Multidimensional Family Therapy for Early Adolescent Substance Abuse Treatment Manual

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Goals and Objectives of the ATM Cooperative Agreement

Substance abuse disorders among adolescents are a serious public health concern. As the number of adolescents presenting for treatment to the nation's public treatment systems continues to increase, the need for effective substance abuse treatment models multiplies. Few rigorous evaluation studies on the effectiveness of adolescent substance abuse treatment have been conducted. Those that have been conducted are limited by variation in programs and lack of definition of the approaches evaluated, along with problems related to small samples and marginal follow-up rates. More importantly, the field lacks manualized treatment approaches that can be easily disseminated to treatment providers who work with our nation's substance involved youth (Morral & Stevens, 2003).

To address the need for evaluating, documenting, and disseminating effective substance abuse treatment models, the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT) funded the Adolescent Treatment Models (ATM) program, in which ten exemplary adolescent treatment programs in the United States were evaluated. The goals of the CSAT ATM Project Cooperative Agreement are listed below:

1. Identify currently existing potentially exemplary models of adolescent substance abuse treatment
2. Collaborate with the treatment providers to formalize their models into disseminable manuals that can be replicated by other programs
3. Determine with whom the model has been tested and the amount of services the adolescents actually received
4. Evaluate the effectiveness and cost associated with each model
5. Collaborate on cross-site comparisons of these models with one anotehr and with other studies of adolescent substance abuse treatment
6. Participate in professional activities to disseminate the resulting models and findings.

The ATM project targeted substance abusing adolescents; however, the ATM treatment models represent a wide range of levels of care, clinical approaches, provider organizations, geographic locations, and evaluators. As part of the ATM collaborative agreement, The Center for Treatment Research on Adolescent Drug Abuse (CTRADA) conducted a randomized clinical trial designed to target early adolescent substance abusers. The study was conducted in collaboration with staff from The Village of Miami, Florida and involved a comparison of two manual-based treatment conditions for adolescent drug abuse: (a) an empirically supported, family-based treatment , Multidimensional Family Therapy (MDFT) and (b) adolescent group therapy. This treatment manual describes MDFT as it was delivered as part of the ATM collaborative agreement. For this study, as described in this treatment manual, MDFT was specifically adapted for young adolescent substance abusers. As such, this manual presents one version of MDFT, which as a treatment system with flexible treatment parameters has been modified to treat a range of populations (e.g., outpatient, residential, and day treatment).

Overview of the Study

The early adolescent population has been identified as a group in need of specialized treatments. Early adolescence is a developmental period that offers clinically important and intervention-rich opportunities (Loeber, 1990; Rowe, Parker-Sloat, Schwartz, & Liddle, 2003). Generally, the earlier youth begin to use drugs and experience related problems, the more serious are the consequences (Tarter et al., 1999), and the more difficult it is to steer them on to a positive developmental course. As such, early adolescents were selected in this study as the targeted population for these interventions. In addition, the study is noteworthy in that the interventions were delivered by clinicians in a community-based drug treatment program. As such, the findings from this study are important due to the implications for treating early adolescent drug abuse, further specifying the boundary conditions of family-based treatment, as well as establishing the generalizability of a representative empirically supported therapy to a real-world clinical setting.

Multidimensional Family Therapy (MDFT)—Multidimensional family therapy is a multisystemic family-focused treatment that includes in-home, in-clinic, and telephone sessions working with adolescents and their families. MDFT targets the psychosocial functioning of individual family members, the family members' relationships, and influential social systems outside the family. The comparison treatment employed in the study is a peer group-based model. Group therapy was chosen as the comparison treatment primarily because it is among the most predominant treatments for adolescent drug abuse. Because we wanted to test MDFT in a real-world clinical setting, we compared it to standard treatment for early adolescent drug abuse. Group interventions focused on self-esteem enhancement, decision-making skills, stress/anger management, communication skills, health education, teen pregnancy prevention, and occupational/career planning.

Both treatments were delivered by Village therapists and involved 16 weeks of treatment, with three hours of weekly client contact. Approximately 85 adolescents were randomly assigned to either MDFT or AGT. Both conditions were manual driven and carefully monitored by expert supervisors. All clients were assessed at intake and at 6 weeks and 6 and 12 months following intake on multiple dependent variables. To validate clients' responses, urine tests and collateral assessments were also conducted at intake and 6 and 12 month follow-up assessments.

II. Multidimensional Family Therapy Approach to Early Adolescent Substance Abuse Treatment

Evolution of the MDFT Protocol

MDFT is a family-based outpatient treatment developed for clinically referred adolescents with drug and behavioral problems (Liddle, 1992). The approach strives for consistency and a coherent and logical connection among its theory, principles of intervention, and intervention strategies and methods. The intervention methods derive from target population characteristics, and they are guided by research-based knowledge about dysfunctional and normal adolescent and family development. Interventions work within the multiple ecologies of adolescent development, and they target the processes known to produce and/or maintain drug taking and related problem behaviors. Similar developmental challenges may be common to all adolescents and their families, and these are central assessment and treatment focuses (Liddle & Rowe, 2000). At the same time, considerable variation may be demonstrated in the expression of these generic developmental challenges. In MDFT therapists are sensitive to these individual adolescent and family variations. With each case, therapists seek to understand the unique manifestations of developmental problems.

MDFT is not a narrowly focused treatment protocol but can be more accurately described as a treatment system. The approach has been operational in different treatment applications. Different versions of this approach have been developed and tested according to several factors, including study population characteristics, the intent of the study at the time, and findings from an ongoing clinical research program on the MDFT model. The MDFT research program to date is summarized elsewhere (Liddle & Hogue, 2001). The approach has varied in elements such as *treatment length* (e.g., in one study, 16 sessions over 5 months; in another, a flexible number of sessions from 4 to 25), *dosage* or *intensity* (the amount of therapist contact per week), *intervention locale* (in-clinic or a combination of in-clinic/home-based locales), inclusion of *particular therapeutic methods* (e.g., clinical use of within-treatment drug screens and case management), and *formats* (e.g., using a single therapist or a therapist and therapist's assistant [case management assistant]). MDFT has been used effectively by both experienced family therapists and line clinicians with no family therapy experience. Ideally, the person who trains and/or supervises the implementation of MDFT should have a background in family therapy and/or adolescent development.

The MDFT approach has been developed and tested since 1985 in four major, completed randomized clinical trials, a randomized prevention trial, and several treatment development and process studies, which have illuminated core change-related aspects of the therapeutic process (Liddle & Hogue, 2001). Since 1991, this work has been performed at the Center for Treatment Research on Adolescent Drug Abuse (CTRADA). CTRADA was the first National Institutes of Health/National Institute on Drug Abuse (NIDA)-funded research center on adolescent substance abuse. MDFT studies have been conducted at various urban locations in the United States, including Philadelphia, the San Francisco Bay area, central Illinois, and Miami. The study

populations were ethnically diverse (and their problem severity varied as well), from high-risk subjects in early adolescence to multiproblem, juvenile justice-involved female and male adolescent substance abusers with co-occurring disorders. This approach has been recognized as one of a new generation of comprehensive, multicomponent, theoretically derived, and empirically supported adolescent drug abuse treatments (Center for Substance Abuse Treatment, 1999; Lebow & Gurman, 1995; National Institute on Drug Abuse, 1999; Nichols & Schwartz, 1998; Selekman & Todd, 1990; Stanton & Shadish, 1997; Waldron, 1997; Weinberg et al., 1998; Winters, Latimer & Stinchfield, 1999). MDFT is included in NIDA's list of empirically supported drug treatments (www.nida.nih.gov) and in the American Psychological Association's Division 50 issue on empirically supported drug therapies in *The Addictions Newsletter* (Liddle & Rowe, 2000). MDFT is also included in the Office of Juvenile Justice and Delinquency Prevention's Strengthening America's Families—Exemplary Programs Initiative (www.strengtheningfamilies.org) with the Center for Substance Abuse Prevention. MDFT was recently profiled in the Drug Strategies Report on State of the Art Adolescent Drug Abuse Treatments (Drug Strategies, 2002). Awards recognizing the development of the approach have been presented to the model's developer by the American Psychological Association (1991), the American Family Therapy Academy (1995), the American Association for Marriage and Family Therapy (1996), and the Florida Association for Marriage and Family Therapy (2000).

This manual describes the version of MDFT that was tested in the Adolescent Treatment Models study funded by CSAT from 1998 to 2002 (Stevens & Morral, 2003). The version of MDFT tested in CTRADA's ATM study is a 12-16 week version of MDFT (delivered over 3-4 months), specific for early adolescent drug abusers. Adolescents in this project were 12-15 years old and met ASAM criteria for outpatient drug abuse treatment. Because MDFT was being tested as an early intervention model, youth with drug use or delinquency problems warranting intensive outpatient services were not appropriate for this level of treatment. Thus, adolescents with an extensive psychiatric and juvenile justice history were excluded from the program. Youths also had a family member willing to participate in therapy and research assessments. Most youths had between one and two arrests but very few had previous drug treatment. The sample was approximately 48 percent African American and 44 percent Hispanic, with the remainder being from White Non-Hispanic and other ethnicities. Males made up slightly over 70 percent of the sample. Adolescents reported using approximately twice per month, and marijuana was the substance of choice for almost all youth in the study.

MDFT is based on a developmental psychopathology framework and targets the multiple ecological factors maintaining drug use and other problem behaviors (Liddle, 1999). In general, MDFT targets four treatment domains: (a) the individual adolescent, (b) parents and other family members, (c) the family's transactional patterns, and (d) family members' interactions with extrafamilial systems. Specific to the Miami study of the ATM cooperative, MDFT focuses on the same domains, but highlights developmentally relevant processes common with early adolescents including: (a) the adolescent's developing sense of self, (2) peer relationships, and (3) relationships with parents. These domains represent arguably the most important spheres of influence and change during early adolescence.

Overview of the Treatment Model Intervention

It is important to have a sufficiently complex, multivariate framework to comprehend and act on what could be called the core clinical phenomena—the situations and processes that determine poor developmental outcomes and that, therefore, should be targeted for change. A multidimensional perspective on adolescent substance abuse and behavior problems, and thus a multidimensional framework, orients therapy and the therapist. This framework, made up of empirically based knowledge about how adolescents develop and how development is derailed, drives the therapy.

In research, design and statistical methods are tools to answer research queries. Similarly, in treatment, therapy techniques serve the overall approach. Techniques are tools; they are a means to access and facilitate adaptive change. MDFT therapists are taught an overarching conceptual framework that helps them appraise and respond to diverse clinical situations. The MDFT framework focuses on several areas that are critical to a clinician's understanding of how adolescent drug problems form, develop, and continue and how they can be replaced with adaptive and prosocial development and competence. Therapists are developmentalists in the sense of having a primary job of understanding how development has gone astray and devising means to facilitate its retracking.

Dimensions of Multidimensional Family Therapy

MDFT is an integrative therapeutic philosophy and clinical approach. It relies on the contemporary empirical knowledge base of risk and protective factors and known determinants of adolescent substance abuse to assess and intervene in the lives of teenagers and their parents.

Figure 1 answers the obvious and immediate question that comes from a first encounter with MDFT: What are the dimensions of multidimensional family therapy? The following section gives a thumbnail sketch of each of these dimensions that reflect different aspects of the model's characteristics as well as the sources of influence on the MDFT approach over the years.

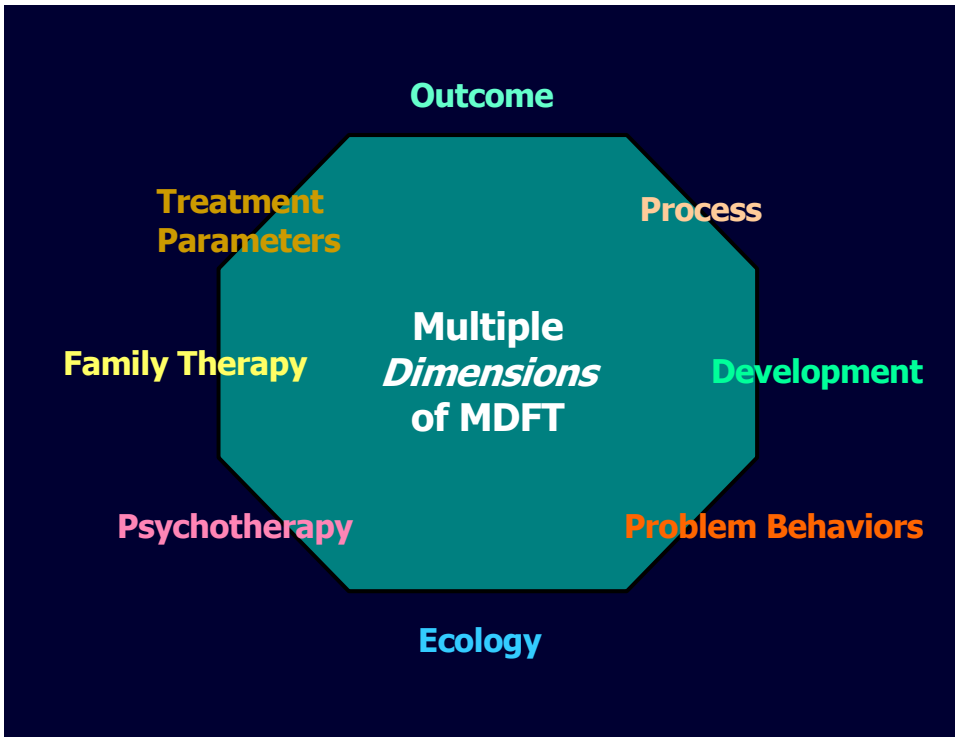

Figure 1. Dimensions of Multidimensional Family Therapy

Outcome

The outcome dimension refers to the model's and the therapist's overriding orientation. In every contact with the case or with persons with whom the family interacts, the therapist asks the question, "What are the optimal and 'good enough' outcomes in this interaction?" Thus outcome refers here to overall case outcomes (e.g., abstinence or great reductions in the use of illegal substances and the connection of a teen to prosocial influences and activities) as well as to smaller, more proximal outcomes (e.g., the outcome of a phone conversation with a parent or the outcomes of a session). This outcome orientation permeates every session and every contact with a client. This outcome orientation encourages, indeed organizes, a therapist to think in terms of long-term, intermediate, and short-term goals and the mechanisms to achieve them.

Process

Whereas a goal orientation is a necessary and critical starting place in clinical work, an outcome orientation is incomplete without a vision of the way particular outcomes might be achieved. Process refers to the way the hoped-for change is facilitated (Stevens et al., 2003).

Development

Development is the knowledge base of clinical work. Therapists use their knowledge of development to set an overall treatment course, as well as to pinpoint particular interventions or adjust those already in motion. Knowing about the expected and normal changes in the parent–

adolescent relationship or normal changes in the individual aspects of a teen's development (e.g., focus on self-identity, puberty, sexual experimentation, identity development, changing peer and family relations, cognitive changes allowing perspective taking informs the therapist's assessment and intervention ability (Rowe et al., 2003). An appreciation and the use of developmental knowledge also include a focus on the teen's family members.

Problem Behaviors

Problem behaviors are deviations from normal development. In research literature, the developmental psychopathology perspective allows clinicians and researchers to understand the development of problem behaviors over time, their interrelationship and sequencing, and the risk and protective factors of high-risk adolescent behaviors. As a systemic approach, MDFT includes the behaviors of the caretakers most involved with the teenager.

Ecology

Adolescent development and treatment necessarily includes the multiple psychosocial ecologies of teens and their families. The ecology dimension reminds the clinician not to narrow his or her understanding to the individual or family level. The therapist has available multiple assessment tools and levels of intervention—and some of these pertain to adolescents' everyday functioning in social ecologies outside their families.

Psychotherapy

This sphere of influence pertains to particular forms of therapy that have influenced the MDFT approach. Particularly in MDFT's early development, behavioral therapies and client-centered therapies influenced the approach. In recent years, thinking and methods from both the drug counseling and chemical dependency perspectives have informed the MDFT approach.

Family Therapy

Structural Therapy (Minuchin, 1974) and Strategic Family Therapy (SFT) (Haley, 1976) were among the earliest influences on the MDFT approach, which was first called Structural-Strategic Family Therapy (Liddle, 1985). The influences of SFT can be observed in MDFT's adoption of the enactment principles of change and intervention. Problem Solving Therapy, which emphasizes crafting a strategy for treatment, thinking in stages of therapy and of change, and focusing on out-of-session tasks as a complement to in-session change enactments, has been a major influence on the MDFT approach as well. Stanton and Todd's (1982) integrative structural and strategic therapy with heroin-addicted adults also was a significant influence in MDFT's early days.

Treatment Parameters

This dimension refers to the structural or organizational aspects of the treatment approach. In the ATM study, treatment duration was 12-16 weeks, with 3 hours per week of total

therapist contact. Sessions were held in clinical offices, the home, school, juvenile court, or wherever the appropriate parties could 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. It is important not to let limits imposed by traditional ways of service delivery (e.g., in-clinic sessions, 1 hour of treatment per week) define what is perceived to be needed with multiproblem adolescents and their families.

Defining the Clinical Model in the ATM Study

MDFT includes four modules: adolescent, parent, family interaction, and extrafamilial systems. We use "module" in several ways. It can refer to (1) the various knowledge bases that constitute our understanding of drug and behavior problems, (2) the intervention targets or locales where the interventions aim to facilitate prosocial or healing processes and block dysfunctional processes or actions, or (3) the pathways to and mechanisms of change. Treatment has three stages: (1) build the foundation, (2) prompt action and change by working the themes, and (3) seal the changes and exit.

General Theoretical Assumptions and Approach

Theory of Dysfunction

Presumptions about how problems develop and are maintained or how they are exacerbated are fundamental to any intervention and to an overall model. Ideally, there is a connection between how dysfunction develops and continues and a model's techniques. Interventions, which are actualized using particular techniques, target certain content, personal characteristics, or interpersonal processes. A model can also specify processes or means by which the therapy techniques affect the intervention targets—such as specific domains of functioning—to facilitate improved overall functioning. Key components of MDFT's theoretical underpinnings derive from family and developmental psychology (Bronfenbrenner, 1979; Kaye, 1985; Minuchin, 1985) and developmental psychopathology (Sroufe & Rutter, 1984). Epidemiological, clinical, and basic research studies indicate that adolescent drug abuse is a multidimensional disorder (Brook et al., 1988; Bukstein, 1995; Newcomb, 1995). Correspondingly, the MDFT treatment model's philosophy and methods reflect the field's assessment of this disorder (Segal, 1986). A commitment to translate and use clinical and basic research has been a guiding principle in this model's development.

Early adolescence is one of the most sensitive periods in the life cycle. It is a transitional period during which young adolescents experience physical changes (Paikoff & Brooks-Gunn, 1990), new feelings and perspectives about their sense of self and relationships (Archer, 1982), and significant shifts in socially ascribed roles (Dunham, Kidwell, & Wilson, 1986). Because of the "developmental reorganization" (Cichetti & Toth, 1992) that occurs between late childhood and adolescence, early adolescence is a time of heightened vulnerability to emotional and behavior problems and substance use disorders. Moreover, problems during this critical period increase vulnerability to a range of negative outcomes throughout adolescence and into adulthood. Generally, the earlier youth begin to use drugs and experience related problems, the

more serious are the consequences (Tarter et al., 1999), and the more difficult it is to steer them on to a positive developmental course.

Given the increased susceptibility to problem behaviors during the early adolescent transition, this is a critical period for intervention efforts (cf., Cicchetti & Richters, 1993; Conger & Ge, 1999; Hser, Grella, Collins, & Teruya, 2003). Furthermore, the difficulty of treating severe drug abuse in late adolescence and adulthood has motivated researchers and clinicians in the drug abuse field to identify effective "early interventions" that may halt the progression of deviance before negative behavioral patterns become highly resistant to change (Hogue & Liddle, 1999). MDFT treatment development efforts aimed at more effectively treating young adolescents have focused on three specific areas: 1) the adolescent's developing sense of self, 2) peer relationships, and 3) relationships with parents. These domains represent the most important spheres of influence and change during early adolescence. MDFT interventions in each of these areas are based on developmental research and the risk and protective factors framework.

Risk factors

Drug use and drug abuse correlates have been organized into several domains—individual, family, peer, school, neighborhood/community, and societal (Hawkins, Catalano & Miller, 1992). These domains reflect both the intervention philosophy and focuses of MDFT. The correlates—the pieces of the puzzle (Petraitis, Flay & Miller, 1995)—of adolescent substance use and abuse include systemic-level factors, such as extreme economic deprivation, and proximate ones, such as family conflict and disruptions in family management. Individual factors, such as parental psychopathology or drug and alcohol use, and an adolescent's failure to bond to school, problems in emotion regulation, or poor interpersonal skills and peer relations, are implicated in drug problem development as well (Brook et al., 1988).

MDFT's multisystemic family-based approach, rooted in social science versions of systems thinking (Bronfenbrenner, 1979; Minuchin, 1985), is consistent with contemporary understandings of risk and protective processes. Risk factors do not exist or operate in isolation—multiple risk factors interact over time and can have a cumulative impact (Bry, McKeon & Pandina, 1982). Their interaction within a given timeframe can create synergistic effects yielding higher levels of risk, deteriorating functioning, and few development-enhancing circumstances.

Risk factors are also mutually influential and reinforcing (Brook, Whiteman & Finch, 1993; Thornberry, 1996). This conceptualization coincides with contemporary ideas about reciprocal effects in human relationships (Lerner & Spanier, 1978; Sameroff, 1975). An adolescent's academic problems and low commitment to school might make normal developmental tension at home worse. Avoidance of conflictual topics and negative interactions are common coping behaviors in clinical families (and others) in this situation. Together, these circumstances create the motivation and opportunity for affiliating with like-problem peers.

Drug use is most common and pervasive in young adolescents who are characterized as identity diffuse and have problems with identity development (Jones, 1992, 1994). In addition, Oyserman and Markus (1990) uncovered a relationship between "possible selves" – "the elements of the self-concept that represent the individual's goals, motives, fears, and anxieties"

(p. 113) – and delinquency status. These authors showed that delinquents were much more negative and pessimistic in describing the person they expected and hoped to become than were nondelinquents. The clinical relevance of these findings is that possible selves provide direction for the adolescent's actions, thus skilled clinicians can use these representations to explore alternatives to the way the adolescent is living his life.

