is description of the youth's circumstances, the presumed mechanism of action here is experiential and not didactic or psychoeducational). This process, which is facilitated mostly in individual meetings with the parent and clinician seems to be ultimately a motivation for the parent. It is as if the parent concludes that they will not let their child continue to deteriorate, continue to get in trouble, or stay off track developmentally. Furthermore, parents moving through this process conclude that they can and should have a role in their child's change, and they begin, again with the partnership with the clinician, to craft a role and particular remedies that they can offer to help alter their child's current circumstance. The parent's re-engagement with their youth is seen not only as instrumental to the therapeutic process, but also something that evolves and emanates very much from the parent themselves, seemingly as a result of what some parents have called a soul searching about their child, their parenting, and most of all themselves.

Parent–Adolescent Interaction Focus

As discussed, some interventions begin with targeting and changing individual ideas, emotions, and behaviors (although these, eventually, have interactional aspects as well). But MDFT, as was the case with particular family therapy models over the years, also assess and change family transactions directly. Shaping changes in the interactions that are part of the parent–adolescent relationship are made in sessions through the structural family therapy technique of enactment. A clinical method and a set of ideas about how change occurs, enactment involves elicitation and frank discussion in family sessions of important topics or relationship themes. These discussions reveal relationship strengths and problems. Expanding their repertoire of experience, perceptions, and behavioral alternatives, therapists assist family members to express, expand, discuss, and solve problems in new ways. As

a behavioral activation strategy, this method also creates opportunities to search for behavioral alternatives as clinicians actively guide, coach, and shape increasingly positive and constructive family interactions. For discussions to involve problem solving and relationship healing, family members must be able to communicate without excessive blame, defensiveness, or recrimination. Therapists guide retreats from extreme stances since these actions undermine connection and problem solving, rekindle hurt feelings, and sap motivation and hope for change. Individual sessions review and process these important issues and prepare family members for family sessions where the topics can be discussed openly and expanded ways of relating attempted. The content focus of any given session is important. Skilled therapists focus in-session conversations on meaningful topics in a patient, sensitive way.

Focus on Social Systems External to the Family

Clinicians help the family and adolescent relate more effectively with extrafamilial systems. Families may be involved with multiple community agencies. Success or failure in negotiating these relationships affects short-term, and in some cases longer-term, outcomes. A give-and-take collaboration with school, legal, employment, mental health, and health systems influencing the youth's life is critical for engagement and durable change. An overwhelmed parent appreciates a clinician who can understand and coach or help negotiate directly with complex bureaucracies or obtain adjunctive services. Achieving these practical outcomes lessens parental stress and burden, enhances engagement, and bolsters parental efficacy. Therapists team with parents to organize meetings with school administrators, teachers, or probation officers. Since successful compliance with the legal supervision requirements is an instrumental therapeutic focus, therapists prepare the family for and attend the youth's disposition hearings. School or job placement outcomes are additional instrumental aspects of achieving an overall positive case outcome – they represent real world settings where youths can develop competence and build escape routes from deviant peers and drugs. In some cases, medical or immigration matters, or financial problems may be urgent areas of stress and need. We understand the interconnection and synergy of these life circumstances in improving family life, parenting, and a teen's reclaiming of his or her life from the perils of the street. Not all multisystem problems are solvable, nor are all or even most aspects of the youth's day-to-day social environment malleable. Nonetheless, in every case, our rule of thumb is to assess comprehensively, declare priorities, and as much as possible, work actively and directively to help the family achieve better day-to-day outcomes relative to the most consequential and changeable areas in the four target domains, and in their interactions.

DECISION RULES ABOUT INDIVIDUAL, FAMILY, OR EXTRAFAMILIAL SESSIONS

MDFT clinical interventions work from "parts" (subsystems) to larger "wholes" (systems) and then from these larger units (families/family relationships) back down to smaller units (individuals). Session composition is not random or at the discretion of the family or extrafamilial others, although sometimes this is unavoidable. Session goals and stage of treatment drive decisions about session participants. Session goals may be multiple, existing in one or more categories. Typically there are session-specific goals suggesting who should be present for all or part of an interview. For instance, first sessions, from strategic (i.e. relationship formation, giving a message about family involvement) and information-gathering (i.e. family interaction is a key part of what therapists access, assess, and ultimately attempt to change) perspectives, include all family members for a significant part of the session.