Peers become a significant source of support and intimacy in early adolescence. During and shortly after puberty, youth begin spending more time with friends and less time at home (Berndt & Perry, 1990). Whereas younger children select friends based on common interests and activities, adolescents tend to form peer relationships based on psychological or attitudinal similarities (Steinberg, 1991). Research has consistently shown that young adolescents with positive life styles are apt to select prosocial peers, whereas young adolescents oriented toward antisocial or problem behavior are likely to select similarly deviant peers (Bush, Weinfurt, & Ianotti). On the positive side, peer-related protective factors can buffer the young adolescent from drug abuse (Wentzel & McNamara, 1999). For example, peer crowds oriented toward positive behavior (e.g., sports, academics) may actively disapprove of drug use (Youniss, McLellan, & Strouse, 1994). Furthermore, intimacy in peer relationships allows young adolescents to express emotions (Berndt & Perry, 1990) and thus to prevent the buildup of negative affect that may contribute to drug abuse (Diamond & Liddle, 1996).

Young adolescents' relationships with their parents necessarily undergo a process of change and transformation (Steinberg, 1991). Developments in cognitive skills, emotional experiences, and social roles change the ways young adolescents relate to parents, and parents of young adolescents experience life transitions of their own that impact the nature of the parent-adolescent relationship (Silverberg, 1996). The relatively minor increase in parent-child distance and conflict during the early adolescent transition does not preclude the desire for acceptance from and attachment to parents. Research demonstrates that an early adolescent's well being is closely connected to parental acceptance, involvement, and support (Lieberman, Doyle, & Markeiwicz, 1999).

Poor parental monitoring is perhaps the most critical family factor in the initiation of early adolescent substance use (Steinberg et al., 1994), as much of early adolescent drug use occurs in the adolescent's own home, in the absence of adult supervision (Steinberg, 1991). Authoritative parenting, which combines warmth with challenge and supervision, is associated with the most favorable adolescent outcomes, including school achievement, prosocial peer affiliations, low levels of drug use, and a coherent sense of identity (Eccles, 1999; Steinberg, 1991; Fletcher & Jefferies, 1999). Conversely, permissive-neglectful parenting is associated with pervasive difficulties (Brook et al., 1999). Perhaps most importantly, protective factors such as consistent discipline and monitoring within the family limit access to and attraction to drug using, deviant peers (Steinberg et al., 1994).

Poor family-management skills may be related to a parent's functioning in other domains, such as parental psychopathology or family disruption created by unemployment. Family management difficulties set the stage for inconsistent parental monitoring, increased frustration, and an inability to address the normal challenges of parenting teenagers. Temperamentally difficult children and teenagers can influence family management strategy, ability, and consistency. Subtle rejection of these children and teenagers by parents is not uncommon (Baumrind & Moselle, 1985). Parents in this situation often experience loosening of their

influence and control over the adolescent as the teenager's peer affiliations become stronger (Dishion et al., 1995; Rueger & Liberman, 1984). Although decreased direct parental influence during the adolescent years is normal, in clinical families parents are known to have, or view themselves as having, very little parental influence (Patterson & Chamberlain, 1994; Schmidt, Liddle & Dakof, 1996). Some researchers have argued that part of the deviation-amplifying process (and part of what needs to change) involves increases in parents' tolerance for deviant behavior (Bell & Chapman, 1986).

Protective factors

A risk factor focus must be complemented by a therapist's ability to know about, focus on, and expand protective factors—particularly those having to do with establishing connection to prosocial pursuits and new kinds of relationships within and outside the family. Eliciting hidden strengths is critical (Minuchin & Fishman, 1981). A basic goal is establishing a receptive mindset in both the parent and teenager regarding the fundamental role played by personal relationships in promoting development in the adolescent's life.

A good relationship with one's parents buffers against development of problem behavior (Wills, 1990). Many recent studies underscore the importance of parents to their teenager's ongoing development (Resnick et al., 1997), as well as the parents' capacity to stop the progression of problems once they have begun. Steinberg, Fletcher & Darling (1994) found that particular parenting practices, such as providing emotional support, can reverse the course of negative peer influence even after problem behavior has started. Although its primary goals are to change the adolescent–parent relationship in developmentally normative ways and to change the family environment generally, family relationships are not the only target of change in MDFT.

A therapist does not simply memorize the list of risk and protective factors and seize opportunities to discuss them. Rather, clinicians assess and intervene in transactional and interinstitutional processes while using and translating the knowledge base of risk and protective factors, which constitutes a higher objective and skill. Assessing and intervening in the dynamic "moving targets" of reciprocal interactions (i.e., an adolescent's behavior elicits a parent's reactions, and parenting practices influence the teenager's behavior and elicit reactions as well [Lytton, 1990; Stice & Barrera, 1995; Vuchinich, Bank & Patterson, 1992]) is a major challenge.

Adolescent development

The MDFT approach targets a youth's relationships across developmental niches. For example, considerable time is spent with the adolescent in individual sessions in this family-based treatment to gain indirect access to his or her intrapersonal world and peer network. These therapeutic contacts vary. Sometimes they are sessions in the usual sense, but on other occasions they may also take the form of an outing to a movie or a restaurant or an adolescent-led guided tour of the teenager's neighborhood. The role of influential antisocial peers in the development and amplification of child and adolescent problem behaviors is well established (Dishion et al., 1995). Because adolescents are generally not willing to discuss the details of their antisocial activities with peers in the presence of their parents, access to the adolescent's conception of and activities within his or her peer world, as well as to the intrapersonal aspects of the adolescent's

development (Oyserman & Markus, 1990), is gained by spending time with the teenager alone (Liddle, 1995). Varying the treatment setting to forge relationships with individuals who have "been there and done that" as far as the treatment programs are concerned has been a key factor in gaining the needed access to the teen's psychological and emotional world. Access is earned. A teen's referral to treatment by juvenile court or his or her coercion into therapy by a parent or school official has nothing to do with gaining the needed access to the adolescent's psychosocial world. Only a personal relationship between the therapist and adolescent can create the kind of access that predicts change.

For practical clinical reasons and on the basis of research evidence, adolescent problem behavior and drug abuse are defined as problems of development (i.e., deviations in the normal developmental course or failures to successfully meet developmental challenges). These problem behaviors are determined by the interplay between the youth and the social systems—family, peer, school, and community or neighborhood—in which he or she lives. Adolescent drug abuse is "embedded within the proximal peer environment, which in turn, emerges and is amplified within a context of low adult involvement and monitoring" (Dishion et al., 1995, p. 803). Because of the many factors involved in the creation and continuation of adolescent drug use and abuse, and the number of functional impairments that exist with drug-abusing adolescents, a broad-based, comprehensive treatment strategy is necessary (Kazdin, 1994; Newcomb, 1992). The therapist devises an individualized treatment plan targeting aspects of functioning in individual, familial, and extrafamilial systems known to be related to the creation and continuation of drug abuse and related problem behaviors. The treatment plan is a collaborative effort; each family member and influential extrafamilial other is involved in its creation. Adolescent substance abuse is a systemic problem—a set of behaviors and circumstances that combine to derail attainment of current and future developmental milestones.

Key Concepts:

- **The family is a primary context of healthy identity formation and ego development.**
- **Peer influence is contextual; it interacts with the buffering effects of a family against the deviant peer subculture.**
- **Adolescents need to develop an interdependent rather than an emotionally separated relationship with their parents.**
- **Symptom reduction and enhancement of prosocial and normative developmental functions in problem adolescents occur by targeting the family as the foundation for intervention and simultaneously facilitating growth and healing processes in several domains of functioning and across several systemic levels.**

Specifically, in relation to early adolescents, the above points certainly apply. However, there are additional developmental considerations that need to be taken account as well. Three specific examples include (a) puberty, (b) cognitive changes, and (c) emotional experience and expression.

Puberty and Early Adolescence

Key Concepts:

- **Puberty is a series of events with interindividual differences in sequence, onset, rate, duration and offset of various bodily and physiological changes.**
- **The observable changes of puberty signal to those in the teen's social world impending changes in the adolescent's potential and readiness for greater responsibility, autonomy, adult reproductive capacity and sexuality.**
- **Pubertal changes must be examined within the social environment and in the context of the family.**
- **Parents' expectations about the behavioral and emotional implications of the adolescents' physical maturation may significantly affect how the adolescent processes and adjusts to these developments.**

The simplistic model of associating puberty and hormonal changes with emotional lability and negative affect has been supplanted by more complex theories (Buchanan, Eccles, & Becker, 1992). The effects of puberty are most likely mediated by social and environmental factors and are understood in terms of the cumulative effects of numerous variables as well as reciprocal causality (Simmons & Blyth, 1987). For instance, puberty is seen as a general change-inducing stressor, which may become a real liability for some adolescents if it puts them in a position of differentness from peers (Simmons & Blyth, 1987). Research tends to support the notion that biological changes during puberty have little direct effect on behavior, feelings, attitudes and adolescent-parent relations (Bulcroft, 1991; Savin-Williams & Small, 1986). This body of research would therefore reinforce the continued salience of interpersonal, affective and behavioral targets during therapy with adolescents. In fact, the combined effects and interactions of pubertal changes, environmental and life events, social factors, norms and expectations are far more powerful determinants of change during adolescence than is the unitary influence of hormonal and physical changes of puberty. Pubertal changes must be examined within the social environment and, in particular, in the context of the family.

Research suggests that the adolescent's experience of his own physical development during puberty appears to be related to the quality of family interactions and the responses of family members to these changes. For instance, adolescent girls tend to have improved self-esteem immediately after the onset of menarche, but this association is mediated by the quality of the mother-daughter relationship and the punitiveness of the father (Lackovic-Grgin, Dekovic, & Opacic, 1994). Parents' expectations about the behavioral and emotional implications of the adolescents' physical maturation may significantly affect how the adolescent processes and adjusts to these developments (Brooks-Gunn & Reiter, 1990). The biological maturation process actually appears to be affected by family environment as well as biologically driven processes.

The onset of menarche appears to be accelerated by conflict in the home and by divorce (Belsky, Steinberg, & Draper, 1991; Wierson, Long, & Forehand, 1993). Biological changes occur within and may even be shaped by the context of the familial environment (Holmbeck & Hill, 1991).

Cognitive Development in Early Adolescents

Information processing and problem solving skills have a bearing on the everyday practical problem solving and decision making abilities of the adolescent. Maladjusted adolescents often show deficiencies in cognitive problem solving skills with inadequacies in their ability to generate solutions, to see multiple perspectives in interpersonal situations, to plan out steps toward achieving goals, to explore pros and cons, and to consider possible obstacles (Spivak, Platt & Shure, 1976). It is not enough for the therapist to help the teenager formulate therapy goals, she must also help him to devise the means to reach these goals.

At some point during the adolescent years, the potential increases for a qualitative structural shift from concrete to formal operational thinking as evidenced by the emergence of sophisticated scientific and logical reasoning. Many adolescents develop the capacity to think about possibilities and new ideas, think through hypotheses, think ahead, and plan and think about the relations among different sets of ideas (Keating, 1980). Often, the new thinking patterns draw the adolescent into the world of theories about self and life (Flavell, 1963), about the world as it is and as it might be. The application of this type of thought process enables the adolescent to reach objective conclusions about cause and effect. In social cognition, cognitive developments are accompanied by improved abilities to take on the perspective of others and engage in positive social interaction (Offer & Sabshin, 1984). Such cognitive developmental changes also signify necessary shifts in family development to accommodate the changes occurring with the individual adolescent. In many families, however, parents find it difficult to respectfully encourage their teenager to discuss and negotiate issues such as household rules and chores. Such disengagement does not provide opportunities for growth producing discussions. New ways of thinking are born out of a recognition that the old ways are inadequate. Thus, the family needs to provide a setting in which the adolescent feels comfortable in and benefits from expressing and developing ideas and independent opinions. MDFT therapists work to facilitate productive negotiations between teenagers and parents while preventing the derailment of such conversations and foreclosure on the adolescent's problem solving and decision making processes.

Emotional Expression

The developmentally sensitive therapist understands that adolescents in treatment may not express their emotions easily or openly. This is especially the case for younger adolescents who typically have difficulty identifying as well as expressing their emotions. It is important that therapists do not assume that they know what the adolescent is experiencing or feeling during the session. The therapist needs to systematically check-in with the teenager, asking concrete questions such as "Do you feel like your side of the story is being heard?" or "Do you feel like you're being treated like you are too young or too old?" or "Does this plan seem fair to you?". Asking adolescents more abstract questions such as "How do you feel?" may be hard for most teenagers to answer and may make them feel self-conscious, inadequate, and may be

counterproductive. When teenagers do not or cannot respond directly to such questions, the therapist may hypothesize, or ask parents to hypothesize about what they suppose the adolescent is feeling. Parents often have a good idea about the nature of and possible reasons for the adolescent's feelings, and the parent's expression of their hypotheses can be a good starting point for conversation. This allows for the teenager to either agree or disagree with feelings he may have difficulty expressing. In some cases in which early adolescents are incapable of identifying their emotions, therapy is facilitated by moving from the affective to the behavioral realm of intervention and change.

Research on family functioning reveals that the adolescent is greatly influenced by the emotional climate of the family environment. Adolescents' global and immediate emotional states tend to reflect those of their parents (Larson & Richards, 1994) and young adolescents' general levels of emotional expressiveness correlate with their parents' (Bronstein et al., 1993). There is evidence that the open expression of nonhostile emotion in the family promotes healthy adjustment during the transition to early adolescence, including positive social behavior for boys and high self-esteem for girls (Bronstein et al., 1993). MDFT therapists work to help the family modulate its emotional climate both in and outside of therapy. The therapist short-circuits the escalation of negative emotion by blocking such interactions and asking family members to reflect on their feelings, on the effectiveness of their methods of communications, and on the action potential of emotions. Intense emotions are understood in a historical context thereby avoiding pathological personality ascriptions that perpetuate beliefs about other family member's incompetence or instability. MDFT therapists work with family members in the session to identify deep felt emotions and find more effective ways to express them and helps the family generalize these skills to situations outside of therapy.

Theory of Change

Adolescent developmental psychology and psychopathology research has determined that (1) the family is the primary context of healthy identity formation and ego development, (2) peer influence operates in relation to the family's buffering effect against the deviant peer subculture, and (3) adolescents need to develop an interdependent rather than an emotionally separated relationship with their parents. Therefore, a multidimensional change perspective holds that symptom reduction and enhancement of prosocial and normative developmental functions in problem adolescents occur by (1) targeting the family as the foundation for intervention and (2) simultaneously facilitating curative processes in several domains of functioning and across several systemic levels. Particular behaviors, emotions, and thinking patterns known to be related to problem formation and continuation are replaced by new behaviors, emotions, and thinking patterns associated with appropriate intrapersonal and familial development.

Key Concepts:

- **MDFT systematically assesses and targets adolescent functioning in six health-related domains: drug use, identity development and autonomy, peers and peer influence, bonding to prosocial institutions, racial and cultural issues, and health and sexuality.**

- **Interventions have both intrapersonal and interpersonal aspects.**

MDFT systematically assesses and targets adolescent domains of functioning: drug use, adolescent identity development and autonomy, peers and peer influence, bonding to prosocial institutions, racial and cultural issues, and health and sexuality. In addition, MDFT intervention techniques have both *intrapersonal* (i.e., feeling and thinking processes) and *interpersonal* (i.e., transactional patterns among family members or between a family member and extrafamilial persons) aspects. For example, changing the parenting practices of parents of adolescent drug abusers involves addressing personal aspects of the parents' lives apart from their roles as parents. Thus the approach also conceives of intervention targets chronologically. Change in particular areas first is used as a departure point for subsequent, and usually more difficult, areas of work. Recent process studies have provided beginning empirical support for this epigenetic, multiperson, and multidomain framework for change (Diamond et al., 2000; G.M. Diamond & Liddle, 1996; G.S. Diamond & Liddle, 1996).

Because teenagers who abuse drugs also generally have functional impairments in two or more domains, MDFT simultaneously targets all domains in which there is poor functioning. The therapist reviews the risk factors for problems of interaction involving relevant persons in the adolescent's life as well as interactive problems or effects across domains.

Clinical problems or symptoms are seen as processes that involve synergistic and cumulative effects—the unfolding and worsening of active risk factor dynamics. Therapists try to slow or stop the momentum of these interacting risk and development-derailing processes by replacing them with hopeful, relationship-oriented, and concrete alternatives.

The nature and strength of these cascading negative processes create the rationale for multicomponent and comprehensive interventions. As drug use severity increases, when such levels exist alongside several risk (but few protective) factors, and when such development-detouring processes have been present over extended periods, the processes needing change have become quite stable. Although easy to identify, these processes are a challenge to change (Loeber, 1991). When advanced, the problem behaviors have become interdependent elements of the adolescent's lifestyle (Newcomb & Bentler, 1989). This is most common with teenagers who were early drug users and who exhibited behavior problems in childhood (Kandel, Kessler & Margulies, 1978; Kellam et al., 1983; Shedler & Block, 1990). In these situations, change in more functional domains will be required to decrease the drug taking, correlated behavior problems, and lifestyle patterns and to increase competence and developmental adaptation. Research on successful maintenance of drug-free lifestyles of adolescents following residential treatment reveals that most favorable outcomes occur after changes in several functional domains (Brown et al., 1994).

Key Concept:

The amount and the nature of the time a therapist spends with each case, his or her attention to the implementation details of the MDFT model, and the nature and quality of the clinical supervision influence case outcome.

In the context of understanding the formidable forces involved in problem development and effective intervention, it is important to maintain a deep appreciation of the human elements of working with drug-using teens and families. The therapist's caseload, and high-quality, consistent, and clinically focused supervision (versus administrative supervision), influence case o
utcome and model development (Schoenwald et al., 2000). These sensibilities—respect for the work's difficulty and cognizance of the circumstances required to do this work effectively—are critically important in therapy and therapist development (Bank et al., 1991; Liddle, Becker & Diamond, 1997; Linehan, 1996).

Key Concept:

Multiple risk factors and a network of biopsychosocial influences have created an adolescent's drug abuse; hence, multiple dysfunction-producing and dysfunction-maintaining characteristics and processes must be targeted for change.

Problem behavior can desist when meaningful concrete alternatives are created, accepted, attempted, and adopted by the adolescents and families. Motivating both the parents and teenager is a therapist's responsibility, and specific techniques to accomplish these short-term objectives have been developed and tested. (See Adolescent Engagement Interventions on page 71 and Parenting Relationship Interventions on page 115 for descriptions of these techniques; Diamond et al., 1999; Liddle & Diamond, 1991; Liddle et al., 1998; Schmidt, Liddle & Dakof, 1996). If multiple risk factors (Newcomb, 1992) and a network of influences (Brook, Nomura & Cohen, 1989) have created and maintained adolescent drug abuse, then the same complex of interrelated influences must be systematically assessed and targeted for change.

Key Concept:

Assessing the multiple domains of adolescent and family functioning is not accomplished in a session or two. It occurs over the first several sessions with each family member alone, in conversation with the entire family and extended family, and with parents and the adolescent together.

The therapist's systematically organized and planned conversations with parents, teenagers, and other family members focus on past, current, and hoped-for circumstances in the multiple ecologies (Liddle, 1994). Focusing on and assessing multiple domains occurs over the first several sessions with each family member alone, in family conversations that may include extended family, and with the parents and adolescent together (Liddle, 1995).

Key persons in the adolescent's environment (e.g., those in school or the juvenile justice system; peers) are included in the treatment. For example, a therapist may expend considerable time in helping organize a meeting between school officials and parents. Many parents are unaccustomed to or unskilled in orchestrating such events. Reestablishing a teenager's affiliation with some aspect of school (e.g., prosocial activities, academic mastery) andjob training is a vital part of adolescent drug treatment.

Adolescent treatment must be practical. The therapist may work as a coach with the teenager and parents—preparing them for a school conference and defining possible and desirable outcomes. In another case, the focus might be on the teenager's noncompliance with juvenile justice system sanctions and the influential role a parent might play in an upcoming court hearing.

Although MDFT has a practical, results-oriented focus, new behavioral alternatives or potential solutions are not offered prematurely. Problem behaviors, such as affiliating with drug-using peers and disengaging from school and family relationships, are both interrelated and stable. MDFT interventions take into account the relationships, interactions, and factors that contribute to such connections.

Early treatment efforts include conversations focusing on the specific life circumstances of the teenager and parents, and small steps toward larger changes are introduced gradually. These small steps might involve discussions with the teen in which he or she is helped to evaluate different areas of his or her life.

Key Concept:

Attempts to implement problem solving in relationships will not work without the developmentally appropriate levels of attachment and communication having been reached.

The principle of relational epigenesis (Wynne, 1984) is an overall guide for problem assessment and intervention sequencing. This theory proposes a preferred sequence of developmental processes (i.e., attachment or caregiving is an early-stage relationship process, whereas mutuality in relationships is a more evolved, later-stage process characteristic). Although these processes overlap, like all developmental stages, optimally they follow one another in a predictable way (i.e., attachment or caregiving, communicating, joint problem solving, mutuality). When the preferred sequence of development or skill acquisition does not occur, functioning is impaired. In family therapy this means that attempts to implement problem solving in relational systems will not work without the requisite functioning or developmental levels of attachment and communication having been reached (Doane, Hill & Diamond, 1991). For example, it is difficult for parents to feel motivated to try new parenting behaviors if their basic emotional commitment to parenting has weakened (Dix, 1991; Liddle et al., 1998; Patterson & Chamberlain, 1994). In this "first things first" philosophy, the therapist is guided by questions such as, "What is getting in the way of the behavior of interest?" The therapist then attends to those barriers.

So far, this discussion has focused on the theoretical and empirical bases of the MDFT treatment model. The clinical principles of MDFT are presented next. Then, for the remainder of the manual, theory–research–practice connections within each module of the core approach are discussed.

Principles of Multidimensional Family Therapy

Therapy principles are defined as fixed or predetermined rules guiding clinical orientation and behavior (a therapist's prescribed behaviors and proscribed behaviors; Waltz et al., 1993).

Principles of Multidimensional Family Therapy

1. **Adolescent drug abuse is a multidimensional phenomenon.**
2. **Problem situations provide information and opportunity.**
3. **Change is multidetermined and multifaceted.**
4. **Motivation is malleable.**
5. **Working relationships are critical.**
6. **Interventions are individualized.**
7. **Planning and flexibility are two sides of the same therapeutic coin.**
8. **Treatment is phasic, and continuity is stressed.**
9. **The therapist's responsibility is emphasized.**
10. **The therapist's attitude is fundamental to success.**

The following are the 10 principles of MDFT:

1. **Adolescent drug abuse is a multidimensional phenomenon.** Its conceptualization and treatment are guided by an ecological and developmental perspective. Developmental knowledge informs interventions—presenting 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 adolescents or other family members, as well as crises and complaints pertaining to the adolescent, provide not only critical assessment information but important intervention opportunities as well.

3. **Change is multidetermined and multifaceted.** Change emerges from interaction among systems and levels of systems, people, domains of functioning, 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.** 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 extrafamilial others. Resistance is normal. "Resistant" behaviors are barriers to successful treatment implementation, and they point to important processes for therapeutic focus. It is difficult for adolescents and families to create lasting lifestyle changes.

5. **Working relationships are critical.** The therapist makes treatment possible through practically oriented, outcome-focused working relationships with family members and extrafamilial sources of influence and through articulation of personally meaningful relationship and life themes. These therapeutic themes emerge as a result of inquiry about generic individual and family developmental tasks and the idiosyncratic aspects of the adolescent and family's development.

6. **Interventions are individualized.** Although they have generic aspects (e.g., promoting competence of adolescents or parents inside and outside the family), interventions are customized according to each family, each 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 associated with positive developmental outcomes.

7. **Planning and flexibility are two sides of the same therapeutic coin.** Case formulations are socially constructed blueprints that guide ongoing treatment because formulations are revised on the basis of new information and in-treatment experiences. In collaboration with 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 is phasic, and continuity is stressed.** Particular standard operations (e.g., adolescent engagement and theme formation), parts of a session, whole sessions, phases of therapy, and therapy overall are conceived and organized in phases. Continuity—linking pieces of the therapeutic work together—is important. Sessions have parts, and they are woven together into seamless wholes. Similarly, there is a weaving together of the parts of treatment and an active attempt by the therapist to maintain continuity and linkages between sessions and "chunks" of therapy.

9. **The therapist's responsibility is emphasized.** Therapists are responsible for (1) promoting participation and enhancing motivation of all relevant persons, (2) creating a workable agenda and clinical focus, (3) devising multidimensional and multisystemic alternatives, (4) providing thematic focus and consistency throughout treatment, (5) prompting behavior change, (6) evaluating, with the family and extrafamilial others, the ongoing success of interventions, and (7) revising interventions as necessary.

10. **The therapist's attitude is fundamental to success.** Therapists are advocates for adolescents *and* parents. They are neither child savers nor unidimensional "tough love" proponents. Therapists are optimistic but not naive or Pollyannaish about change. Their sensitivity to environmental or societal influences stimulates ideas about interventions rather than reasons for why problems began or excuses for why change is not occurring. As instruments of change, therapists know that their personal functioning can facilitate or handicap their work.

Basic Requirements for Clinics Offering MDFT

Treatment Locale

Most sessions (individual sessions with adolescents and parents, sessions with parents and adolescents together, and sessions with other family members or relevant extrafamilial persons) are predominantly home based. Sessions are also frequently held in other accessible, appropriate locales (school, court). The clinical contact location also may vary according to the phase of treatment, the living circumstances and preferences of youth and families, and the session's objectives.

Treatment Duration and Intensity

Studies have tested variations in duration and intensity of treatment (Liddle & Hogue, 2001). The ATM study called for delivery of the intervention in a 3 to 4-month period with 3 hours of client contact per week. Sessions were conducted with individual adolescents, various combinations of family members, and other relevant individuals in the adolescents' lives (i.e., school personnel, JPOs, etc.). Phone contact was frequent and used for reviewing and planning for next steps. Phone contacts also presented opportunities for "minisessions" or focused conversations that served to motivate, to hold in place, or to make new suggestions about how to cope or new courses of action. The most frequent contact with family members occurred during the first 3 months of therapy. In the fourth month of treatment the amount of contact decreased.

Nature of Clinical Contact

In MDFT, phone contact with the parent and the adolescent is frequent and moves beyond reminder calls. MDFT therapists use time on the phone to follow up, extend the work done in sessions, and conduct troubleshooting on what is being tried at home and how it is going. In MDFT the therapist has face-to-face or phone contact with extrafamilial systems such as school, juvenile justice, or case management-related personnel (e.g., academic tutoring, job training). Contact with extrafamilial subsystems is often more frequent at the beginning of therapy, tapering off as the case reaches the final treatment phase. In all situations, the amount of clinical contact occurring will vary according to the stage and module in which the family and therapist are working.

Staffing Requirements

Most therapists using the MDFT approach have at least a master's-level degree in counseling and an average of 2 to 3 years of experience.Certain characteristics are sought in clinicians who will be trained to use the MDFT model. First, a family therapy background and systems orientation are helpful. The multisystemic model, which clearly includes a basis in family or systems therapy concepts and methods, is taught in the context of this orientation. Clinicians must be willing to conduct case manager-style interventions along with traditional therapeutic interventions. Previous experience with drug-using and delinquent adolescents is desirable as well. Preferred personal characteristics include intellectual curiosity, a capacity to

work in different domains (cognitive, affective, and behavioral), an ability to form good personal relationships, and an openness to receiving feedback about one's personal clinical style. Finally, a clinician's demonstrated motivation to become an exceptional therapist (and the realization that this achievement takes years of focused work and experience) are two of the most powerful predictors of success with the MDFT system. Therapist characteristics and skills helpful to the MDFT approach are discussed in publications on clinical supervision and training (Liddle, 1988; Liddle, Becker & Diamond, 1997).

Clinical Supervision Requirements

Clinical supervision is vitally important in the implementation of the MDFT approach. The multidimensionality of the therapeutic orientation is matched in the supervision philosophy and methodology. Multiple supervision methods are used in a coordinated way to produce the desired level of adherence and clinical competence. Therapists prepare written case conceptualizations and segments of videotape or audiotape for presentation and analysis by the supervisor and feedback from other clinicians. Therapists review their own taped work, and they are assigned to continually study the MDFT manual and related clinical materials. As the competencies and learning needs and issues of therapists become manifest, supervisors adjust their supervision and teaching.

Therapists are expected to take considerable responsibility for their continued learning and development, although individual and group supervision is provided. Individual supervision allows focus on sensitive topics (e.g., personal or stylistic matters of clinician development), as well as an individualized focus on the standard review of weekly outcomes, adjustment of strategy or method, and planning of next steps (Liddle, Becker & Diamond, 1997).

Overview: The Three Stages of the MDFT Treatment Program

This section summarizes the key activities in each therapy stage. Detailed implementation guidelines, examples, and troubleshooting tips on making these procedures work appear throughout the manual.

Stage One: Build the Foundation (5 weeks)

1. **Create a new system.** Treatment creates a new social system. When the process works, it joins together the therapeutic system and the family system to create a new entity with a common purpose. Thinking organizationally, therapists strive to understand the many systems and subsystems involved in the treatment process and the nature of their past and current interactions.

2. **Welcome the adolescent and the family to a new life space.** Starting treatment is a big event. Many outpatient treatment programs do not place sufficient emphasis on the beginning stage of treatment or on the process of welcoming teens and their parents and engaging them in a treatment program. Clinicians know that treatment of adolescents is challenging, and research confirms that more teens and their parents drop out of outpatient drug therapy than remain. The beginning phase of treatment, when a therapist does all that he or she can to help

all family members feel welcome and understood, is of enormous importance.

3. **Explain the program.** Do not assume that parents or adolescents will have a positive or accurate perception of treatment. An orientation to the program or treatment that covers "how to benefit from therapy" and "what the treatment entails" is vital. The mindset of family and extrafamilial sources of influence about the new treatment can be addressed by asking about previous treatment experiences or, in the case of the extrafamilial persons, asking about their history with the youth and experiences with other treatment programs. Expectations are important, and they can be shaped.

4. **Address the circumstances that bring the client into treatment.** Many teens will be referred to treatment by school or juvenile justice personnel. Some of these adolescents will have serious legal problems and will be ordered to treatment as a condition of their probation or involvement with the juvenile justice system or because of their problems in school. It is important to address the specific circumstances that bring them into the program. Therapists should look for points of cooperation and resistance and develop a positive realistic conception about what treatment is and what it might be able to do.

5. **Develop a temporal orientation.** In this 4-month version of MDFT, not all the interesting or important issues that will be presented can be addressed. Therapists must choose which focal areas might have the most clinical yield (e.g., which seem most malleable and which areas are accessible immediately). MDFT intervention has a fixed number of weeks in which the program will be delivered. Thus, prioritizing treatment focuses is critical. A 4-month calendar in the case notes will remind therapists of the strict timelines within which they must work.

6. **Remember, intensive involvement is the norm.** Because the available time to work with a case is predetermined, remembering the therapeutic principle of intensive involvement with a case is critically important. With some cases, particularly at the beginning of treatment, there may be in-person or phone contact with one or more persons in the treatment system (e.g., the adolescent, parent, or other family members; school, legal, court, or probation staff) every day. A core premise of the approach is that positive outcomes will be related to working effectively in several areas (modules) of a case at the same time.

7. **Use current crises to mobilize positive forces and create focus.** Pioneers in MDFT's earliest development of structural family therapy (Minuchin, 1974) and problem solving therapy (Haley, 1976; see Liddle, 1984, 1985) understood how important it is to seize opportunities presented by current crises pertaining to the adolescent. School failure, conflict in the home, out-of-home placements, and consequences of current drug use, including arrests and legal problems, are examples of crises with potentially enormous therapeutic value. Inherent in these events are the information and opportunity to create a workable (i.e., acceptable to the client, potentially effective according to the approach) therapeutic focus and the kind of step-by-step change that can last.

8. **Use distress to facilitate motivation.** The distress that accompanies a crisis is a therapeutic

ally. It is part of the dynamic that will create motivation for change. Even if no crisis is present, distress, which is perhaps different for each family member and relevant extrafamilial others, is present. The subjective distress of each family member should be accessed; framed, if necessary; amplified; and used to create a foundation and motivation for treatment.

9. **Translate therapy goals into an organized and orchestrated treatment that yields various kinds of sessions** (individual, familial, extrafamilial). Although the term family therapy is still used, today's family therapies are better defined as *family-based* treatments. The term "family therapy" creates an image of working with the whole family, week after week. MDFT is a therapy of systems and subsystems. A hallmark of this approach is its theory-grounded and systematic use of individual, familial, and extrafamilial sessions. Different therapy stage and subsystem-specific therapeutic goals dictate a therapist's decision about session composition (see Guidelines for Subsystem Sessions on page 178 for more details about setting up individual and family sessions). Therapy goals are formulated according to a number of factors. Case-specific treatment is theory based (i.e., development) and principle driven (see Principles of Multidimensional Family Therapy on page 25).

10. **Create expectations.** Negativity, hopelessness, helplessness, and despair frequently accompany adolescents and their parents to treatment. At the outset and as needed throughout therapy, treatment addresses these powerful emotions. It is important to create expectations that the teen's life course can be redirected, new alternatives can be introduced, the drug-taking lifestyle can stop, family life can change, and parents' stress and burden can be lessened.

11. **Elicit and shape the stories.** A therapist's skill is revealed when he or she uses generic knowledge about family life, positive psychosocial development, and problem solving as a way to make sense of the idiosyncratic details of a teenager's and his or her parents' lives. The therapist facilitates this process by eliciting details about the teen's life, the parents' lives, and the family's life together. The developmental issues of adolescence (e.g., a teen's desire to be heard) are the immediate context in which the teenager's and parents' expression of their life story occurs. At the same time, the family's history together is also relevant and must be explored as well.

12. **Work multisystemically.** Classical family therapy assumed that changing a family's interactional style and patterns would yield changes in the symptomatic functioning of the child or adolescent. Contemporary family models do not reject the importance of interactional change in the family, but today's models do place this focus as one among many. MDFT therapists pay attention to the individual, intrapersonal functioning of family members and to how important sources of influence that come from outside the family complement and work synergistically to change family interactional patterns (Liddle, 1995). Working with multiple systems in a coordinated way, inside and outside the family, is fundamental to MDFT.

13. **Talk with everybody** (family and extrafamilial persons). There are advantages and

disadvantages to doing a treatment program within a fixed period. A major advantage is that time can be used to focus on and organize the therapist's and family's mindset ("We have only so much time available") about getting something done. At the same time, working in a time-limited model can influence therapists to narrow their focal areas and targets of change. It is important to be aware of the interplay of the pressure to create a workable focus (which may enhance motivation) with the inclination to expend energy and time trying to include family members or extrafamilial persons in treatment. Phone calls to important therapeutic system members serve various functions. They are strategic, in that they might prepare individuals for a new focus, and functional, in the sense of providing a convenient context for interventions themselves.

14. **Build multiple alliances.** In the beginning of treatment, a key concern is whom to develop alliances with and how to accomplish this time-consuming, challenging task. Each person within and outside the family is treated as an individual who has his or her own idea about topics important to treatment—the need for therapy, who is the problem, how the problem came about, and how it might be solved. This may be an obvious point, but the mandate of success in multiple therapeutic alliances, including those with relevant persons outside the family, is more difficult to implement than to understand.

15. **Use treatment to retrack development.** The developmental lens guides every aspect of assessment and intervention. MDFT therapists are developmentalists. Minuchin (1982b) warned that therapists who work with the most challenging clinical situations have an occupational hazard—they can, unwittingly, become sleuths for psychopathology or family dysfunction. Searching for individual, family, and community strengths is a critical aspect of MDFT. Accentuation of these resources is the antidote to the pessimism that frequently pervades the teen's and his or her family's lives. Knowing about the developmental tasks for adolescents, parents, and family balances the assessment of "what's gone wrong" with the instigation of processes that retrack the development of all family members.

16. **Work the phone.** The concept of a *session* does not have the same meaning as it once did. Therapists think more in terms of *therapeutic contact,* and variations of contact, with clients (and their multiple constituents inside and outside the family). Telephone work is a critical part of this therapy approach. More than serving as reminders ("I was just calling to remind you about our session tomorrow"), phone calls to family members are opportunities to give important new information that may not have been available or offered in a face-to-face session. They are also valuable opportunities to follow up on previous events or interventions. Phone calls serve an intervention function with extrafamilial persons as well. Interventions are thought of in a more broad-based way than they were previously. They do not require face-to-face contact, nor do they have to occur within the confines of an office or a traditionally defined session.

17. **Craft themes.** Good therapy focuses on events and circumstances that have personal meaning to each participant. Although themes materialize or become apparent through content, they exist at a level different from the content that is revealed in the retelling of life events or discussion of everyday events. A theme in a therapeutic context represents a

recurring part of reality; it is a different kind of "truth." Themes point to a consistency in or repetition of events, feelings, or outcomes of relationships; a summary statement; or a characterization of a relationship's core nature. These characterizations of past relationships or events can also be used as a reference point for future, hoped-for relationships or life themes.

18. **Visit the school and neighborhood.** Particularly if he or she is not accustomed to doing such things, a therapist will sometimes avoid school visits and neighborhood assessments early in therapy. However, the establishment of therapeutic alliances (not exclusively with family members) is a critical early-stage accomplishment in this treatment. The MDFT protocol includes school contact and neighborhood visits throughout treatment. This reflects commitment to an *ecosystemic assessment and intervention* philosophy. The information obtained by a visit to a school, neighborhood, or juvenile justice system setting (e.g., family court, probation officer meeting) is critical to initial case formulation and to the implementation of a comprehensive multicomponent intervention. Changes in drug use will be related to changes in the real world circumstances of the teen. It is not possible to intervene directly in all aspects of the adolescent's environment. At the same time, it is vital to know as much as possible about all those corners of teen and family life.

19. **Test different pathways and kinds of change.** MDFT assumes that multiple pathways and kinds of change are possible; such combinations may be necessary to change firmly entrenched drug-using lifestyles. Many teens have lived in less than optimally functioning families and developmental circumstances for years. Because important assessment information comes from the feedback received after intervention, early-stage therapy probes for receptivity, for the pathways and kinds of change that may be available, and for which ones may be more sealed off, at least temporarily.

Stage Two: Prompt Action and Change by Working the Themes (6 weeks)

1. **Develop from the foundation.** Setting a treatment foundation involves the articulation of themes. There may be several, and they may relate to individuals, subsystems in the family, the family as a whole, or its extrafamilial influences and forces. Themes create reference points for the treatment. These reference points induce consistency and continuity. Focusing themes and working change strategies (enactment, individual emotion processing or regulation, or problem-solving work) facilitate the processes and circumstances that can reverse and provide concrete alternatives to a teenager's drug-using and problem-behavior lifestyle.

2. **Therapeutic leadership: Mobilize the troops.** Whereas treatment's first phase offers beginning experiments in change, in the second stage of therapy the therapist mobilizes various systems, including self-systems (i.e., individuals), and articulates the stakes involved (i.e., often a life-or-death situation for a teenager). The therapist counters the forces (e.g., pessimism in the family; dysfunctional beliefs and attitudes about drugs; influential, deviant peer culture) that perpetuate the interacting and often escalating negative outcomes. Barriers to change can combine to produce a legacy of failure and development gone wrong, a legacy

made up of powerful, things-cannot-change feelings, thoughts, and behaviors.

3. **Increase action and change orientation.** Whereas mobilization works in the realm of emotion, increases in action and change orientation use the focused emotions to prompt new and consistent planning and action. With younger adolescents, it is often difficult to get to focused emotion, and therapists must focus on more behavioral aspects of treatment. Therapists must show a fierce commitment to the possibilities of change and communicate this commitment to the family and involved extrafamilial others, in every contact with the teenager, parents, and extrafamilial others to avoid a slide toward greater deviancy and build connections to prosocial pursuits and developmental adaptation. Establishing concrete alternatives to drug use and the drug-using lifestyle (e.g., school and academic skills, GED alternatives, confronting the legal problems, skills, and options to disaffiliate with deviant peers) helps clients fight despair.

4. **Think successive approximations.** Shaping is a behavioral psychology principle, a step-by-step approach to change. The change process is conceptualized sequentially (affective, cognitive, and/or behavioral elements may be present and applicable). In assessing the multiple developmental ecologies of teens, therapists ask, "What are the missing aspects of the teenager and family's lives? What set of circumstances and what specific day-to-day activities and intrapersonal and interpersonal processes could reverse the current development-destroying circumstances?" These questions, asked in individual, family, and extrafamilial sessions, begin a change process. They are small steps that facilitate materialization of the missing and developmentally needed processes or behaviors.

   Once these new behavioral forms, emotions, or adaptive thoughts emerge, they are helped to grow. Gradually, they are coaxed out and made large in conversations that make the experiments in change real. Change in one area is often used as a prelude to or a foundation for changes in more difficult or challenging areas. For example, change in a parent's emotional reactions to a son or daughter prepares the parent for changes in actual parenting practices (G.S. Diamond & Liddle, 1996; Liddle, 1995; Schmidt, Liddle & Dakof, 1996). A changed emotional set or response to one's teen makes a focus on behavioral parenting strategies possible.

5. **Work with the most accessible areas first.** The first stage of therapy involves determining areas of the parents' and teenager's lives that will be most accessible. These will not be the only available areas or necessarily remain available. In the second stage of treatment, the therapist is more consistently in an action-prompting mode to confront avoidance and inaction through alternative-oriented plans that attempt to create new intrapersonal, interpersonal, and contextual circumstances.

6. **Link available focus areas to less accessible ones.** MDFT therapists think in terms of direct and indirect pathways to achieve a goal. The available focal areas may often be the very pathways that link to work in areas that were previously unavailable. The adolescent's drug use is a primary case in point. Many teenagers deny their drug use and do not accept an agenda to work on it during the first phase of treatment. With these adolescents, a therapist

tries to establish other focal areas of treatment (e.g., problems with school or parents, legal difficulties, unhappiness with life) and uses these accessible areas as routes toward what the teen has closed off from the therapist and others. Many teenagers, for example, become willing to talk about drug use and other problems in a straightforward way if the therapist is willing to do (or actually does) something concrete for them (e.g., intervenes at school, with probation, in family court). Process research confirms that, even in situations in which there is an initially poor therapeutic alliance, certain therapist methods change a negative alliance to a positive one (Diamond et al., 1999).

Getting a teen to focus on drug use in outpatient treatment can be a challenge. Drug tests during therapy quickly move the therapy to a place where drug taking and/or the consequences of drug use and abuse, such as legal problems, can be addressed. (See Clinical Guidelines: Dealing With Drugs in MDFT on page 79). Additionally, using the available leverage and pressure issued by legal or school authorities may be a therapist's best course of action at the outset of a case.

7. **Make theme development more rich.** When topics and areas of work are woven together, they become rich in definition and meaning. Asking for deeper levels of details about the themes and linking previously separate events enables a therapist to develop themes that are more meaningful to the adolescent or parent. Focusing on life themes (such as a conclusion about one's life at a particular time) and the emotions that accompany them can be a motivating force. The direction for new and future actions can be inherent in that. Using themes as a reference point in therapy provides a focus, including a focus on the day-to-day changes that are the local pathway out of current circumstances.

8. **Think and work in all modules.** A multidimensional model infers working in a number of realms simultaneously. It is possible to focus on core themes, keep these areas primary during the middle phase of therapy, and check in and work minimally in other areas. Certainly time limitations, caseloads, and accessibility may hinder this principle's implementation with any given client. But a multidimensional model of change requires a multidimensional intervention methodology. This necessitates the therapist's not allowing his or her therapeutic focus, particularly in the middle stage of treatment, to become so concentrated on one area of work that other important areas are ignored. This principle works with number 7. The therapist must focus on important areas of work and, at the same time, be in a position to incorporate other focuses if needed. The therapist's sound judgment allows this dialectic to stay fluid and productive.