MDFT works in four interdependent and mutually influencing subsystems with each case. The rationale for this multiperson focus is theory-based and practical. Some family-based interventions might address parenting practices by working alone with the parent for most or all of treatment. Others might only conduct whole family sessions throughout (i.e. family interaction as the single or most important pathway of youth change). MDFT is unique in how it works with the parents alone and with the teen alone as well, apart from the parent and family sessions, in addition to targeting family level change in vivo, and multisystems change efforts (i.e. multiple pathways of change). Individual sessions have communicational relationship-building and substantive value. They provide "point of view" information and reveal feeling states and historical events not always forthcoming in family sessions. We establish multiple therapeutic relationships rather than a single alliance as is the case in individual treatment. Success in those relationships connects to clinical success. A therapist's relationship with different people in the mosaic comprising the teen's and family's lives is the starting place for inviting and instigating change attempts. The strategic aspects of these actions are probably obvious by now. There is a leveraging, a shuttle diplomacy, that occurs in the individual sessions as they are worked to determine the most important focal content, and then grow motivation and

readiness to address other family members in joint sessions.

MANUALS AND OTHER SUPPORTING MATERIALS

A previous but standard version of the manual is available online and a new version of the complete MDFT manual containing all core sessions (the basics of which are outlined and described above, in the sections of the four domains of work), clinical and supervision protocols is forthcoming. MDFT has an online training program, which includes a curriculum, worksheets, and therapy video segments for clinical sites training in the approach. A multistep certification procedure includes site readiness preparation, clinical and supervision training procedures including supervisor/trainer preparation protocols, and adherence and quality assurance procedures. Independent MDFT training institutes have been established in the United States and Europe. Many clinical articles have been written over the years, and two MDFT DVDs are available.

Like the treatment, the training process is thought about in terms of stages and milestones to achieve in each stage. The methods of training and supervision are thought of in terms of what they are intended to achieve, and the goals of each stage have generic and idiosyncratic aspects. As with all therapies, there is content and knowledge at the outset that seems important. Certainly adolescent, parent, and family development are vital is content about how to think about the formation of problems that may be expressed primarily by individuals but can always be understood by pulling back the zoom lens and understanding surrounding rings of relationships and social settings. Training and supervision methods are multimodal; they involve case conceptualizations and presentations and discussion that focuse on making sense of symptomatic behavior and, above all, generating options for action and intervention, live supervision where sessions are observed and help offers during the session via phone, and videotape review, where the pressure of a live supervision context disappears, and one can reflect and disentangle a session or particular segment. Like the four corners of the MDFT system, the supervisor uses different methods to offer clinicians the needed opportunities to stretch their clinical range and build repertoire, to think on their feet and improvise, and eventually, to become their own "supervisor" in sessions – capable of being both "in" and "meta" to an interview so as to allow redirection or persistence if that is what is needed given the feedback from the interview.

EVIDENCE ON THE EFFECTS OF TREATMENT

MDFT has been developed and tested since 1985. In 2012, the 12th MDFT controlled trial will be completed. This research program has presented evidence supporting the intervention's effectiveness for adolescent substance abuse and delinquency. Four types of studies have been conducted – efficacy/effectiveness randomized controlled trials (RCTs), process studies, cost studies, and implementation/dissemination studies. The projects have been conducted at sites across the United States with diverse samples of adolescents (African American, Hispanic, and Caucasian youth between the ages of 11 and 18) of varying socioeconomic backgrounds. Internationally, a multinational MDFT controlled trial with over 440 clinically referred adolescents in Germany, France, Switzerland, Belgium, and the Netherlands is complete. Study participants across studies met diagnostic criteria for adolescent substance abuse disorder and included teens with serious drug abuse and delinquency. MDFT has demonstrated efficacy in comparison to several other state-of-the-art, active treatments, including a psychoeducational multifamily group intervention, peer group treatment, individual cognitive behavioral therapy (CBT), and residential treatment.