9. **Storyboard it: Think in stages.** The idea of stages also applies to smaller units of work. Thinking in terms of stages *in a session* can facilitate goals for any given meeting or treatment session. Preparing for a session by breaking it up into parts requires clear thinking and careful planning. Using storyboards (visual scripts) in therapy is a way to visualize the steps that might be involved in facilitating a particular in-session (short-term) outcome (Liddle, 1982).

   A session in the middle phase of treatment is often conceived of as a three-act play (plot and

story development, conflict, resolution). The first act sets the stage. Individual sessions with a parent or teenager may determine the agenda and develop the details that will be worked out in a joint session. The second act, the middle of the session, may involve an attempt to address issues that have been unresolved in a face-to-face joint session (parents and teenager). Therapists try to create an appropriate environment to help family members improve the way in which these issues have been addressed thus far. The goal is concrete progress in addressing these issues in a reasonable, step-by-step manner (a positive step in and of itself if they are addressed in adaptive ways) (G.S. Diamond & Liddle, 1996, 1999). Again, thinking in phases, the third part of the session may involve an intentional closing up of the work for that day, an attempt to create a certain cognitive frame around these events, and setting the stage for the next attempt at moving the relationships and issues along. This may occur between sessions or at the next formal session (in the home or in the clinic). The storyboard is a session plan that flows directly from the case conceptualization; it has continuity with the therapist and family's previous work together. A typical middle-stage session is articulated before the session starts in the imagination of the therapist and supervisor.

10. **Think of crises, slips, and detours as opportunities.** Experienced therapists know that crises, slips, and detours are usable. Crises are used to refocus and request even more effort from the involved adults. A teenager's relapse or slip demands attention; perhaps the intervention needs to be recalibrated. A detour may indicate that the direction and strategy are faulty and need immediate rerouting or adjustment (Liddle, 1985). Perhaps roadblocks are being created by extrafamilial people unwilling to give the teenager another chance. All these situations require creativity and a nonreactive mindset about unpredictable events. Important information is being conveyed in the unanticipated or negative therapeutic event; it is important to craft a response that maximizes the chance that the event can be used therapeutically and as an opportunity to take further steps toward needed change.

11. **Use family enactment.** Enactment is the art of helping a family have a new kind of conversation about what are usually difficult topics (prompting and shaping new kinds of interactions). Enactments happen spontaneously in family interviews and can be seen when a family demonstrates, through conversation, an aspect of its interactional problems right in the session (interactions of family members are consistent, and in the context of therapy, as elsewhere, these patterns show themselves). The therapist tries to instigate interaction because interaction is a manifestation of the relationships that are, in part, related to the creation and perpetuation of problems. Thus family interaction is one target of change, and developmental knowledge guides and informs enactment.

    Enactment refers to theoretical principles about the change process (including prompting or shaping of new behaviors) and active therapeutic methods to prompt change (actions to foster new kinds of dialog about important topics). The middle phase of therapy is the one in which enactment is given significant play.

    Enactment is difficult for most therapists—it raises the emotional temperature in sessions and sometimes prompts the displeasure of a family member toward the therapist. Therapists must

overcome their fear of setting up and creating enactments. Knowing enactment allows the therapist to conduct a fully multifaceted and orchestrated set of interventions.

12. **Work the sequence: Receptivity, skills, opportunity and context, practice, introduction of variation, generalizing.** A therapist should conceive of a *sequence of interaction* between two or more persons as a unit of a broader context of interaction and interactors. These interactional sequences break old relational molds and create what Minuchin (1974) called new relationship realities. Attention to the small details of individual reactions in a sequence often provides clues for how to shape the interactional sequence (Diamond & Liddle, 1999; Liddle, 1995).

13. **Work the core sessions** (think domains, people, and topics). Although there are core aspects to MDFT treatment, MDFT is not run on a programmed, session-by-session basis. Treatment is organized according to modules. For example, the therapist aims to help each parent in that individual's parenting role *and* personal life. The rationale is that changes in parenting practices lead to impaired functioning and well-being in nonparental realms. With teenagers it is necessary to specify areas of developmental need and make these areas important treatment focuses [(examples are identity development, psychosocial competence, and balancing autonomy with connectedness to family (The ratio in the balance of which treatment foci are emphasized will look different in younger adolescents than later adolescents; for example, balancing autonomy with connectedness to family will be emphasized less with younger adolescents)]. The developmental knowledge bases mentioned previously can help determine what the core treatment emphases ought to be.

    The therapist asks, "What actions need to be taken or can be taken to create alternative experiences and new organization in this adolescent and family's life that counter the previous deviance- and drug-related lifestyle patterns?" A sense of "What's missing in this picture?" thus applies to interaction in a session as well as to sequences or courses of action (generating alternatives) that prompt action outside of sessions (e.g., school intervention, increased monitoring, change in family routines).

Stage Three: Seal the Changes and Exit (5 weeks)

1. **Remember that time is an important treatment dimension.** Because the treatment program is delivered in 3 months, the therapist's every action must be guided by time.

2. **Make an honest appraisal of current status.** The treatment's final phase, especially in this relatively short-term, time-limited version, depends on a brutally frank estimation of what has and has not been accomplished in treatment. The therapist should seek a "good-enough" focus and determine which core change targets will be sufficient to create immediate and (it is hoped) lasting change. Change includes avoiding a slide toward greater dysfunction, gravitating toward deviant peers, and deepening disaffiliation with school and other important social institutions, including the youth's family. Altering the trajectory of and pull toward greater deviance by making sure that problem behaviors do not become more severe can be a major accomplishment in itself.

3. **Accept "rough-around-the-edges" outcomes.** Rough-around-the-edges is a phrased used to describe potential perfectionism or standards about changes that may be too high (on the therapist's part). Its connotation is that it is helpful for the therapists to be mindful of the difficulties of any kind of change attempt and of the dangers in holding a teen or family to too high a standard. It is not yet known which kinds of changes (e.g., changes in peer status, family changes, changes in individual skills or competence) are the most influential mediators of bottom-line outcomes such as drug use and abuse, but even a partial change may be sufficient. Abstinence and the development of an alternative to the drug-using and drug-abusing lifestyle of the teen are an unequivocal goal of MDFT.

4. **Emphasize and make overt the changes in any and all domains.** The therapist's exit is the client's new beginning: The family and extrafamilial others remain. One important aspect of the final phase of therapy includes establishing meaning for the changes that have occurred and putting into words some of the changes that may yet have to be made (i.e., constructing bridges to still-needed changes). It is important to emphasize that family members have each other and, it is hoped, other sources of support and guidance as well. The specific successes and accomplishments of therapy are discussed and used as evidence of and prompts about how new crises or problems will be handled. The family's new skills are used to help them exit from the treatment program. An emphasis is placed on the adolescent's continued orientation toward self-care, development, and health, including his or her involvement in prosocial activities, and the family's capacity to support continued progress—facing normal developmental tasks.

5. **Assess next steps and future needs.** Needing future services is not thought of as a sign of failure. Recall that a teenager and his or her family have completed a 4-month treatment.

Although treatment occurs in 12-16 weeks in MDFT, it is important to keep the following points in mind:

- Method is a variable, and so is time. A critical dimension in the ATM study was the amount of time that was available to see a teenager and his or her family. The amount of time is a given and presents an interesting scientific and intellectual dimension on which to evaluate treatment.

- Look beyond once-a-week therapy. Although there is a fixed period of time within which the therapy must be delivered, there is flexibility about how much time can be spent with the case during the 16 weeks (within the alloted treatment parameters). Certainly caseloads and a family's receptivity to an intensive model (an undeveloped area of clinical research) will affect how much time a therapist can spend on each case per week.

- Look beyond "in-the-room" treatment. Another critical barrier that must be overcome to consider this treatment a true ecological therapy is where the services will be provided. Just as "sessions" have an expanded meaning (e.g., some occur on the phone), expansions of how much therapy occurs (beyond once a week) and where it occurs are critical for the

therapist to understand.

Modules Are Intervention Targets

Four focal areas (or modules), each of which is a primary developmental arena, organize treatment: (1) adolescents, (2) parents and other family members, (3) family interactional patterns, and (4) extrafamilial systems of influence. The adolescent focus includes the adolescent and his or her peer world. The parent focus includes parents (biological, step) and parent figures (informal or unofficial caretakers) and other family members and extended family who may or may not live nearby. Family interaction concerns the transactional system made up of the parents, family, and adolescent. Extrafamilial focuses include significant others and other systems external to the family.

Whole and Part Thinking

The multiple ecologies in which teenagers reside are both wholes and parts (see whole and part thinking in Appendix A. Key Terms and Abbreviations). While functioning as "whole" biopsychosocial units, families are also part of and influenced by other systems of input and organization. A therapist's job is to understand each system or ecology (family, school, peer, community) as *both* a whole *and* a part and to devise interventions that fit this conceptual framework. Interventions target processes within subsystems as well as processes that are happening or need to happen between subsystems as well.

Multiple Domains of Simultaneous Intervention

What are the interventional implications of this perspective? Each of the four modules has aspects that could be understood as distinct from the others. Together they represent the adolescent's psychosocial world. Each area is one of the multiple "locales" in which assessment and intervention occur. These domains reflect organizational units in which risk and dysfunction-producing processes occur. They could also be considered the multiple pathways to follow to activate different versions of change or to instigate changes in one area with stage-specific processes in mind. The primary treatment goal is to alter development of the adolescent and his or her social context in a way that establishes healthy socialization and development. If adolescent drug abuse is a manifestation of a particular lifestyle (Newcomb & Bentler, 1989), then it is the lifestyle that needs to change.

Interventions are a series of small steps that occur sequentially, partly by design and partly according to feedback recalibrated or revised in microsequential human interactions (Liddle, 1985) moving toward positive outcomes in various functional domains.

Each MDFT module—adolescent, parent, parent-adolescent interactions and extended family, and extrafamilial systems (Liddle, 1999)—is critical to the change process. Each contributes to the creation and continuation of the drug taking and related problem behaviors, as well as to the possibilities of changing the life course to turn it away from the developmental detours of drugs and delinquency. The modules relate to empirically established areas of risk and protection for youth and families, as well as to knowledge about how adolescent drug abuse and related problem behaviors begin, continue, expand, or end.

Interventions With an Adolescent

Establishing a therapeutic alliance with a teenager is distinct from a similar effort with a parent. It is critical to establishing the foundation of treatment and creating circumstances under which treatment can progress (G.M. Diamond & Liddle, 1996; Schmidt, Liddle & Dakof, 1996). Just as there are developmental tasks in life, so there are developmental stages in therapy. This first-stage work is called adolescent engagement interventions (AEIs), which include:

- Presenting therapy as a collaborative process
- Defining therapeutic goals that are meaningful to the adolescent
- Generating hope by focusing on the adolescent's internal locus of control and by presenting oneself as an ally
- Attending to the adolescent's experience (Diamond et al., 1999).

Diamond and colleagues (1999) demonstrated how initially poor therapist–adolescent alliances can be improved.

Alliance-building interventions occur in both individual and family sessions (Liddle, 1995). It is important for therapists to understand the need for (and inevitability of) different therapeutic alliances with each family member. Therapeutic alliances also exist with outside systems. Adolescents must be made to feel that the treatment program can meet some of their needs and that they can gain something by coming to treatment (Liddle, Dakof & Diamond, 1991). Research has revealed that a focused and systematic use of certain cultural themes (e.g., the journey from boyhood to manhood) enhances early-phase engagement as well as the middle-phase work with adolescents (see The Adolescent Subsystem Module on page 60 [Jackson-Gilfort et al., 2001]). Although the field is still learning about similarities and differences between male and female adolescent drug abusers (Jainchill, Bhattacharya & Yagelka, 1995), MDFT has begun to articulate gender-sensitive strategies for formulating and addressing the unique needs of female drug users within the context of family-based treatment (Dakof, 2000).

The therapist helps teenagers learn how to (1) learn more about their feelings and their thinking patterns, (2) communicate effectively with parents and others, (3) effectively solve social problems, (4) control their anger and impulses, and (5) gain social competence. Much of the work consists of preparing parents and adolescents in individual sessions so that they can come together in joint sessions to talk about issues that have meaning for them. Individual time with adolescents is used to develop alternatives to impulsive and destructive coping behaviors such as drug and alcohol use. Achieving therapeutic objectives with the adolescent requires the therapist to contextualize interventions designed to enhance social and life skills in the peer culture and address the influence of life on the streets. The therapist is systematic and detail oriented in pursuit of the facts of street life as well as of the adolescent's perception of that life and its consequences for his or her future. In this way, the therapist facilitates the process of engaging the adolescent with prosocial peer influences and positive familial influences.

As mentioned previously, when working with early adolescents, MDFT therapists attend

to potential problems with identity development. Drug use is most common and pervasive in young adolescents who are characterized as identity diffuse and have problems with identity development (Jones, 1992; 1994). As a result, MDFT therapists spend much of the early stage of therapy getting a picture of what the teenager's life is like, how the teen feels about herself and about the path her life is taking. These discussions are important in building the therapeutic alliance (Diamond, Liddle, Hogue, & Dakof, 1999), but also in helping the adolescent explore her evolving identity and her hopes and dreams for the future. It is the therapist's job to help the adolescent link these "possible selves" to concrete, manageable steps that they can monitor and fine-tune together.

Second, research has consistently shown that young adolescents with positive life styles are apt to select prosocial peers, whereas young adolescents oriented toward antisocial or problem behavior are likely to select similarly deviant peers (Bush, Weinfurt, & Ianotti). An obvious clinical implication of these findings is to link drug abusing peers to more positive influences. Because of the power of peer relationships in influencing the adolescent's developmental trajectory, intervening with the peer system is critical in MDFT. There are several levels of intervention when considering changes that need to occur in the adolescent's peer network. Therapists have important discussions with adolescents one-on-one to uncover the nature of these relationships and how these friends can support or interfere with the adolescent's goals.

Interventions With Parents and Other Family Members

Interventions with parents

The primary objective of MDFT is to reconfigure the drug-using and deviance-prone lifestyle of the teenager with a replacement lifestyle, literally a new way of being in the world. This new way of living is characterized by more prosocial pursuits, including a more adaptive and active connection with institutions of socialization that keep the teen from continued deviance and easy access to drug-using and delinquent peers. This involves retracking the teen's development.

An adolescent's symptoms may be related to outside factors and forces. MDFT intervenes multisystemically with many different forces in the teen's life, and the adolescent's parents are a source of influence. MDFT has a stepwise way of reaching parents. This procedure parallels the sequenced way teens are reached in the first phase of therapy. Parenting relationship interventions (PRIs) (e.g., enhancing feelings of love and commitment, validating parents' past efforts, acknowledging difficult past and present circumstances, generating hope by increasing parents' internal locus of control, generating hope by presenting the therapist as an ally to the parents) were designed to close the emotional distance between the parents and adolescent (Liddle et al., 1998). This can enhance parents' individual functioning and, in turn, enhance their motivation and willingness to try a new kind of relationship with and parenting strategies for their adolescent.

Damaged or disrupted attachment relations are linked not only to adolescent dysfunction (Allen, Hauser & Borman-Spurrell, 1996) but also to impaired parental functioning (Hauser, Powers & Noam, 1991). The ultimate aim of PRIs is to increase parents' commitment and involvement with their adolescent, even with an adolescent who has abused drugs and is

seriously involved in criminal activities (Schmidt, Liddle & Dakof, 1996). Therapists then foster parenting competency by supporting consistent and age-appropriate limit setting and regular monitoring of school attendance, school performance, and other activities.

Interventions with other family members

Although work with the adolescent drug abuser and his parents is central to MDFT, the approach recognizes that other family members often play key roles in drug taking and maladaptive patterns of teenagers. Siblings, adult friends of parents, and extended family members are taken into account during assessment and interventions. Individuals who play key roles in the teen's life are invited to participate in family sessions, or sessions are held with these individuals alone. Cooperation is achieved by stressing the serious circumstances the youth is facing at the time of therapy (e.g., school expulsion, arrest, juvenile court problems) and the need for all significant others (particularly adults) who can influence the adolescent to join forces in an organized, alternative-seeking manner.

Interventions To Change the Parent–Adolescent Interaction

Once the therapeutic foundation is successfully established with adolescents and parents through therapeutic alliances, explaining the treatment program, beginning the process of formulating goals with the parents and teen separately, and increasing parental involvement with the adolescent, the therapist requests direct change in the parent–adolescent relationship. Enactment is the foundation for facilitating change in the relationship domain (G.S. Diamond & Liddle, 1996, 1999). Although the parent–adolescent relationship is a focal topic with both the parents and the teen individually, it is in joint interviews that the relationship can be observed and assessed directly and the interaction between parents and teen shaped.

Historically, a fundamental aspect of all family-based interventions has been targeting theory-specific dysfunctional family interactions, which were associated with the development and continuation of problem behaviors. Although contemporary family-based models may include many other targets, assessing and trying to change family interactions remains important. These problem interactions may be (1) current manifestations of problems that began as developmental struggles (e.g., increasing independence for the teen), (2) problems that have grown or evolved over time (e.g., noncompliance, school problems, affiliation with deviant peers, drug use and delinquency, legal problems, and family disengagement and despair), or (3) events such as family crises (chronic or acute) or traumas (e.g., parental substance abuse, physical or sexual abuse, physical abandonment). Studies have illustrated how changes in family interactional patterns are related to changes in the symptomatic behavior of children and adolescents (e.g., Alexander et al., 1983; Mann et al., 1990; Robbins et al., 1996; Szapocznik et al., 1989), including changes in the in-session behavior of drug-abusing teens (G.S. Diamond & Liddle, 1996; Schmidt, Liddle & Dakof, 1996).

An early marker of progress in the parent and adolescent relationship is how discussions are handled. Initially, the basic focus is on a "first things first" philosophy. Therapists work on basic communication skills and patterns (see Bolton, 1979). For instance, can the parents and adolescents state their points of view? Can they listen and indicate that they heard the other's

point of view? Excessive blame, defensiveness, and recrimination are characteristics of early-stage conversations and indications of the troubles that the relationship has seen.

Therapists understand that a session or any discussion creates a context. Over time, new experiences of the other individuals and of the self, as well as the new outcomes from the new kinds of conversations, contribute to new relational outcomes. When parents and their adolescents come together and relate in new ways, the adolescents become more confident and competent in expressing their needs and addressing their responsibilities and parents become less likely to abdicate their roles as parents and more likely to provide support, which serve as a buffer against the adolescent's involvement in substances and deviant peer groups. Family relationships can change; changed family relationships, manifested in new emotions being expressed and new interactional patterns, contribute to reductions in adolescent symptoms and gains in prosocial behavior.

Interventions With Systems External to the Family

MDFT targets multiple realms and aspects of the adolescent's functioning for change

The family has not been found sufficient to create or maintain change in all cases, particularly when the teen's and/or parents' level of functional impairment is high. When external forces conspire against change or adoption of prosocial competencies, the need for well-organized and integrated multisystems work becomes acute. Multisystems interventions, including those that resemble case management, are therapeutic, particularly when coordinated with individual and family interventions.

Common examples of multisystem interventions include the following:

- If a parent is overwhelmed, help in negotiating complex bureaucracies or in obtaining needed adjunct services may be critical.

- Parents may need help in obtaining services related to housing and medical care coverage.

- The teen may need help with transportation to prosocial recreational activities or self-help programs.

A high level of collaborative involvement is promoted among all the systems to which an adolescent is connected (e.g., school, work, tutoring, juvenile justice appointments). When the adolescent is involved with the juvenile justice system, intensive working relationships are swiftly established with the probation officer or other court staff connected to the adolescent. Therapists also routinely meet with school personnel for case consultation and to help the school understand the treatment and its focus on school attendance and performance. Work with the family and the adolescent alone focuses on devising plans for improving the teen's school-related behavior (i.e., removing obstructions to school attendance and improved performance). Other interventions may include promoting consistent monitoring by institutions and advocating for the adolescent's special educational needs.

Therapeutic case management

Practical tips for integrating therapeutic case management activities into an overall intervention plan are listed in Table 1. Therapists should maintain a current file of all available resources in the region and the names and numbers of the appropriate contact persons. Therapeutic case management provides wraparound services that allow the adolescent and family to receive solid, practical support while they learn to function differently. These interventions also can stabilize a family in crisis and keep the teen and family in the treatment program.

Table 1. Procurement and Organization of Resource Information

	Case Management Tasks	Therapeutic Tasks
School	• Daily monitoring of attendance • Monthly compiling attendance and in-school behavior records • Pick up school records • Monitor parental receipt and signatures on all school reports and forms • Attend school meetings/conferences and multidisciplinary team meetings/as requested by therapist • Prepare and enable parents to facilitate on schools interventions prior to termination • Maintain active contact with schools, alternative education programs, etc. • Monitor contact and progress with tutoring programs	• Assess family needs • Assist in curriculum planning • Advocate for client with school system including requesting full battery as needed for appropriate placement. • Educate parents about school system; enable them to impact the process • Discuss interventions and outcomes with family • Prepare and enable parents to facilitate all school interventions prior to termination
Work	• Make referrals to appropriate agencies • Take parent to appointments at job agencies, vocational rehabilitation, or interviews	• Assess family needs • Discuss interventions and outcomes with family • Include work issues of ethics in therapeutic intervention
Prosocial support	• Monitor attendance at	• Assess family needs and

	all prosocial activities • Take clients to 12-step meetings and record all meetings as needed • Facilitate parental access to support groups and/or 12-step meetings as necessary • Evaluate appropriateness of recreational activities in terms of content, staff competence, and rapport • Determine cost, hours, attendance requirements • Facilitate mentor contact and monitor contact	interests • Determine which activities are most appropriate for client • Determine if an increase or decrease in attendance at activities is necessary • Discuss interventions and outcomes with family
Economics	• Facilitate access to all economic services available • Take clients to apply for and obtain services as necessary • Maintain updated contacts with providers	• Assess family needs • Set up a plan with the family to determine how to best meet their needs • Attend meetings with service providers when clients' behavior has impacted receipt of services and advocate for client • Discuss interventions and outcomes with family • Prepare and enable family to facilitate all economic interventions prior to termination
Medical	• Facilitate health care service access • Make referrals/appointments to appropriate agencies • Take family members to appointments with health care providers as necessary	• Assess family needs • Confer with medical professionals about family's health needs (particularly in the case of psychiatrists) • Implement HIV preventive interventions • Discuss interventions

	• Obtain results from providers as necessary • Visit family members at inpatient facilities when appropriate as requested by therapist	and outcomes with family
Legal	• Maintain contact with juvenile probation officer • Attend court hearings as needed • Visit clients in detention as requested by therapist • Take family members to Immigration and Naturalization appointments as necessary	• Assess family needs • Advocate for client when appropriate • Make court appearances when necessary and when attorneys' agenda fits with therapeutic plan • Discuss interventions and outcomes with family

Sample narrative. It is important to orient the adolescent and family to the MDFT treatment program. Explain to the parents and adolescent the practical focus on extrafamilial systems and activities. The following excerpt comes from a first session and illustrates how therapists typically explain the program's extrafamilial focus.

Therapist: [to Mrs. Jones and Willis] *Part of what we're trying to do is to find out the different sides to every story.*

> [to mother] *Are there things that you're not happy with? Are there things that you want to see him doing? You had hopes for him, dreams for him.*
>
> [to adolescent] *Willis, part of what I will do is to get to know you a little bit, to get to know where you stand on some things, what you'd like to see change, and I'll try to help you find a way to deal with things in a way that works better for you and for your mom, too.*
>
> [to both] *Our program gets involved with the social workers at probation. I know Miss S.* [social worker]. *I'll be calling her to say that Willis is in our program. I will keep connected with her and keep tabs on what is happening there.*
>
> *If there are problems in the school, I will get involved there as well. I always like to let them know we're on the scene, we're working on the same team really, trying to get things right for Willis. Sometimes kids have had trouble in school, and it's helpful if we're able to go to bat for them a little bit. We might say, "Could you slow things down? Don't kick this kid out; we're trying to stop the slide—we're trying to do something good here."*
>
> *What I'm saying is that there are some things outside this room that I get involved with. So I'd like to encourage you to call me between our meetings and say, "this or that*

happened," or "the school called." If something comes up at home, if there's an argument—a problem—either of you could call me. It's not just when you're here, but I'm thinking about these things all the time. Don't forget that I'll be in touch with other people who are involved with your situation, too. So I wanted you to be aware of that part of our program.

Today is our first meeting and it's real important for me to find out from you, Mrs. Jones, and from you, Willis, what's going on with each of you. Can I meet separately with each of you now? Then we'll all come back together at the end of our time today.

III. MDFT Sessions: Operational Features of the Approach

The Three Stages of Treatment: An Indepth View

MDFT treatment unfolds in phases, but like all stage models, it has variation and overlap between the stages.

Stage One: Build the Foundation

The early work of therapy involves establishing an alliance with both teens and parents. These are distinct relationships, with their own courses, expectations, and contracts for what therapy can and will be. Success with one in no way guarantees success with the other. The alliance between therapist and parent, for instance, does not necessarily predict an equal working relationship between a therapist and teenager. An effective therapist–parent relationship may, in fact, lead to difficulties in the therapist–teenager alliance. MDFT thus goes to great lengths to ensure that excessive focus on parental issues does not transform *family* therapy into *parent* therapy.

Adolescents are able to discuss some, but certainly not all, aspects of their lives with their parents. They remain in contact with a healthy, vital peer network and sphere of activities. The therapist connects and at times translates the parents' and adolescent's experience with each other. Seeing the adolescent and parents separately throughout therapy accentuates this function.

However, the instigation of these engagement and reconnection processes is no small feat, given the degree of often longstanding emotional distance, disenchantment, and hostility evident in these families (Burke & Weir, 1978; Mann et al., 1990). Living in environments such as these exacts a severe psychological price (Rook, 1984). A critical step in reconnecting the parents and adolescent occurs at the outset of therapy. Without success in this area, the therapist's efforts at relationship repair often remain incomplete. This challenging therapeutic task depends on the engagement of the teenager in treatment.

Engaging the adolescent. At the outset, the teenager is helped to feel that therapy can address his or her concerns. The adolescent is assisted in formulating personal thoughts and feelings about his or her life and family and over time is helped to express some of them to his or her parents. In the beginning phase of MDFT, the therapist helps the teenager articulate a different agenda from that of his or her parents (see The Adolescent Subsystem Module: Adolescent Engagement Interventions on page 71).

Key Concept:

Alliance building begins with demonstrating genuine interest in and commitment to the adolescent's well-being.

These adolescents commonly feel disrespected and abused and believe themselves to be hardly worth listening to. Most often they are told to "just listen and be quiet." Many people such as members of their families, school personnel, and probation officials have agreed on the undesirability of the teenager's behavior and/or personality. MDFT aims to create a new experience for the adolescent, one in keeping with some of the most basic elements of any counseling relationship. Alliance building assumes genuine interest in and commitment to the adolescent's well-being. Presenting the possibility of a relationship in which the teen will be cared about, respected, and listened to is a basic first step of engagement. For an adolescent to be successfully included in family therapy, the therapist must believe that it is important to elicit the teenager's story and, further, that it is in everyone's best interest to attend to the teenager's needs and complaints. This module suggests a way of engendering such collaboration.

Setting a foundation is crucial. What follows enumerates key aspects of the therapist's message. More detailed transcript versions of this approach are available elsewhere (Liddle et al., 1992). The messages contained in the sample sentences (*italics*) in this module are intended to stimulate a discussion with the adolescent.

This therapy is for you, too.

Adolescents enter therapy under various circumstances, most of which deter engagement. The wise therapist (i.e., one who is interested in including the teenager in treatment) is one who immediately and successfully addresses a common teenage lament: that therapy cannot help them and that therapy is simply something their parents want.

I can and will be on your side at least some of the time.

This works as an alliance-building theme. Family therapy with adolescents necessitates multiple alliances, all of which need constant attention. Teenagers are often surprised by the therapist's genuine interest, respect, and support.

It is possible that your parents do not understand you.

By bringing this content into the therapy, the therapist establishes the need for parental understanding of their adolescent's feelings.

They may not know enough about who you are, who you are becoming, what your life is about, and what your interests and ambitions are.

The interpersonal and social context of the teenager's experience is vital. Troubled adolescents often feel alienated from their parents, indeed from life itself (Harlow, Newcomb & Bentler, 1986; Newcomb & Bentler, 1988).

Some aspects of who you are will always remain private (we can talk about this between us if you like), but it is important for your parents to know about some of what is

going on with you.

Therapists should be sensitive to teenagers' boundaries, especially those pertaining to information that they may want to keep private. Acknowledging this is critical. Therapy must be a place where the teenager not only can express himself or herself but can also be heard.

Adolescent development literature has long recognized identity formation and development as important tasks for teenagers (Erikson, 1968) but only recently has documented their intimate connection to positive family relations (e.g., Grotevant & Cooper, 1986; Hauser et al., 1984; Youniss & Smollar, 1985). Thus, indepth knowledge of adolescent development guides a clinician's thinking and behavior. This aspect of the module also connects the adolescent's recognition of problems in his or her life to those in the family.

When your parents understand you and know you more fully, they can appreciate what youare going through (e.g., adolescent transitions, resentments about the past).

The interpersonal or social aspect of the adolescent's experience continues and is made more complex by discussing the parents' response. Parents are not the only family members who feel hopeless about change. Teenagers frequently manifest their hopelessness by not believing their parents can behave differently toward them. It is important to address the parents' lack of response to the teenager in the past while being positive about the possibility of change.

When your parents begin to understand your experience, it may be possible for them to change the way they interact with you. I will help them with this.

MDFT assumes that families can be better and that parents can do a more effective job of raising their teenagers and caring for everyone's needs. Therapists are bound by an ethical code as well as a code of good sense not to make false promises in therapy; nevertheless, it is imperative to be a spokesperson for change. This is especially critical with teenagers and their parents, who frequently have had years of shared failure and pain and who have often been told by outside agents that their child or teenager is beyond help.

I can help them with the sort of change they need; this is between me and them [e.g.,your parents can treat you better, or their marital problems are not for you to get caught up in; leave that to me].

The adolescent worries that no matter what he does, his parents cannot change toward him or her. The therapist must anticipate the teenager's realization that not every change should be up to him or her. The therapeutic agenda is defined as a mutual struggle to deal with the necessary transformations in family relations (Hill, 1980). Another aspect of this situation concerns clients with pressing marital problems. Here the therapist reassures the teenager that although he or she knows full well the marital troubles that may be occurring, these matters will be between the therapist and the parents. The therapist informs the teenager that he does not want anything to interfere with the goal of helping the teenager's parents "be better parents."

But, to do all of this, they have to get reacquainted with you. You have to let them know more directly and in a more effective [i.e., age appropriate] ***manner what's going on with you. This will be tough because you are burned out on them (and perhaps they are with you, too), but I can help you get better at telling them about what's going on. You'll havto trust me with that. All this will take time.***

The therapist acknowledges the hurt feelings and lack of motivation as understandable reactions to past failures and hurts and current resentments; it is imperative to deal directly with past trauma (Liddle, Dakof & Diamond, 1991). At the same time, therapy is defined as an opportunity to start over, or at least make the best of the current situation.

Let me know who you are, express that stuff to me [as a prelude to expressing it and working on it with them].

Meeting alone with the teen, the therapist first works to help the adolescent clarify his or her thoughts, feelings, and experiences. Premature attempts at problem solving can escalate into negative emotion among family members, which has been found to have deleterious effects on attempts at problem solving (Forgatch, 1989). Gradually, the individual sessions allow the teenager to practice a new "language," that is, how to discuss sensitive topics with his or her parents in a constructive way.

I assume that you have some valid gripes about your parents and maybe about life in general. But I also assume that the way you have been going about telling your parents and the world about all of this has not gotten the right message through. You'll want to get angry at them and maybe blame them for the way you feel, but for now, I want you to just try to tell them how you are thinking and feeling about yourself and your life.

The adolescent is challenged to be a participant in shaping the way his or her parents behave. The teenager's feelings and experiences are validated but his or her methods are not. Revealing the adolescent in new ways can change the parents' viewpoint and the helplessness and lack of control they often feel (Newcomb & Harlow, 1986). This is intended to counter the teenager's sense that "Therapy is for my parents, not for me."

These thematic keys play a significant role in establishing an alliance with a teen. Working these themes early in the treatment (either in the presence of the entire family or with the teen alone) sets a foundation for engagement.

Engaging parents

During the same period, the therapist sees the parents alone. Assessing and adjusting the emotional connection of the parents to their teen is usually the first order of business in working with tired, helpless, angry, and intimidated parents. Eventually, therapists help parents define their parental belief system and preferred parental styles, paying close attention to the developmental aspects of their ideas. Adolescent identity development that is fostered through a continued familial interdependence rather than emotional separation (Grotevant & Cooper, 1983) and the influence of different parenting styles on adolescent personality are interwoven here. For example, a parent might be told, "Your son does need you to talk to him about his concerns and worries. You can be the best medicine in the world for him." Interdependence and the necessity of both parents and adolescents negotiating the youngster's transition to adulthood (Steinberg, 1991) become content themes and goals of the therapy. Therapists emphasize the themes of emotional depletion, hopelessness, anger, and the urgent need for parental action.

Parental belief systems (Goodnow, 1988; Sigel, 1985) become important topics of discussion with parents. These themes help parents cooperate with one another and build the

parental coalition long considered important by family therapists (Minuchin, 1974). Parents are coached, and their belief systems (Sameroff & Feil, 1984) are explored and, if necessary, reformulated to rekindle the parental imperative (the state of mind in which parents are energized and motivated to try again). The main mechanism for such influence resides in establishing a new, developmentally appropriate relationship. This relationship is one that has successfully negotiated the requisite parent–adolescent transition (Steinberg, 1999).

Families of drug-abusing adolescents must make these efforts in the context of their own relationship history. The therapist and parents discuss the barriers to relationship repair and reconnection and attend to and accept the parents' many feelings about what has happened with their child. Through these discussions, parents begin to feel the therapist's support and understanding, and the therapist attempts to facilitate renewed parental hope and commitment toward their adolescent. Therapists are mindful of motivation and a practical language and focus that places the treatment in a developmental framework.

The following statements (*italics*) illustrate the parental module's content.

> ***It wasn't easy for you. You've been on your own since he was born, raising him on yourown. What I hear you saying is that you feel alone in this. It was a bad, hard situation for you.***

The therapist acknowledges the difficult past and present circumstances that impede parenting and family management practices and acknowledges that the parent has individual problems, disappointments, desires, hopes, and dreams. The parent is provided validation that he or she has a life separate from the parent role.

> ***I know this is frustrating for you. But I have to disagree with some of what you aresaying. You can follow through. I remember the time he stayed away from home for a few days and nights, and you went to the place where he was staying and dragged him out of there. If that's not followthrough, then what is?***

It is vitally important to search for and confirm examples of successful parenting behaviors and to validate the abilities that exist.

> ***So why are we doing this*** [coming to therapy, trying to reach out to your child]***?***
> ***You'redoing this because you love her and you're concerned about her. It tears you apart, and that's why you're here.***

Therapists try to actualize the parents' experience and feelings of love, caring, and commitment toward the adolescent through past feelings of love, joy, aspiration, and pride in the adolescent. This includes focused recollections of rewarding parenting experiences from earlier developmental periods and small pleasures that occurred in the recent past.

> ***Is that really why you're so mad? I think you're just talking about the superficial stuff. Iwant to know what makes this so hard. What's getting in the way of you two working out day-to-day problems? Why is there so much anger and resentment?***

The therapist attempts to bring out important events, core issues, or themes, then facilitates serious emotional discussion of these issues, which may lead to forgiveness. It should be an honest discussion of feelings, responsibility taking, and listening, not blaming and denial.

> ***We're trying to move you out of that rut of being on the run, almost saying, "He'll get usbecause we didn't say this." No, he doesn't have to get you, because you're the parents.***

Parents often feel hopeless. The therapist combats the parents' belief that the adolescent is not in need of or is beyond parental influence. The therapist must be unequivocal in stating the need for the parents to stand by their teenager.

> ***I've seen how tough this is. My heart goes out to you, and I will do everything I can tosupport you.***

The therapist presents himself or herself as an ally who will support the parents in their attempts to influence the adolescent. This is critical to addressing the fundamental dilemma of hopelessness about change.

These themes play a significant role in engaging parents in treatment and in adolescent–parent relationship recalibration. The improvement of concrete parenting skills may then rest on this foundation.

Stage Two: Work the Themes

Key themes

The second stage consists of getting and keeping the right content in therapy, as well as facilitating processes and fostering skills that allow this to occur by working and reworking of MDFT themes that constitute the family's core struggles. Examples include:

- Parental frustration ("I can't take this anymore.")
- Parental helplessness ("There is nothing I can do.")
- Parental fear of setting expectations ("I don't want trouble.")
- Parental abdication ("I give up.")
- Parental meaninglessness, mastery and control, competence and influence, respect, and love and commitment
- Adolescent entitlement ("You can't tell me what to do.")
- Adolescent rejection of parental authority and hierarchy ("We are all equal.")

· Adolescent and parent hopelessness ("Things will never get better.")

· Negative adolescent perceptions ("I can never get a break.")

These key themes will be addressed and expanded on throughout the manual.

Therapist guidelines in working the themes

Therapists use these themes as a roadmap to barriers to positive development and keep in mind several theoretical tenets that help orient the working of the themes:

· Adolescent development research guides therapy.

· There needs to be a renegotiation of the adolescent's and parents' transition through the establishment of modes of interdependence as opposed to the dependence of childhood or the focus on leaving home common with later adolescents.

· Although they transform to meet the adolescent's developmental needs, attachment relations remain important throughout adolescence.

· In the therapeutic alliance, alliances are formed with multiple family members and influential others outside of the family as well.

· Affective themes such as hopelessness and despair are blocks to skills training and problem solving.

· The therapist's use of self is important in establishing a commitment to the teenager and family's well-being.

· The treatment program must be practically oriented and careful to move beyond a control, power, and authority therapy.

· It is important to understand the influence processes of parents and peers (careful of antifamily or peer reductionism).

· The therapist and parents should adopt and foster a "do what it takes" philosophy.

· By the time a teen appears at a treatment program's doorstep, the negative processes in which he or she is involved have often evolved and multiplied. Therapists generally work to counter extreme responses or all-or-nothing solutions.

· Sessions with parents and the teenager have objectives and intended outcomes, in and of themselves, and the work in any given session may be a precursor to future work, focus, or objectives (i.e., they are both a whole and a part of other therapeutic work).

· Life cannot be perfect, and therapy outcomes might be less than perfect. Therapists should be careful of any tendency toward a "cure" or an emphasis on perfect treatment objectives.

Dealing with the past in a present-centered therapy

The MDFT model deals with past hurts and trauma in the lives of teenagers and families. The therapist who wants to do effective work with adolescents and families must not bypass the disillusionment, anger, and despair that many teenagers and their parents bring with them from the past.

Entering the terrain of the past with parents and teenagers can serve therapists well if they can use this content to further therapeutic aims in the present (Liddle, 1994). A family's memories include past dreams and hopes that need to be reclaimed. The ability to talk together about hurtful past events removes obstacles to dialog in the present. Negative emotions, often related to past events, are the major impediment to problem solving in the present.

In the following exchange, an adolescent shares his feelings of hurt and abandonment and his fear, as a child, that he might never see his mother again when she went out drinking. Interestingly, he makes a connection between his fears for her safety in the past and her fears for his safety in the current situation.

> **Willis:** ***When I was young, sometimes I had fun. I always had fun when my mom was around me but I used to be scared when she would leave me and go out to the bar and drink. I was scared she might not come back. Now, she goes and does that when I go out—she's scared, she don't know if I'm gonna come back or not. I used to play outside, and she used to go out Saturday nights. I used to cry and I didn't think she would come back home. And I used to always come outside early on Sunday and sit on the step,'cause the bus stopped right on the corner. And I used to be so proud when she used to get off that bus . . . .***

Therapists must assess what makes the greatest contributions to emotional impasses in current family relationships. Therapists must, if necessary, prepare family members who will have the most difficulty dealing with the past by holding individual discussions with them (see Guidelines for Subsystem Sessions on page 178). The therapist might say to a parent, "Your son has a lot of feelings about what happened in the house 2 ago when you were in your addiction. It might be hard for you to hear from him about this. Can we talk about what might come up for you?" During the conversations themselves, the therapist must ensure that individuals are not talking in a detached or remote way about these events but are able to attach feeling to the recounting of them; it is emotion that can engender the kind of interpersonal exchanges that can lead to change in behavior and perception (Liddle, 1994).

Stage Three: Seal the Changes and Exit

Key Concept:

Change is expected on many fronts. Does the adolescent demonstrate improved judgment, relationships? Has his or her drug use stopped or been greatly diminished? Is he or she able to problem solve and avoid escalation of troublesome encounters with others? Is he or she in school, working? Has the family process of handling difficult situations increased the likelihood of problem resolution? The therapist looks for multiple confirmations that there has been significant fundamental change.

The third and final phase consists of working to (1) keep progress shored up, (2) let the family do its own work, and (3) emphasize generalizability, transfer, and extension of the new ideas and behaviors to current and future situations.

In this phase the therapist refines any other issues that the family needs to address. Change is expected on many fronts. Is the teen in school? Has the adolescent's drug use stopped or been greatly diminished? Is he or she able to solve problems and avoid escalation of troublesome encounters with others? Is the teen still hanging out with drug-using friends? Has the family process of handling difficult situations changed in a way that increases the likelihood of problem resolution? The applicability of the family's new attitudes and skills to a variety of situations is emphasized.

The therapist may help family members articulate the ways in which their beliefs about each other have changed (as well as some that have stayed the same). Parents typically attribute the teenager's behavior and actions to normal processes rather than psychopathology. The therapist might have the family reminisce about a particularly difficult crisis point in the therapy, one in which members persevered and negotiated through to a solution together. The therapist also might review the problem-solving strategies that have been learned during therapy as well as discuss some of the key events on which they were used to seal the changes that have occurred and help the family see that each member has contributed significantly to the treatment's outcome.

IV. Goals, Rationale, and Procedures of MDFT Interventions

Key Concepts of MDFT Interventions

Key Concepts of MDFT Interventions

- **Multidimensionality**
- **Redefining sessions**
- **Multiple therapeutic alliances**
- **Linking**
- **Continuity**
- **Whole–part [holon] thinking**
- **Doing what it takes**
- **"Parental hell"**
- **Working all four corners**
- **What you don't know CAN hurt you**
- **Organizing according to modules and stages**
- **Goals and themes emerge from the interaction of the generic and the idiosyncratic**
- **Culturally sensitive treatment**

Multidimensionality

Adolescent problems arise in many ways and for different reasons. Serious drug problems do not appear overnight. Change in MDFT is ambitious and complex. It involves understanding the individual's functioning as well as the mechanisms of interconnection among the various levels and kinds of systems that affect a teen's life (as well as factors that have been active over time but are no longer apparent).

Multidimensionality is a mindset, a way of thinking about human problems and their resolution to discourage narrow or reductionistic thinking about clinical problems or solutions. Therapists are taught to understand the many systems that are involved in the continuance of drug and behavior problems. They probe to understand the events, personal and family characteristics, and circumstances that over time have led to the current situation in which the teen uses drugs, does poorly in school, has legal problems, is connected to deviant peers, and is disconnected from his or her family.