SUBSTANCE ABUSE

MDFT participants' substance use is reduced significantly. Using an example from one study, MDFT youths reduced drug use between 41 and 66% from baseline to treatment completion. These outcomes remained consistent at 1 year follow-up. MDFT participants also have demonstrated abstinence from illicit drugs after treatment significantly more than youths in comparison treatments. For instance, in a recent study (at posttreatment and at 1 year follow-up) MDFT participants had 64% drug abstinence rates compared to 44% for CBT; in another study, MDFT achieved a 93% abstinence outcome compared to 67% for group treatment. MDFT has been effective as a community-based drug prevention program as well; and using a brief 12-session (over 3 months), in-clinic (community treatment setting) weekly protocol, MDFT has successfully treated clinically referred younger adolescents who recently initiated drug use.

SUBSTANCE ABUSE-RELATED PROBLEMS

Substance abuse-related problems (e.g. antisocial, delinquent, externalizing behaviors) were reduced

significantly in MDFT versus comparison interventions including manual-guided active treatments. Ninety-three percent of MDFT youth reported no substance related problems at 1 year follow-up.

SCHOOL FUNCTIONING

School functioning improves more dramatically in MDFT than comparison treatments. MDFT clients have been shown to return to school and receive passing grades at higher rates, and also show significantly greater increases in conduct grades than a comparison peer group treatment.

PSYCHIATRIC SYMPTOMS

Psychiatric symptoms show greater reductions during treatment in MDFT than comparison treatments (30–85% within-treatment reductions in behavior problems, including delinquent acts, and mental health problems such as anxiety and depression). Compared with individual CBT, MDFT had better drug abuse outcomes for teens with *co-occurring problems*, and decreased externalizing and internalizing symptoms, thus demonstrating superior and stable outcomes (1 year) with the more severely impaired adolescents.

DELINQUENT BEHAVIOR AND ASSOCIATION WITH DELINQUENT PEERS

MDFT-treated youths have shown decreased delinquent behavior and associations with delinquent peers, whereas peer group treatment comparisons reported increases in delinquency and affiliation with delinquent peers. These outcomes maintain at 1 year follow-up. Department of Juvenile Justice records indicate that compared to teens in usual services, MDFT participants were less likely to be arrested or placed on probation, and had fewer findings of wrongdoing during the study period. MDFT-treated youth have also required fewer out-of-home placements than comparison teens. Importantly, parents, teens, and collaborating professionals have found the approach acceptable and feasible to administer and participate in.

THEORY-RELATED CHANGE: FAMILY FUNCTIONING

MDFT youth report improvements in relationships with their parents. On behavioral ratings, family functioning improves (e.g. reductions in family conflict, increases in family cohesion) to a greater extent in MDFT than family group therapy or peer group therapy (observational measures), and these gains are seen at 1 year follow-up. In another example, MDFT-treated youths report gains in individual, developmental functioning on self-esteem and social skill measures.

STUDIES ON THE THERAPEUTIC PROCESS AND CHANGE MECHANISMS

The MDFT studies have demonstrated how to improve family functioning by targeting in-session family interaction and how therapists build successful therapeutic alliances with teens and parents. Adolescents are more likely to complete treatment and decrease their drug taking when therapists have effective therapeutic relationships with their parents and with the teens as well. Strong therapeutic alliances with adolescents predict greater decreases in their drug use. Another process study found a linear adherence-outcome relation for drug use and externalizing symptoms. MDFT process studies found that parents' skills improve during therapy, and critically, these changes predict teen symptom reduction. Culturally responsive protocols have demonstrated increases in adolescent treatment participation. We are beginning to understand the relationship of particular kinds of interventions and key target outcomes. In one example, interventions focusing on actively shaping in-session family discussions and relationship issues change connected directly to differences in drug use, emotional and behavioral problems.

ECONOMIC ANALYSES

The average weekly costs of treatment are significantly less for MDFT ($164) than standard treatment ($365). An intensive version of MDFT has been designed as an alternative to residential treatment and provides superior clinical outcomes at significantly less cost (average weekly costs of $384 versus $1068).

IMPLEMENTATION RESEARCH

MDFT was integrated into a day treatment program for adolescent drug abusers. Key findings include following training, line staff therapists delivered MDFT with fidelity (e.g. broadened treatment focus post-training addressed more approach-specific content themes, focused more on adolescents' thoughts and feelings about themselves and community systems), and with model adherence at 1 year follow-up. Client

outcomes in the program improved after MDFT was introduced, and these outcomes maintained at follow-up. For instance, youths' association with delinquent peers decreased more rapidly after therapists received MDFT training and drug use was decreased by 25% before and 50% after an MDFT training and organizational intervention (and the probability of out-of-home placements for non MDFT youth was significantly greater before MDFT was used in the program).