Multidimensionality refers to case conceptualization, notions about causality, and ideas about how lives can change for the better. Multidimensional thinking reminds a therapist not to overplay or be overly reliant on one pathway, means, or technique to facilitate change. Solving a teen's drug problems involves changing many things that currently support drug use, including his or her individual attitudes and beliefs, individual developmental (prosocial, identity-oriented

issues; self-efficacy) issues, affiliation with and access to deviant peers, failure with and disconnection from prosocial institutions (school and religious affiliation), the family environment (which may include the mental health issues of a parent), and parenting practices. Therefore, the therapist's assessment, conceptualization, therapeutic strategies, and intended outcomes are, in one sense, all the same—they are all multidimensional.

Redefining Sessions

Various treatment parameters have been reexamined in the MDFT approach. There is experimentation with more intensive and extensive versions of MDFT treatment, using the approach with a therapist and therapist's assistant in some studies and, in others, accessing families by meeting with youth and families not only in clinics but in homes. Another aspect of rethinking some basic therapy aspects concerns phone calls. Once seen in the category of "reminders" to come to sessions, phone calls are now used as sessions themselves. Hence, this is one way to redefine the concept of a session. Meeting with the adolescent and family in detention while waiting for a teen's hearing at drug court or meeting an adolescent at a restaurant or movie are ways to continue to gain access to a case. The venue—the session context—changes to provide maximum flexibility and an opportunity to implement the program's principles and clinical methods.

Multiple Therapeutic Alliances

The therapeutic alliance in individual treatment has a longstanding and solid theoretical and, increasingly, research-based history. MDFT, however, requires not only one therapeutic alliance; it requires several—presenting a challenge to successful MDFT. As is the case in the development of multiple constituencies of any sort, in the process of developing multiple therapeutic alliances, different motivation levels and intentions about the youth and treatment will become apparent. At the same time, the therapist, as one who is a competent navigator of multiple subsystems in the family and systems outside the family, begins and facilitates the progression of these multiple relationships simultaneously. Everything focuses on the youth's needs and treatment—how the teen's life course can be directed away from drug use and deviant peers and toward prosocial, developmentally appropriate pursuits. Therapists are aware of and skilled in applying different kinds of competencies needed with teens, parents, other family members, and school and juvenile justice officials.

Linking

Linking is the process of molding and shaping changes across functional domains in different developmental environments (school, family, self) over time. Linking is a method through which therapeutic continuity can be achieved. Change is multiply determined and requires the connection of in-session content themes and accomplishments across sessions. There is a *successive approximations* or a *building block* approach to change. Linking also applies what has happened in the therapy session to future challenges, generalizing gains made in therapy to different areas of the teen's and family's lives. It also involves highlighting the progress made by one family member to motivate and facilitate change in other family members.

Continuity

Emotional, behavioral, and interactional changes are initiated and maintained in systematic steps throughout treatment. Continuity of the therapeutic work is maximized through strategic planning and constant recalibration based on assessment of outcomes. Whereas the foundation between the therapist and the teen, family, and extrafamilial sources of influence is laid in the early stages of therapy, continuity is the goal of the middle stages. Continuity is achieved by working and reworking themes via in-session behavioral enactment and out-of-session tasks. Later stages of therapy involve consolidation of themes and therapeutic gains across sessions (e.g., cognitive sealing, affective recollections, behavioral troubleshooting, refinement).

Whole–Part (Holon) Thinking

The focal areas of MDFT are each considered to be a holon—both a whole and a part. An individual is a "whole" biopsychosocial organism as well as a "part" of other systems such as families, work, peers, community, and ethnic or racial group systems. Systems, both intrapersonal and interpersonal, are interconnected and mutually influencing. An important job of the therapist is to acquire an understanding of how each system works as both a whole and a part and to devise appropriate interventions.

Doing What It Takes

Another mindset concept, "doing what it takes," refers to a clinician's attitude as much as it refers to any specific technique or piece of behavior. The doing-what-it-takes attitude is not only something a therapist strives to develop; it is also something that is conveyed to the youth and family. By the time a teen is referred to MDFT, many problems have occurred. Generally, they have been in existence for some time. Pessimism may be the primary emotional tone in the family and in those social systems that know the youth. This emotional tone influences current and future activity (or, all too frequently, inactivity) relative to the youth's situation. The doing-what-it-takes stance announces a no-more-business-as-usual approach to the adolescent's situation. It emphasizes that a life is at stake, and, indeed, other lives in the family are at stake as well. Therapists carry through on this approach: they cannot announce a high degree of commitment to obtaining outcomes and pursuing all possibilities for change with the teen and family and then fail to deliver. MDFT is not for therapists who are faint of heart. MDFT works with therapists to help them adopt this doing-what-it-takes attitude—a therapeutic position about what is needed to facilitate change in lives that have been overcome and immobilized with failure and that have an absence of options for escape from a developing and deepening lifestyle of deviance and antisocial activity.

"Parental Hell"

MDFT teaches therapists to be active and directive about prompting change in all system members. But the timing and nature of this stance toward change and growth vary. It is important

in working with parents and teens to understand what they have been through. Just as work with the teen moves through phases, treatment in the parental subsystem is phasic as well. One of the first things to do with parents is to understand their world, to appreciate what they have been through with the teen. Families are disrupted—indeed, torn apart—by a teen's drug problems. Parental shame and embarrassment and a sense of deep failure are powerful emotions that many parents in studies have lived with and felt for many years. Parents frequently tell therapists that their adolescent has "put them through hell." Therapists have listened to this oft-heard exclamation and have become committed to understanding all that goes into a conclusion of this magnitude. Therapists thus try to understand the hell that the parent has been in or is in. Although the parents may have participated in creating their self-defined parental hell, this systemic reality cannot be confused with the necessity for the therapist to first find a way to support each family member and each person outside the family who might be involved in the youth's life at the moment (e.g., school and other agents of social control). So the concept of parental hell is meant to remind therapists of the intensity that a teen's problems can create with family members and of the need to first understand the disappointment, pain, and anger that the adult/parent on the scene may feel. With parents of clinically referred teens, the first job is to visit with them the personal parental hell that they have been to or are experiencing. It is from this place that requests for changing their parenting can come (Liddle et al., 1998).

Working All Four Corners

Because MDFT aims to facilitate individual and synergistic change processes in multiple realms of functioning, it is important to have a way to define the areas in which history and current functioning should be assessed and the areas in which change should be worked. "Working all four corners" refers to the assessment and facilitation of change in four areas—the adolescent, the parents, the family transactional environment, and the youth and family vis-à-vis community and extrafamilial sources of influence. This concept works with multidimensionality in the sense that the four corners idea names the multiple realms a therapist must first understand and in which the therapist tries to facilitate change.

What You Don't Know CAN Hurt You

This maxim, paraphrasing "what you don't know can't hurt you," reminds the therapist that a comprehensive assessment is vitally important and that a therapist's knowledge of local resources, policies, and procedures about important parts of family life is fundamental to success. Therapists who wish to advocate for their teens and families must be knowledgeable about such things as court hearings and proceedings and school regulations regarding testing, tutoring, expulsion, alternative school options, and so on.

Organizing According to Modules and Stages

Modules refer to (1) areas or realms of therapy, (2) different bodies of knowledge, (3) intervention locales, and (4) pathways to and mechanisms of change. MDFT consists of four modules: (1) the adolescent module (therapy related to individual work with the adolescent), (2) the parent module (therapy related to individual or conjoint work with parents, parental figures,

or guardians), (3) the family interaction module (therapy related to familial work and the assessment or alteration of relationships and interactions), and (4) the extrafamilial subsystem module (therapy related to work with any system in the adolescent's or parent's social world). Each area is one of several targets for assessment, intervention, and change. Change is conceived in stages, which are necessary to achieve successful outcomes. Attempts to implement problem solving in relationships, without achieving developmentally appropriate levels of attachment and communication, will not be successful.

Goals and Themes Emerge From the Interaction of the Generic and the Idiosyncratic

Therapeutic goals and content themes in treatment are the by-products of an interaction between two spheres. Generic factors relate to issues such as how families operate, the risk and protective factors involved in substance abuse, and the developmental tasks of all early versus late adolescents, for example. Idiosyncratic factors refer to the particular set of individual circumstances, events, and personalities and history that have come together and evolved over time to produce this particular youth and family. Generic refers to universal laws of adolescent development and the development of dysfunction, whereas idiosyncratic refers to characteristics and processes that have worked and continue to work together to give an individual and his or her family identity.

A therapist uses his or her universal or generic content knowledge as a guide for getting to know the youth and family and as a framework to assess areas of high and low functioning. It is in the interaction of this generic knowledge and the youth and family's responses, their own particular stories, that the goals and core content of treatment are born. Clinicians enter treatment with teens with ideas and a knowledge base about how teens and families develop and how dysfunction begins and becomes exacerbated. Yet the therapist does not know what competencies or problems exist in a particular family, in particular lives. The generic content of their lives offers the framework or scaffolding on which the idiosyncrasies that are in front of the therapist can be explored and fleshed out. Once this unfolding and revealing occur, the particular needs of people involved in the case are evident. When needs of the youth and family are evident, then it is a straightforward task to specify the goals. It is in these multiple and interlocking stories, and also in the therapist's process of organizing and assimilating them, that treatment's core focuses reside. Life and relationship themes come from the content of the stories about what has happened in the lives of the teen and family. Therapists develop a way of listening to content that culls redundancy and repetition and identifies "big picture" meanings and implications.

Culturally Sensitive Treatment

Racial and cultural issues are taken into account in tailoring interventions to each adolescent and family. Culturally sensitive treatment emphasizes (1) the therapist's activity within multiple systems of the adolescent's life, (2) the facilitation of active client involvement in treatment, (3) the use of popular culture, and (4) the extensive discussion of salient cultural themes and the use of these cultural themes to elicit life stories, life plans, and revelations about important past events. Based on the information the therapist gains, he or she then can exert positive influence on socialization and involve prosocial adults as mentors.

The Adolescent Subsystem Module

Goals

- **To build a therapeutic alliance with the adolescent**
- **To create a collaborative agenda**
- **To establish a developmental–ecological framework of treatment**
- **To improve functioning in several developmental domains**
- **To transform a drug-using lifestyle into a developmentally normal lifestyle**
- **To facilitate developmentally adaptive competence in multiple settings.**

Rationale

Adolescent drug use and abuse are multidimensional phenomena and, thus, multiple aspects of the teenager's biopsychosocial ecologies must be addressed if treatment is to be transformative.

Procedures

- **Meet alone with the adolescent**
- **Assess the biopsychosocial ecologies of the adolescent**
- **Assess competence in key areas of development**
- **Assess and address multiple life skills**
- **Foster self-examination and appraisal**
- **Facilitate experiencing and communicating thoughts and feelings about important aspects of life**
- **Organize opportunities for the adolescent to explore and address these issues in important interpersonal contexts (family, school, work, peer systems).**
- **Create prosocial, developmentally appropriate, and facilitative alternatives to the drug-using lifestyle**
- **Address drug use directly through drug counseling techniques such as functional analyses of drug use, getting details about the "people, places, and things."**

The Self of the Early Adolescent and Clinical Implications

Key Concepts:

- **Identity development occurs through a combination of role modeling, identification processes, and validation from others.**
- **Relationships with parents and peers are critical in the process of identity formation.**
- **Drug use is most common and pervasive in young adolescents who are characterized as identity diffuse and have problems with identity development.**
- **Delinquent youth are much more negative and pessimistic in describing the person they expect and hope to become than are nondelinquents.**

Research findings related to adolescent identity development have previously been discussed. The clinical relevance of these findings is that possible selves provide direction for the adolescent's actions, thus skilled clinicians can use these representations to explore alternatives to the way the adolescent is living his life.

With younger adolescents, the process of uncovering the adolescent's sense of who she is and who she would like to be is particularly important, since during this time feelings and thoughts about oneself are most in flux and vulnerable to negative influences. Therapists also utilize this time to reinforce their role as advocate for, supporter of, and collaborator with the teen.

In the following vignette with a 14 year-old teenager, the therapist summarizes for the adolescent his impressions after a lengthy discussion of the teen's family relationships, past and current friendships, and school experiences. The therapist makes the connection between the person the adolescent wants to be and the specific steps he will have to take to get there, and then provides encouragement that these new realities are possible.

Therapist: **You've got a strong sense of yourself, huh? It sounds like you've done some thinking and you have some ideas about how you want your life to look.**

Chris: **Yeah. When I was young, when I was little, I looked up to my older brother. But now, since I was like 12, I just want to be my own self. I don't want to be like him.**

Th: **When you look at the people in your life, are there certain things that you know you'd like to have turn out the same way? Or you're going to find your own direction?**

C: Adolescent nods in agreement

Th: **It sounds like there are some clear things that you've said today that I just want to keep in mind because we're going to come back to them – and one of them is that you really want this year to be different than last year, you want to do your work, you want to pass, and it also sounds like you want to go on to high school. It sounds like when you get there you want to make sure that you meet new people who aren't going**

to have a bad influence on you, so that you can do your work there too. You're serious about graduating high school, and I believe that you can do it. And I want to help you stay on track and make sure that happens.

Often, therapists can help adolescents uncover more positive feelings they had when they were younger, and offer ways to reclaim a more positive identity by changing their behaviors, as in the following exchange between a 14-year old and her therapist.

Gloria: **I'm not as good of a person as I used to be. 'Cause before, I acted better and I would go to school, and I would get A's and B's. But that was when I was young, like before I was in 7th grade.**

Therapist: **Is that something you would like to get back? That feeling of knowing you were doing what your parents asked you to do, getting good grades, feeling good about yourself? Because I think it's tough being your age - I know I wouldn't want to be your age again. I think it's a tough time, but I also believe you can really turn things around and feel good about the way your life is going again. That is one of the things I think you can get out of therapy. I really believe you can do it, and I want to help you get there.**

Key Concepts:

- **Intervening with the peer system is critical in MDFT.**
- **Therapists have important discussions with adolescents one-on-one to uncover the nature of these relationships and how these friends can support or interfere with the adolescent's goals.**
- **Therapists also motivate parents to learn more about their adolescent's friends, the places they hang out, and the things they do in their time together.**
- **Therapists explore the adolescent's "possible selves" in the context of peer relationships and establish concrete blocks to positive goals.**

Peer Relationships in Early Adolescence and Clinical Implications

Research has consistently shown that young adolescents with positive life styles are apt to select prosocial peers, whereas young adolescents oriented toward antisocial or problem behavior are likely to select similarly deviant peers (Bush, Weinfurt, & Ianotti). On the positive side, peer-related protective factors can buffer the young adolescent from drug abuse (Wentzel & McNamara, 1999). For example, peer crowds oriented toward positive behavior (e.g., sports, academics) may actively disapprove of drug use (Youniss, McLellan, & Strouse, 1994). Furthermore, intimacy in peer relationships allows young adolescents to express emotions (Berndt & Perry, 1990) and thus to prevent the buildup of negative affect that may contribute to drug abuse (Diamond & Liddle, 1996).

An obvious clinical implication of these findings is to link drug abusing peers to more

positive influences. Because of the power of peer relationships in influencing the adolescent's developmental trajectory, intervening with the peer system is critical in MDFT. There are several levels of intervention when considering changes that need to occur in the adolescent's peer network. Therapists have important discussions with adolescents one-on-one to uncover the nature of these relationships and how these friends can support or interfere with the adolescent's goals. Therapists also motivate parents to learn more about their adolescent's friends, the places they hang out, and the things they do in their time together. In addition to these types of discussions, therapists look for opportunities to bring peers into therapy when appropriate. These interventions are delivered simultaneously, as the work in different therapeutic and developmental domains occurs concurrently in MDFT.

The following segment is typical of the kinds of conversations therapists have with young adolescents one-on-one in the early stage of therapy. These discussions are part of hearing the adolescent's story, what life is like during this transitional period, how things have changed since they were younger, who their friends are now, and what they want for themselves in the future.

Therapist: **So what kind of path are you on? I hear that Melvin's on this path of gambling and getting in trouble from time to time, and he's locked up now, right? And Justin's on this path of getting straight A's and playing hoops, right? And Tyrell's kind of in between the two of them. It sounds like you've got a lot of different kinds of friends.**

Tony: **I don't even hang with them. I used to hang with them a lot, like last year, but not now.**

Th: **How come? What happened?**

T: **I just don't hang with them. I don't know. I'm trying to stay out of trouble and not get locked up or nothin'.**

Th: **Was that hard to do? Did you just make a decision and say, 'I'm not going down that road, I don't want to hang with them'?**

T: **It wasn't hard or nothin'. I just don't hang with them. I ain't gonna be with a crowd of them, knowin' I'm standin' on the corner with them and they're selling drugs, and then I might get locked up.**

Th: **Right. When you're with those guys, you could get locked up for something you weren't even part of.**

In this situation, the therapist is reinforcing the adolescent's decision not to be with the drug selling crowd. Again, the therapist is exploring the adolescent's "possible selves" (Oyserman & Markus, 1990), this time in the context of peer relationships, and establishing concrete building blocks toward positive goals. The MDFT therapist's goal is to encourage Tony to form friendships with those who have similar attitudes to his. As noted above, simultaneous work with the adolescent and parent is also critical in eliciting the parent's reactions to, participation in, and reinforcement of this process of the "new" adolescent emerging.

Therapeutic work in the peer realm involves searching for and reinforcing prosocial activities and interactions. For early adolescents, it is often older peers who have influenced them to initiate drug use and engage in other antisocial behaviors. Yet older peers who have

learned from their mistakes, who are straightening out their lives and becoming positive young adults, can have a significant positive influence as role models for early adolescents. In MDFT, resources that exist in the environment but may not be obvious are sought out by the therapist and included in the treatment. In the following case example, the therapist has worked with Mark and his mother for a few weeks and learned that Mark's older cousin plays an important role in his life and is interested in coming to therapy. In session they examine what life is like for these two young African-American men on the inner-city streets. The therapist learns that as an older peer, Trent has been part of the socialization process contributing to Mark's drug use, delinquency, and school truancy. Trent is now trying to live a "better" life and while he is concerned about the path his younger cousin has taken, he has not been able to express his concern to Mark.

Therapist: **So, do you talk to your cousin about those kinds of things? About what it's like in the detention center, how it was for you there?**

Trent: (Shakes his head no), **Not really. I talked about what I did, not 'hey, yo man, you don't want to go there.' I don't tell him nothing like that.**

Th: **Why? You don't want him there 'cause you're protecting him, you look out for him, right?** ***(Trent nods).*** **Then why wouldn't you tell him 'listen, you don't want to go there'?**

T: **I don't know. I just don't think about saying that, 'oh yeah, I did this, I been there, you gotta do this.'**

Th: **All right. Well, I want you to start thinking about telling him things about where you've been and how you got there. I mean you sound like somebody who's a couple of years older than your cousin, and I think you want to try and keep him straight. So in order to do that it sounds like you need to start telling him things--reasons why he shouldn't be going there. You know what things pull y'all out in the street and keep y'all from going to school.**

The therapist intervenes in this early adolescent's peer subsystem by assessing the unique "big brother" role that Trent plays, asking him to take his role seriously, as well as acknowledging Trent's negative influence on Mark's life in the past. Towards the end of the session, the therapist asks Trent to think about the positive influence he could be on Mark as his "big brother." In this way, therapists in MDFT initiate changes in the peer subsystem, one of the many areas of the adolescent's life that impact him in positive and negative ways.

Therapist: **All right, I just want you to think a little bit about your role as big brother. If you're trying to protect him and keep him safe--certainly you want to keep him safe from the streets. You want to see him do some of the things you haven't done. I mean, that's what older brothers do, okay? I want you to just think about those things Trent, it's important.**

Adolescent drug abuse has different clinical presentations—different "looks." Adolescents may be engaged in more violent behavior than drug use or might be extensively involved in drug use and engage only intermittently in delinquent activities (Loeber, 1988). Broad descriptive terms such as "delinquent" or "adolescent drug abuser," if not misleading, certainly are not helpful for clinical work. The complexity of adolescent drug abuse cases is

illustrated in the following vignette. The therapist intended to draw the teen out and help him clarify and articulate his life experiences.

This excerpt from a conversation between the therapist (T) and Alonso (A) reveals a teen who has experienced quite a bit in his 13 years.

T: 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 'em before, lives in a bunch of different neighborhoods. Boy, that was a lot.

A: Yeah, but . . . .

T: How easy do you think that was for a little boy?

A: To me it was easier than it shoulda been, because I didn't really know the mother and father routine. All I knew was they said, "Go here, go there." I didn't grow up with my mom. I didn't get taught no lessons or nuttin'.

T: At the time you said didn't know any better, right? But you look back on it now and say, man, that was a lot.

A: Yeah.

T: You said, "the mother and father routine?" What is that?

A: You know, 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 'n' 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?

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

A: Right.

T: Come on, really?

A: Nobody didn't care.

T: What about your aunt that died?

A: She used to beat me when I did some bad, too. Yeah, but that was sort of like to help me out, 'cause that was like teaching me right and wrong. You know what I saying? "Don't do that. . . . " Then whoosh.

T: Right, okay, so maybe she was trying in her way.

***A: Mm hmm* [nodding].**

T: What about your stepmom?

A: My stepmom, now she wouldn't really see me do nuttin' good, but she ain't never whup me. Oh, you know, "He's a nice kid."

T: You think she loved you?

A: Yeah, I know she loved me.

T: Okay.

[later in the session]

A: I remember when I was a kid I used to be like, damn, they did drug dealing, you know, that's real bad. . . .

T: Mm hmm, yeah. . . .
A: But then I started doing that when I was like 12 years old.
T: Mm hmm.
A: So that does, that did, have an influence on me.
[later in session]
A: . . .so I was like truant. Well, that was when I started smoking cigarettes, and smoking weed, when I was in like the fifth grade. I was 10 years old.
T: Where'd you get the weed?
A: Check this out. In the Meadows, there's the rich part, there's the Chico part, and the black part. Well, I used to stay in the Chico part. . . . But I had a cousin who lived in the black part, so I walked to his house. My cousin was older than me. He was like 13, I was around 9 or 10. And all the people he'd hang with was older than him. And all of them smoke weed. And I started smoking weed, and I didn't used to tell nobody 'cause I thought it was bad—"Oh, he smoke weed, it's bad. . . ."
T: It is bad.
A: Yeah,* [laughs] *but I started smoking cigarettes too, 'cause I used to always see my mom smoking. And I'd get sick in the stomach. Then I started smoking weed. Now, when I was little, my stepmom, 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. But when I started drinking, that's when I started getting drunk and stuff you know. But back then I used to just drink, and they'd be, "Oh, don't drink that bomb," and they'd take it from me. And I'd be like, "why'd you take it from me."
T: And how old were you then?
A: I was like 8.