CONCLUSIONS

The MDFT is an extensively studied therapy for youth substance abuse and delinquency. Several characteristics can be noted. The MDFT is a flexible treatment system. Different versions of the approach have been implemented in diverse community settings by agency clinicians, with both male and female adolescents from varied ethnic, minority, and racial groups. Study participants were clinically referred, drug-using teenagers, and generally showed psychiatric comorbidity, delinquency, and juvenile justice involvement. Assessments included standardized measures, theory-related dimensions, and measures of import to the everyday functioning of target youth and families (in addition to substance use outcomes, school outcomes, family relationships, for instance). The MDFT has been tested against active treatments, including individual CBT and high-quality peer group and multifamily approaches, as well as services as usual. It has been varied on dimensions such as treatment intensity and demonstrated favorable outcomes in its different forms. An intensive version of MDFT was found to be a clinically effective alternative to residential treatment. MDFT has been effective as a prevention program with at-risk, nonclinically referred youths, and as an effective, short-term intervention for clinically referred young adolescents. The research program has used rigorous designs in conducting efficacy/effectiveness trials, followed CONSORT guidelines, used intent to treat analyses, and participated in multisite RCTs. We developed psychometrically sound adherence measures, and trained therapists, supervisors, and trainers in drug abuse and criminal justice settings nationally and internationally. MDFT process studies have clarified some of the approach's mechanisms of action, and economic analyses indicate MDFT to be an affordable alternative compared to standard outpatient or inpatient treatments. MDFT has favorable outcomes in reducing delinquency, externalizing, and internalizing symptoms. In recent work, HIV and *sexually transmitted disease (*STD) risks have decreased as well. Process studies show change in key components of the outcome equation (affiliation with drug-using peers, family and school functioning, as examples). The RCTs track outcomes with 1 year follow-ups, and outcomes retain at this assessment. A new study includes sustained positive outcomes at 4 years' post intake assessments. MDFT presents a well-defined clinical focus in how it establishes individual relationships with parent and youth, works with each alone in individual sessions, targets family interactional changes, and also works with individuals and parents vis-á-vis the teen's and family's social context.

List of Abbreviations

CBT cognitive behavioral therapy
MDFT multidimensional family therapy

Glossary

Context adolescent development and treatment necessarily includes the multiple psychosocial social contexts of teens and their families. The context dimension reminds the clinician not to narrow his or her understanding to the individual or family level only. Interventions target many levels, aspects of functioning, and different individuals. Some of these pertain to adolescents' everyday functioning in social settings outside their families.

Multidimensional the dimensions of importance in MDFT include **research** (use of developmental theory and findings, different kinds of research in the MDFT research program), **multiple levels or domains of human functioning** (intrapersonal (cognitive, emotional, behavioral), and interpersonal (transactions and transactional patterns in family relationships and of individuals relative to extrafamilial individuals in relevant social systems and communities)), and **multiple determinants of problem behaviors and multiple determinants, pathways, processes and methods used to create change** (i.e. adolescent-focused sessions and interventions, and parent-focused sessions and interventions are important in and of themselves, and they also create opportunities to prepare for family sessions, and to process and review the family meetings).

Structural family therapy (Minuchin) the influences of SFT can be observed in MDFT's adoption of the enactment principles of change and intervention.

Strategic family therapy (Haley) emphasizes crafting a *strategy* for treatment, thinking in terms of *stages of therapy and of change*, and focusing on *out-of-session tasks* as a complement to in-session change enactments,

Treatment parameters refers to the organizational aspects of treatment. Sessions are held in clinical offices, home, school, juvenile court, or wherever the appropriate parties can be convened. Using the phone – to call the parent, adolescent, or other family members (e.g. to follow up after face-to-face contact, make more suggestions to follow the action plan set in the previous contact) – is common.

Further Reading

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http://www.youtube.com/watch?v=tu-r27w6mgg – MDFT In Practice Video

http://www.youtube.com/watch?v=FiOiOERc82o – Multidimensional Family Therapy, An Introduction (Part 1 of 2).

http://www.youtube.com/watch?v=YzjGqlPlU-g – Multidimensional Family Therapy, An Introduction (Part 2 of 2).

http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=16 – NREPP.