A drug and assessment screening instrument (e.g., Global Appraisal of Individual Needs [GAIN] [Dennis, 1999] or Problem Oriented Screening Inventory for Teenagers [POSIT] [Rahdert, 1990]) can be used in treatment. These self-report scales provide a quick assessment of the teenager's life and help identify desired changes.

Suitable change is defined as a decrease in or stopping of drug use and other correlated problem behaviors, as well as the creation of or an increase in developmentally appropriate competence in family, peer, and school relationships (Masten & Coatsworth, 1998).

Research on families gives therapists considerable understanding of the kinds of parent–adolescent interactions (i.e., processes) that are related to positive and negative developmental outcomes. This knowledge guides construction of interventions that block negative interactions (Diamond & Liddle, 1999; Liddle et al., 1998) and amplify existing but hidden strengths (Schmidt, Liddle & Dakof, 1996).

Particular kinds of change (e.g., creating willingness to reflect on one's current life circumstances) facilitated in a preferred sequence may be necessary before other kinds of change (e.g., creating a willingness to talk with one's parents about these feelings) are possible (Haley, 1976; Howard et al., 1993; Miller & Hester, 1986). Such introspection is difficult for younger clients. In these cases, MDFT therapists work in other areas, such as parental monitoring. MDFT therapists do not demand introspection with adolescents who are not at this point developmentally.

The engagement phase with the teenager is devoted to specifying a personally meaningful agenda—a reason for participating in treatment that may or may not coincide with the agendas set by others (Liddle & Diamond, 1991; Liddle et al., 1992). After the engagement phase, individual sessions with the teenager focus on his or her drug taking and other related problem behaviors. Intrapersonal and interpersonal aspects of drug taking and/or delinquent behaviors are discussed. The adolescent's relationships inside and outside of the family are also assessed. Another segment of the session with Alonso follows, illustrating this relationship focus. Although the extent of impairment of this case is different than most youth treated in the CTRADA ATM study, the case is illustrative of the therapeutic process utilized in MDFT.

A: ***When I was like 11, that's when everything got bad. Like in the same year, three close people died, I got kicked out of school, out of Central. I only went there for 1 year. . . .***

T: ***Why'd you get kicked out of school? What happened?***

A: ***I don't know just, like, reckless behavior and stuff like, you know what I'm saying. Bad attitude, you know what I'm saying.***

T: ***Did you go to school or was it that you didn't go?***

A: ***Oh no, I used to go to school.***

T: ***You went, but you'd just get in trouble.***

A: ***Oh yeah, I used to have fights and stuff like that. . . .***

T: ***Right, right.***

A: ***. . .and they don't really allow that. So then my mom said "Well, you got kicked out of school, you're getting kicked out of here." She sent me back with my dad.*** **[later in session]**

A: ***But I always liked my dad, you know what I'm saying. Because, I mean, he got like 15 kids, and he always look out for me, you know what I'm saying. Well, he look out for everybody, the man got money. So whatever, I went back, and I didn't like my mom because I was 11, and she had already kicked me out one night. And I was a little kid, and I had to sleep on the roof of the building, you know what I'm saying. And it was cold.***

T: ***And that's what you did, you slept up on the roof of the apartment building?***

A: ***Yeah. But then I just, one day, 'cause I was sick of being there, I just ran away, bam, I never came back. I packed all my stuff, out of the door.***

T: ***And where'd you go?***

A: ***I was living on the street. I was living with my one of my dawgs*** **[slang for a teen's friends]** ***on the West side.***

T: ***Mm hmm.***

A: ***But that couldn't last, you know what I'm saying, you can only stay at someone's house for so long, you know. But he gave me some drugs, he showed me how to, you know, to hustle.***

T: ***To serve*** **[to deal drugs]**, ***right?***

A: ***Yeah. And, I wasn't really doing it for a bad reason. Like, I was doing it because, you know what I'm saying, I needed to stay alive on the street. My mom, she didn't know any of this—didn't know about my serving.***

T: ***So you're 12 now, and you're serving in the West side.***

A: Yeah, this only lasted like, 3 months, not even—2, 2½ months.
T: Mm hmm, and what happened?
A: Through all this time I'm talking to you, I'm doing drugs, every day.
T: What were you doing?
A: Cocaine, everything, you know what I'm saying?
T: So from 10 to 12—we're still at 12?
A: Ten to—we're still at 12.
T: Ten, eleven, twelve.
A: I'm doing drugs every day.
T: And you're doing cocaine every day. Okay.
A: You know what I'm saying, because I was living so messed up, and even on the streets, I'm gonna have to fight, run from cops, you know what I'm saying. . . .
T: You were carrying?
A: I carried weapons.
T: Who gives a weapon to a 10-year-old boy?
A: I bought 'em.
T: And where does a 10-year-old boy buy a weapon?
A: On the West side, it ain't that hard.
T: Really.
A: I knew everybody. Yeah, I knew most of them but, even when I was a little kid I didn't look like I was a little kid, I looked a little older. When I was 11 they thought I was 13.
T: Okay, so you bought a gun.
A: Yeah, so I said, man, look man, I'm homeless, pssh.
T: And you were.
A: I'm sleeping with fresh clothes that I'm buying from selling drugs, a lot of money in my pocket, I'm sleeping on a bench.
T: Mm hmm.
A: In the middle of a park, you know, so I'm like, somebody might just come up, dig in my pockets. I say one thing, they blow my head off; I need my piece.

Key Concept:

A drug-using lifestyle can be understood as an *indicator* of difficulties in meeting previous and current developmental challenges, a *predictor* of problems in meeting future developmental milestones, or a *creator* of problems in crucial developmental areas.

A drug-using lifestyle can be understood as an indicator of difficulties in meeting previous and current developmental challenges, a predictor of problems in meeting future developmental milestones, or a creator of problems in crucial developmental areas (Baumrind & Moselle, 1985; Shedler & Block, 1990; Dishion et al., 1995). That is, drug use may be a marker or reflector of problems in family functioning, but it may also create disharmony or exacerbate already conflicted family relationships. Thus, a therapist's attempt to focus on drug use assumes that drug involvement both reflects problems in functioning and development and is, itself, a current stimulus for other problems and negative relations.

Remarkable changes have occurred in how substance abuse has been conceptualized (Miller & Brown, 1997). Understanding drug use contextually means that diverse aspects of the drug user's environment are understood as contributing to the continuation of drug taking. Prompting change within and between several persons requires a foundation of interconnected therapeutic relationships or alliances. This clinical objective is decidedly more complex and ambitious than is required in standard individual treatment. However, the multidomain assessment and intervention requires a more comprehensive scope than the previous generation of treatments (Kazdin, 1994).

The most important therapeutic alliances in MDFT are those of the therapist–adolescent and therapist–parents. Process research indicates that when successful, the therapist–adolescent alliance proceeds through stages (therapy socialization, expression of concerns, agenda setting, and beginning problem solving) (Diamond et al., 1997).

An initial negative alliance with the adolescent can be reversed by certain therapist behaviors. For example, one study found early-stage therapeutic participation in drug-using African-American adolescent males could be enhanced when certain themes were discussed (the "journey from boyhood to manhood," social exclusion or marginalization, experiences in public spaces where young black men are thought to be more suspect and potentially dangerous, or "alienation" from mainstream societal beliefs and values) (Jackson-Gilfort & Liddle, in press). Such themes may be too developmentally advanced for younger clients. However, some of these themes are pertinent to African American teens but would be approached in a developmentally appropriate manner.

It is a challenge to achieve a workable focus with unmotivated adolescents. An effective means of achieving this focus is through the teen's and parent's emotional life (Liddle, 1994). The therapist elicits the emotions related to important life circumstances and events. Feelings about parents, siblings, peers, and oneself; emotions about family life; or disappointment, hurt, and anger are important markers of, as well as pathways into, the adolescent's world (Diamond & Liddle, 1999). When emotions such as these are accessed, working with them can be instrumental in facilitating motivation for self-focus and for resolving in-session impasses between family members (G. S. Diamond & Liddle, 1996). Another portion of a session involving the therapist and Alonso illustrates a focus on emotional expression.

A: My mom knew I was doing good. And we started building up a little bit of a relationship, but [when] you grow up like that, not liking your mom, your mom not liking you—you just can't expect to make a connection after all that. I still had that in my head that she locked me up for all this, you know. If she woulda been doing her job, maybe I woulda learned.

T: So she kind of acted like she expected there to be instant love.

A: Yeah.

T: And you're saying it can't be instant.

A: Yeah.

T: Okay, you were like willing to try, but it just wasn't gonna happen over night, right? Is that what you're saying?

A: Yeah. Exactly.

These small steps toward expressing emotion are not insignificant. Focusing on these feelings, and the past and present issues from which they emanate, is a standard way in which therapy becomes defined for the teenager and initial treatment content and focus are established (Diamond & Liddle, 1999).

Key Concept:

Knowing adolescents' conceptions of the roles of drug use, their peer network, and other aspects of their lives creates a window into their world, a pathway to change.

With many adolescents, articulation, whatever one may think of its content, is difficult. It seems to be an activity to which they are unaccustomed or in which they sometimes appear to have little skill. Thus, using their discussion about their drug use is a helpful first step. Knowing teenagers' conceptions of the role of drug use, their peer network, and other aspects of their lives, provides a window into their world.

Themes characterize and encapsulate the emotionally meaningful past and current events, experiences, or circumstances of teenagers. Frequently, these themes relate to aspects of the identity and self-definition of the adolescent's or parents' development (Dix, 1991; Oyserman & Markus, 1990) and to relationship-oriented themes as well (Diamond & Liddle, 1999; Liddle, 1994).

Although teenagers can eventually accept a treatment goal of drug use reduction or elimination, this is rarely their initial position. Requiring an adolescent to admit to a drug abuse problem may preclude many teenagers from receiving treatment. Whereas traditional drug abuse treatments sometimes focus exclusively and directly on substance use and abuse, many contemporary treatments emerging from the psychotherapy field have developed strategies that focus on changing substance use indirectly (Miller & Brown, 1997). Although it is preferable to influence drug taking directly by having access to and targeting the immediate behaviors that continue and support substance use, such access and direct intervention are not always possible. In fact, with moderate and more severe juvenile justice-involved adolescent drug abusers, direct access or willingness on the adolescent's part is unavailable most of the time.

The first stage of treatment is particularly important in the adolescent subsystem module (Liddle & Diamond, 1991). Offering a unique, supportive, but challenging therapeutic relationship in which the adolescent has, alternately, an advocate, a supporter, a representative, and a translator vis-à-vis other family members and extrafamilial others is a viable way to launch drug treatment with treatment-referred or treatment-mandated youth (Liddle et al., 1992).

The extent to which teenagers allow a focus on drug-taking behavior in treatment varies. A critical method of achieving a drug use and abuse focus in treatment uses drug screen (urine testing) results. Urine screening can be done weekly at the outset of treatment (or throughout treatment in some cases). With the adolescent's agreement, and as part of the treatment program's guidelines, these results are shared with parents. This procedure is defined as a program requirement and is explained to the adolescent and parents at the outset of treatment (see Clinical Guidelines: Dealing With Drugs in MDFT on page 79 for the protocol on how to use urinalysis results in a session). Sharing drug screen results with other family members in family therapy was first done in the Addicts and Families Project (Stanton & Todd, 1982).

Although clinical targets for teenagers have much in common across cases (for example, these targets might be intrapersonal or interpersonal processes and are organized into domains that pertain to the self, parents, the family, and extrafamilial persons), the sequence of attending to them and the combinations in which they might be addressed vary. Many of today's substance abuse interventions do not focus exclusively or even primarily on substance use. They address, as do MDFT and other multicomponent, comprehensive, ecologically focused, and developmentally based models, a "complex array of adjustment problems" (Miller & Brown, 1997, p. 1272) known to be related to the creation and continuation of drug taking and related difficulties. Current treatment development focuses on elaborating on different ways to address drug taking. Sometimes the focus is directly on drug use and working with the drug-taking behaviors of the youth simultaneously with work in other domains (e.g., family relationships). When this focus is available for use with the teenager, it should be used. In cases where access to drug taking and discussion of drug use are not present initially and the therapist cannot gain access to it, the focus on drug use is achieved in a more indirect manner.

Adolescent Engagement Interventions

Key Concept:

Adolescent engagement interventions build alliances with adolescents and are crucial to engaging an adolescent in treatment.

The majority of substance-abusing adolescents will come to therapy only because their parents or the juvenile justice system ordered them to treatment. Adolescent engagement interventions are techniques for building alliances with drug-using adolescents (Liddle & Diamond, 1991; Liddle, 1993, 1995). These interventions are rooted in empirical and clinical knowledge about the difficulty of engaging adolescents in treatment and the adolescent development literature that emphasizes the adolescent's disconnection from prosocial institutions (including family and school), which constitutes a major risk factor for drug use and associated problem behavior.

Because active participation by a teenager in the therapeutic process increases his or her chances for success, it is vital to help the adolescent formulate a personal therapeutic agenda. Without it, engagement will be compromised. The adolescent must be convinced that therapy can be personally worthwhile. The therapist must show the teenager, through both words and actions, that therapy will be more than just helping the parents become more powerful and controlling. The exploration and discussion of monitoring is especially important during early adolescence to help parents, as well as adolescents, understand the appropriate function of parental monitoring. A certain level of parental control is developmentally appropriate for younger adolescents, but it is during early adolescence that parents must start to shift their approach to parenting that will enable their adolescent to have increased autonomy. Engagement and alliance-building strategies are continued throughout the therapy. These strategies have been developed in the context of previous research (G.M. Diamond & Liddle, 1996) and include the following:

1. **Developing a collaborative mindset**—The therapist presents therapy as a collaborative process as opposed to a coercive or authoritarian process.

2. **Forming goals**—The therapist attempts to help the adolescent define therapy goals that are meaningful to and worthwhile for the adolescent and delineates therapy tasks related to that goal.

3. **Generating hope (via contingency and control beliefs)**—The therapist and teenager discuss the degree to which the adolescent believes that his or her life can change for the better. This includes having the therapist make statements that combat the adolescent's belief that he or she cannot effect positive change in his or her life.

4. **Generating hope (by the therapist presenting himself or herself as an ally)**—The therapist states that he or she is willing to work with the adolescent and, in this relationship, to facilitate the adolescent's expression of his or her beliefs and opinions. The therapist presents himself or herself as an ally who will support the teen's quest for positive change.

Many substance-abusing adolescents feel they have little control of their emotions, thoughts, behaviors, and daily life. Although they may not be able to precisely articulate how they experience the world, many adolescents have an unmistakable sense that something in their lives is desperately wrong. Several interventions are used to alter this sense. First, MDFT has high expectations for the adolescent and attempts to increase the teen's own self-expectations by providing alternatives—holding up certain desirable behaviors and saying, "This is what you can do, this is what you can be, this is how you can get along in the world, and this is how you can interact with your parents." The materials used to sketch this portrait of higher expectations for each family (e.g., attributions, emotions, the past) may be different, but the message is always the same: "You can do better, and I'm going to help you do better."

In addition, MDFT presents high expectations of the parents to the adolescents. Teenagers are told about the goal of helping their parents be better parents—to be more fair, to listen to and acknowledge them, and to be more responsive. By talking to adolescents about their parents' parenting, the therapist makes the teenagers aware that responsibility for change does not lie solely with them. This serves to counter some of their pessimism about the possibilities for change. It can be a difficult balance to maintain, but adolescents should feel some degree of responsibility to help alter their parents' behavior—but not too much responsibility. The therapist creates a partnership with teenagers that helps them deal with their parents and how their parents treat them with a consequent understanding that this will be changing as the adolescent matures. Adolescents appreciate having, and often need, a spokesperson, even one who is not always completely on their side. They are accustomed to a world that does not respect them, expects them to be unreasonable, and in general incorrectly understands adolescence as a time of necessary storm and stress (Offer, Ostrov & Howard, 1981).

In addition to increasing their expectations, MDFT literally and figuratively helps adolescents find a different language to use and thus a different way of being in the world. In one case, a therapist tried to help a boy communicate his unhappiness and frustration through words rather than through violence and self-destructive actions.

The desired language is one in which the adolescents can, to the best of their ability, explain their subjective experiences, world views, hopes, dreams, complaints, and disappointments. Work with the parents is just as intense, so they will be receptive to their adolescent's new language. The following is an example of the type of communication that therapists encourage:

Therapist (T): So you felt as if you didn't know what was happening with your mom, Willis? Were you really scared?
Willis (W): I was little—6 or 7 years old!
T: You thought maybe she was dead or something?
W: Yeah! Every night she used to go out.
T: Every night you used to wonder if she'd come back.
W: Yeah! But she don't care at all.
Mom (M): Why should you say I don't care?
W: You don't care!
M: You know I care.
W: You don't care. All your feelings is against me. You don't care what my feelings is against you. 'Cause you never will let me talk.
M: 'Cause first of all, I never in my life let anybody worry about me. I didn't even let my mother worry about me. 'Cause I always felt I could take care of myself.
W: But you don't feel like I came from you!
T: Now, keep going, keep going! It's important that she hear what you're saying. Come on, Willis—don't bail out. You said you came from her—*[to mom] *Do you hear what he was saying? What was he saying a minute ago?
M: He was saying that he came from me, and he wants to worry about me.
W: 'Cause you're the only one loves me!* [pauses]. . . . *Always seems like nobody else cares about me.

Key Concept:

MDFT literally and figuratively helps and adolescent develop a different language—a new way of conceiving and expressing his experience in the world.

Many teenagers have difficulty finding words to express their concerns and share their inner experience. In the following description of a family session, the adolescent chooses to act out his efforts to get his life back on track.

During a session in which the family is discussing Willis' tendency toward property destruction, he seems to tire of the topic and proclaims, "Look, I'm trying to get my life straight! I want to go to school, get a job, buy a car. . . . " He then goes on to say that he wants to go down the "good road" and that he is trying his best. He even gets out of his chair to demonstrate his efforts to walk down the good road and slipping onto the bad road. The therapist senses that Willis is trying to communicate something very important to his mother and her partner. So the therapist asks them to all talk together about concrete things that can help Willis "walk toward the good side." The therapist also asks Willis to tell his mom and his mom's partner about the

bad side. Willis' mom and her partner ask him about his friends—who they are and what they do. They talk about whether he can say no when his friends try to convince him to smoke marijuana. The therapist congratulates him for his good intentions and responsible talk during the session. Willis goes on to talk more about how his friends influence him to smoke marijuana. He even impersonates their voices and uses their words to demonstrate what happens out on the street and shares some important beliefs of his own about smoking marijuana.

Developmental progress occurs at the cutting edge of a teen's current stage of functioning and understanding (Baumrind & Moselle, 1985). To acquire higher levels of social reasoning and interaction, an adolescent must overtax his or her previous schemes of thought and action. Growth occurs by mastering the disequilibrium that constitutes the impetus for development. Drug users tend to "turn on and tune out" and have no context that facilitates or guides their entry into the necessary fray of life. Treatment, which first occurs through the mechanism of alliance building between a therapist and adolescent, serves as a context to reinstate a core developmental challenge.

This engagement of the adolescent and the definition of an agenda for him or her in therapy is a primary goal in MDFT. It requires the therapist to work with both parental and adolescent systems simultaneously, even though the activities in each may seem contradictory. The therapist can increase the probability of the teenager's success by assuming a posture of respect and support for the adolescent's personal experience, both inside and outside the family.

This therapeutic posture is not one of "child-saving" but rather one of acknowledging that the adolescent has his or her own story that can be "heard" in this therapy. This is especially important because drug-using teenagers have been found to experience a lack of personal control over their own lives. The teens also feel a profound meaninglessness or lack of direction (Newcomb & Harlow, 1986), and this is magnified in younger teenagers concomitantly experiencing puberty and identity confusion. MDFT addresses these influential organizing themes by, among other interventions, working alone with the adolescent for significant periods at all stages of therapy.

Case Example: There Is Something in This for You

The following case excerpts, which come from the end of session one and the beginning of session two, illustrate how a therapist might develop and work with the content theme "there is something in this (therapy) for you." Sam, a 16-year-old adolescent boy, is the youngest of four children. At the time he entered therapy, Sam regularly used alcohol and marijuana. He had a history of severe school and behavior problems since the second grade. Sam had difficulty expressing himself verbally and instead often resorted to violence. This seemed to be his predominant way of dealing with his hurt, anger, and disappointments. By the time Sam came to the Adolescents and Families Project, almost everyone (i.e., schools, other therapists, probation officers, his parents) had given up on him. They had judged Sam to be too out of control, too violent, too incompetent, and too unintelligent to be a good therapy candidate. One goal of Sam's therapy was to support his feelings while helping him change how he expressed those feelings. An effort was made to make his language and behavior more civilized and appropriate. Although his parents had separated a year earlier, they both agreed to attend therapy.

The therapist spent most of the initial session talking with Sam's parents about their family history and current problems. During this discussion, Sam was somewhat indifferent and periodically belligerent. He was seen alone for the last 10 minutes of the session.

Therapist (T): So what do you think of this?
Sam (S): It's cool.
T: You've never been in therapy like this, have you?
S: No, not like this.
T: Do you feel nervous, do you feel . . . .
S: No. **[matter of factly]** ***It's just another counseling.***
T: I don't think it's going to be another counseling. That's not the way I work. I think we could do a lot here. But, I guess one thing I want to know is whether you're going to work with me. You know what I mean by that? **[Sam nods]**
T: You see, I'm really interested in who you are in this family, and who you want to be, as your own person, Sam. But, I'm going to need your help. Do you think you can help me with it?
S: I can try.

The therapist begins to set the foundation for engaging Sam in therapy. The therapist established his expertise and confidence, tested whether Sam is willing to accept optimism, and acknowledged that he has a point of view that needs to be expressed. Because the family, school officials, police, and juvenile justice system officials generally see adolescents like Sam as antisocial, addicted, or disturbed, asking for a teenager's help can counter the biased conceptions that the adolescent has about adults in authority. The adolescents, parents, extrafamilial sources of influence, and therapist are all equally central to this approach.

T: Well, you told me last week, when the big fight happened with your father, that you don't like dealing with your anger that way.
S: I don't, man, but that doesn't mean any of you are gonna make me change. . . . Maybe I'm wrong, I'm not saying I'm not.
T: Would you be interested in learning how to deal with things better?
S: **[pauses]** ***Yeah. I would.***
T: That's something we could do here. You know, you didn't look so happy when you were hitting your dad. **[Sam had kicked and hit his father in the family assessment the previous week.]** ***And you told me you hate when you get mad at him. I didn't think you looked too happy. Tonight I felt that there were times when you weren't happy. You didn't like what they were saying. Maybe you don't feel they understood you enough. Maybe you feel as if you get between your parents. You know, it's a hard situation, your parents being split up. They're still working things out. It's going to influence you. I know that's rough. So, I want to help you work through some of that in a way that would work for you. But I'm gonna need your help.***

Key Concept:

Crafting themes requires recognizing, highlighting, and carrying forward to other sessions indications that the adolescent would like something to change.

MDFT looks for opportunities to develop positive themes and goals with the adolescent and parents. These must be recognized, highlighted, and carried forward in sessions and from one interview to the next.

The therapist must carry forward these themes, or as Minuchin & Fishman (1981) call them, "partial truths," and lend them back to the adolescent or parent. In Sam's case, by keying in on Sam's statement about how he would like to find a better way to handle his anger, the therapist demonstrated to Sam that his words are remembered and taken seriously. His statement is used to remotivate him during difficult times or in the early stages of work to help illustrate therapy's possibilities.

Sam presented as a poor therapy candidate. Most people believed that Sam's feelings should be avoided. He was cast as a youngster whose predominant feeling (and the one that he was most adept at communicating) was anger. MDFT work was begun with Sam with the assumption that Sam was more complex. MDFT distinguishes the therapist as a person who can understand adolescents, confirm their right to have and present their perspective,[1] and sometimes at least, take their side.

T: What does that all sound like? Do you want to give it a try?
S: **[indifferently]** ***Yeah.***
T: Would you like to see things change?
S: Sure.
T: What kind of things? What would you say?
S: I don't know, just how I get along with everybody.
T: Do you feel like you get along with your mom now?
S: Yeah. Better than I used to.
T: How about your dad?
S: All right.
T: It sounds as if he would like to be closer to you. Is that something you share?
S: I don't know.
T: You don't know? Hmm . . . . Well . . . it's perfect that you say that, because that's exactly the kind of thing I'm gonna ask you not to do. I'm going to ask you to say "yeah, this is what I hate or this isn't what I want." Even when it's difficult. But sometimes they're hard to say. You're afraid you're gonna hurt somebody, or get angry at them, or you might not get what you want. But I want to help you be more straight with them.

[1] *Understand* and *confirm* perhaps do not carry enough of the connotation of how these realities are both understood or confirmed *and* shaped, simultaneously. At this stage of therapy, however, given the developing therapeutic alliance between therapist and teenager, it is probably more accurate to say that the aim is for a more "pure" understanding and confirmation of the reality of the adolescent's life as he or she experiences it.

This dialog served simultaneously as an intervention and assessment. The therapist attempted to obtain answers to the following questions: Is the adolescent willing to respond to the framework that the therapist is offering? Can the teenager identify with these concerns and begin to articulate his own story? In which direction is the adolescent leaning about the possibility of a therapeutic relationship at this early point?

Whereas some adolescents will quickly respond to the therapist's offer of empathy and understanding, others remain not only distrustful but hostile. The term "resistance" takes on new perspectives in light of such factors.

Another theme here concerns the definition of a relationship that will serve as a context to develop new relational and conceptual skills. In essence, the therapist told Sam that it is important for him to communicate more effectively with the world and, in a sense, with himself about his reactions and experience. This is extremely important with younger adolescents who are involved in behaviors with adult ramifications, as younger adolescents are less able to maintain a "big picture" perspective. The young adolescents cognitive skills are not as well developed, making it difficult for them to make connections between what is happening currently to long term events. Further, in the case of younger adolescents who get into drugs at this age, not only is their developmental trajectory to adulthood interrupted but also their trajectory to older adolescence.

In the previous example, Sam's tentative responses are a cue to not push too much. By meeting Sam's tempo, but sometimes extending the apparent limits, the therapist and Sam together coestablish a session's pace.

Establishing a link to the first interview, the therapist began the second session by meeting with Sam alone. New information, as it emerges, must be factored into therapy.[2] Before this session, Sam had received the news that his probation officer wanted to send him to a boys camp for a year because he hit a teacher at juvenile hall. This crisis was used to heighten the importance of Sam's participation in treatment. The segment begins with Sam explaining that, if he is sent to the camp, he will run away.

S: I mean, I don't care about doing time.
T: What do you mean, you don't care about doing time?
S: Oh, I care about doing time, but I don't want to be that far away from my parents where I can't . . . .
T: Sam! I don't get it. I appreciate that you want to be around them, but how does it happen that you get in such tangles with them?
S: My dad just starts arguing and I snap. I know they're not going to get back together, but it still hurts me when they start arguing, even if it's petty.
T: I want to ask something of you tonight, and it's going to be really hard, because I think you're in a lot of pain in this family, right?
S: Kind of.

[2] One of the most difficult challenges for any therapist is providing therapy with consistent themes (which, of course, develop and evolve over the course of therapy) while incorporating new content into these themes. This new content often serves as a major factor in the themes' transformation.

T: What?
S: Yeah. Maybe.
T: You admitted it to me the first time we met!
S: I know.
T: Why don't you like to admit it?
S: I don't know, man. [starts to cry] Everything is just messed up.
T: So, you try to be tough so nobody knows you're hurting? Does it feel safer that way?
S: Yeah, usually, then people don't ask me what I'm feeling.
T: People don't ask you questions because they just think you're wild and out of control?
S: What?
T: Talk with your parents about how upset you are. Because I think they would have a different take on you if you could be straight with them.

Sam began an important process. He is starting to share what might be called the story of his life. This example illustrates how the affective realm is used, in part, to engage the adolescent in the therapeutic process of examining his or her life and generating alternatives. (Work in the emotional domain is done with the parents as well; see The Parents and Other Family Members Subsystem Module on page 108).

Key Concept:

Catharsis or emotional expression, per se, is not a therapeutic goal. However, focusing and facilitating a teen or parent's emotional expression may be necessary as a pathway to, and perhaps as a mediator of, individual change.

Again, MDFT targets multiple realms of life for assessment and intervention. The affective realm is but one of several targets of the therapy. Not all teenagers are willing or able to talk about their emotional disappointments, nor is it necessary for every adolescent to do so. Catharsis or emotional expression, per se, is not a goal of the therapy. However, conversations about one's feelings are one important aspect of multidimensional work. They are a pathway to create individual change, solidify engagement, establish and maintain alliances, and help family members establish new and healthy ways of being with each other.

Key Concept:

An important goal with all teens is to help them acquire a new language, a means of making sense of their lives and behavior, as well as a means of communicating this meaning and interpretation to others.

In this session, the therapist facilitated Sam's description by empathically appealing to the affective side of the story. Affective content became a therapeutic foundation with Sam and his family. This addresses the question: "Can I create a setting in which (partly as a result of his interactions with me) Sam can relate to his parents?"[3] At the outset of such hoped-for transactions, as was the case here, it is sometimes sufficient to simply have adolescents sort out, in conversation with the therapist, their many and frequently overwhelming feelings. Ultimately, however, an important goal with this teenager, and with many others, was the development of a *new language.* This term is used to describe a new way for adolescents to relate their experience to the world and replace defiant acts and self-administered anesthesia (e.g., alcohol and drugs) with more functional thoughts about themselves and others, feelings, and behavior. The goal is to help teens find a new way of being in the world. Treatment develops new options and interests for the teen.

Clinical Guidelines: Dealing With Drugs in MDFT

Many family therapy models have ignored the topic of drugs (except Stanton and Todd [1982], Kaufman [1985], Waldron [1997], and Fals-Stewart and, in the alcoholism area, O'Farrell and Steinglass and colleagues) or have been less than clear about how to address drug use within a family therapy-oriented treatment. Family therapists are not alone in this regard. Miller and Brown (1997) describe a similar situation in the fields of psychotherapy and alcohol and drug abuse.

Early in the development of family therapy, drug treatment was left to the experts in the alcohol and drug field, whereas most of the drug experts kept out of mainstream family therapy and psychotherapy. The classical family therapy philosophy warned against overfocusing on the symptom (whichever symptom happened to be present). Some perspectives in family therapy, most notably Haley's (1976) problem-solving therapy, did not ignore the symptom and used symptomatic behavior as a motivator to focus on and leverage change in family and other relationships. Even in Haley's approach, classic family therapy thinking remained—the key to changing individual symptomatology was in changing family interaction. These early periods of family therapy rejected "disorder-based" thinking. Although this has changed considerably (see Pinsof & Wynne, 2000), it is easy to see how this preoccupation affected family therapy's movement into clinical specialties such as drug abuse.

[3] Although *modeling* certainly is a factor in a change process of this nature, the MDFT conception of change centers more on the work that occurs in the therapeutic relationship between therapist and adolescent and on the changes that are practiced outside the therapy session than on a modeling theory per se.

MDFT, Drug Abuse, and Standard Family Therapy Practice

There are several areas of agreement between MDFT and standard family therapy practice:

- It is important to look at drug use and abuse in the context of other symptoms.
- The therapist should try to link drug use and abuse to family relationships and to individual functioning and contextual circumstances.
- It is important to overtly define drug use as a form of communication about the adolescent's circumstances.

The following are two areas of disagreement:

- In early-stage family therapy terms, dysfunctional children were "saving" the family by holding together parents who might otherwise separate or divorce. MDFT holds no such beliefs about why symptomatic behavior exists. Although a teen's drug taking may indeed be related to problems in the family, some of which may be longstanding, it is also possible that the antisocial behavior of the teenager, including drug abuse, may be more related to peer, interpersonal, or other environmental factors than family relationships. Drug use and drug taking are seen as problems of development.
- MDFT does not assume that changes in family functioning (changes in parenting practices or in parent–adolescent relationships) are sufficient to alter drug-using behavior in all cases. (See Schmidt, Liddle & Dakof [1996] on the relationship of parental change to adolescent changes in drug use and behavior problems; Palmer & Liddle [1994] on the association between parent–adolescent relationship changes and adolescent school performance [grades]; and G.S. Diamond & Liddle [1996, 1999] on resolution and nonresolution models of in-session parent–adolescent relationship conflict.)

MDFT, Drug Abuse, and a Chemical Dependency Model

There are two areas of agreement between MDFT and a chemical dependency model:

- Drug abuse has serious health and social/emotional developmental consequences.
- The specifics of drug taking must be focused on directly (e.g., not all symptoms are the same, not all can be treated by the same methods). Methods such as conducting a behavioral analysis of the circumstances of drug use (e.g., people, places, and things), determining the course and development of drug use, and identifying ways it is presently maintained are core aspects of any responsible treatment of adolescent drug abuse.

The following are some areas of disagreement between MDFT and a chemical dependency model:

- In MDFT creating a framework for dealing with drugs and one's life in an overt manner is most important and useful. This framework promotes cooperation and creates the kind of context that enhances health and development rather than patienthood.

- Although it is true that parents can enable the drug use of their teen, in MDFT it is assumed that changes in the parents' behavior and family environment that are organized by parents can have an influence on the drug use of the teenager.

- In MDFT teaching clients that they use drugs because they have a disease may not enable them to examine the multiple aspects of life that can provide concrete alternatives to a lifestyle of drug and antisocial involvement. (See Alexander's [Alexander & Hadaway, 1982] "adaptive model" of drug use and abuse as well as Peele's [1986].)

- Generally, the greater the number of risk factors present, the more directly the therapist focuses on drug taking and drug abuse early in treatment. The following risk factors are used as guides for tailoring and calibrating MDFT interventions.

    - Early-onset drug use
    - Frequent use of hard drugs with marijuana and alcohol
    - Regular and patterned drug use (versus binge or episodic use)
    - Strong bonds with drug-using peers
    - Drug use by parents, another significant adult, or sibling
    - Neighborhood or community risk influences
    - Significant disconnection from school and family.

How To Deal With Drug Use and Abuse

The following are points to keep in mind when discussing drug use in the context of MDFT:

1. Family or parent involvement is critical. But a change in parenting or in parent–adolescent interaction is not necessarily sufficient for a change in adolescent drug use, especially if several risk factors are present.

2. The more patterned the use, the more important interventions to domains outside the family become. These interventions are intense, comprehensive, and able to directly influence the drug-using behaviors. The circumstances that are maintaining the drug-using behaviors are not all interpersonal, familial, or related to the past or current quality of parenting.

3. The therapist uses individual sessions with parents in specific ways (e.g., to buy time, to teach them about what aspects of the teenager's behavior they should attempt to influence and what they should not deal with directly, to teach them how to be more than a detective, to teach them how to talk to their adolescent about many topics, including drug behaviors).

4. MDFT uses individual sessions with the teenager in another important way: framing the therapy, what it is about, and what it might do (e.g., get them off my back, get probation off my back, do an inventory of my life, work on particular behavior, talk over my life with a mentor or friend).

5. The parents' stand against drug use and their clear communication of this stand is a strongly predictive protective factor (see Hawkins, Catalano & Miller, 1992). An important part of the therapist's function is to help clarify, refine (if necessary), and articulate the parents' stand against drug use. Some resources to assist the therapist in this endeavor that can easily be adapted with the MDFT parenting module are Parents: The Anti-Drug (www.theantidrug.com) and The Parent's Role, and Tips (www.drugfreeamerica.org/parents.html).

The following points illustrate how drug use and drug taking are conceptualized and discussed in MDFT. This type of strategy is important because it is challenging to facilitate a successful drug abuse focus in treatment with teens.

Drug use is indicative of a health-compromising lifestyle. This focus places less emphasis on the morality of drug use and abuse and more emphasis on the context or lifestyle. Parents are encouraged and assisted to directly articulate to their teen why drug use is a problem.

Drug use is something that one willfully does for definable reasons. The frame for the teenager is "sometimes choices on one occasion happen over and over again; they become habits." Succeeding in this realm means that workable and useful frames are created.

Parents are more important in early adolescence than later when peer influence assumes greater strength. Their interventions need to take peer influences into account as directly as possible.

Generally, when teens are using drugs a great deal, there are consequences that are upsetting to them such as dating problems, work problems, school failure, family disaffiliation, and/or extreme negative feelings about themselves.

In some cases, drug use can be part of a natural experimentation process coupled with a teen's propensity toward risk-taking (see Newcomb and Bentler, 1989). But adolescent drug abuse is a sign of developmental difficulty and dysfunction and indicates the need for intervention.

Overall, MDFT seeks to develop drug use as a physical and mental health issue and a lifestyle issue like smoking, driving while under the influence, not using seat belts, dropping out of school, poor nutrition, unsafe sexual practices, and delinquent and antisocial activities. Asking about and discussing in detail smoking, use of condoms, use of seat belts, drinking or drug use while driving, or drug use in situations that compromise safety and well-being can develop content themes.

The goal is for the adolescents to talk with the therapist about their lives, including their psychological and physical health and their conception of health and lifestyle issues, the neighborhood (e.g., safety, availability of drugs), and other social influences such as parents and peers. Health and the facilitation of development are promoted, and factors that detour teens from mainstream connections and possibilities are discouraged.

In-Session Interventions Pertaining to Drug Use

The therapist does not reveal to parents an adolescent's discussions about drug use in individual sessions**,** but he or she does talk with them about what drug use represents. It is important to establish confidentiality ("Is it okay that I will talk with your son about his drug use, although we will not always talk about it here with you present?"). The adolescent is to discuss with his or her parents not only drug using per se but the context in which drug use and other problem behaviors have existed. The previously outlined technique of establishing a separate therapeutic relationship with the teenager and the parent is used to orchestrate discussion of sensitive issues about drug taking and delinquent and antisocial acts.

The symptom frame is used sparingly and not this way: "You are doing this because you are afraid to grow up," or "You are keeping your parents together or keeping them involved with you and not with each other." Even though drug use may be connected to these "other things" and unhappy relationships with parents, the treatment has to focus on drug use itself (the circumstances of use, patterns of use, social environment of use). Therefore, it is important to talk about it directly.

The way MDFT programs talk about drugs is different from the way other programs talk about drugs. Research on adolescent rolelessness (see Nightingale & Wolverton [1993], the Carnegie Council on Adolescent Development Report [1989], and Takanishi [1993]) in our society reveals that many teenagers do not have sufficient contact with or opportunity for relationships with adults (e.g., socialization and natural mentoring). Adolescent behavior and problems must be understood from this perspective as well. Similarly, the introduction of cultural perspectives is not excluded or incompatible with this perspective (Jackson-Gilfort, Liddle & Dakof, 1997).

The adolescent is not only drawn to the peer subculture but is actually pushed toward it by adults who are afraid, repulsed, hurt, and angered by the young person's behaviors and the consequences of that behavior (Steinberg, 1991). This is what therapy must undo.

Some issues to explore are what drug use means to the adolescent and what his or her philosophy of use is. The therapist attempts to obtain details about the adolescent's life as it pertains to using—not only details about how much and what kinds, but the real details—by asking questions such as: Who do you do it with? What is your relationship to them? What is the

social setting when you use? What happens that is fun or pleasurable? The therapist looks for exceptions to the rule—that is, if the teen feels good while doing drugs, are there any aspects that are not fun, such as the danger involved? It is important to emphasize the social aspects of drugs such as the comradeship, socializing, sexual freedom, and release of social inhibitions.

Key Concept:

Guided by detailed description of his or her lifestyle, the therapist becomes an expert on the adolescent's world.

No level of detail is too small. The therapist tries to feed into some of the natural egocentrism of the teenager (the telling of one's exploits). The therapist should not be impressed with, shocked by, or in awe of what the teen does. He or she should hear the details in a way that works to interpret and reframe them as the dialog continues. This process might be facilitated by using what is known about the peer worlds that adolescents inhabit such as the worlds of "jocks," "geeks," "brains," and "gang bangers." The therapist should get the teenager to be a tour guide to these different worlds and in particular to the group with which he or she is most identified.

All of this tries to get at the world that is walled off from most adults (see Multimedia Interventions on page 104). Adolescents are not cooperative with adults about these details, which are hidden for good reason—the consequences are or can be grave.

The therapist works alone with the teenager to get a ground-level view of the adolescent's everyday life. It is as if the therapist researched the daily comings and goings of teenagers by having them carry beepers so that they could check in with the researcher and report their activities frequently. The method of using some version of daily or near-daily diary cards (Linehan, 1993) to track drug use, circumstances of using, and feelings and thoughts while using has been tried.

Open discussion about drugs that is not punitive, coercive, or moralistic can be a startling new experience for youth. Enlisting teenagers in an outpatient therapy, even with the sanction of the court, requires great skill. In addressing these challenges, a therapist's capacity to define treatment in personally meaningful and motivating ways is critical to successful engagement. Content and process aspects of this framing process are evident in what we call the NYPD Blue intervention: "You are at a turning point in your life. What you do here can help or hurt you. I can help your situation" (with parents, school, probation). This is one of the standard stances taken by interrogating detectives with a suspect who finds himself in a tight spot. Here the suspect is being detained because he is under suspicion for committing a crime and the detective, in the interrogation, offers a deal if he will admit to the crime or provide information about another suspect.

This general strategy has been a common one in the behavioral therapies for some time (see "Building a Relationship Bridge on page 127): "I want to know whether you are interested in joining with me against the drugs, the streets, and the other things. Are you interested in learning how to take a stand against drugs and the forces that pull you to them?" In addition to its recent adaptation in family therapy, this method has been used as part of the chemical dependency model of addiction and intervention: "It is something that you cannot help; you do it, but it is out of your control." In this strategy, drug use and what comes with it (school failure, poor social skills, affiliation with losers) are unfortunate because they can get the user in trouble

and prevent him or her from experiencing what life has to offer. The following conversation completes this framing technique:

> ***Therapist (T): You are using now, right?***
> ***Adolescent (A): Yes.***
> ***T: Can you stop doing it? Or would you like to have some help in stopping it? I would like to help you take a stand against all of this trouble that's happening in your life.***

Another frame has to do with defining treatment in a different way, such as:

> ***T: I would like to see whether you would be interested in using this time to take a look at some areas of your life. To check in and do an inventory (what's going well, what's not), and ask yourself, "Where am I going?" —that kind of thing.***

Sometimes, the adolescent's agenda in relation to his or her parents can be used ("I can help you deal with your parents. They are very much on your back these days.")

In situations in which the youth says that he or she is not using, drug tests come into play. Urinalysis (UA) provides a basis to urge the teenager into discussion. A UA focuses so directly on the drug use and provides such corroboration of using behavior that it actually lets the therapist get past focusing on the drugs per se.

UAs have many other uses in ongoing treatment. If they indicate drugs are not present, they show the parents and other influential people or systems that change (in this realm at least) is occurring. This buys time, relieves pressure, and helps everyone develop a more cooperative, positive spirit about the teenager.

Several steps are involved in using drug screen results in treatment.

1. The therapist needs to establish that the topic can be discussed. This is not a small accomplishment. Even if the youth is dishonest and deceitful, the premise is that a frank discussion of use is better than continued secrecy and covertness. Furthermore, it is this change in the context (making drug use something that is discussed openly) that could be an important step toward change. Of course, when this discussion continues without change occurring, it may indicate that things will not progress beyond this first stage (even though this stage changed the context of the teen's use).

2. The therapist works directly on modifying some aspects of the circumstances of using—any modification is better than none at all.

3. The therapist works to get the teen to "observe" and comment on his or her own use or lifestyle, particularly the social circumstances and psychological, intrapersonal aspects such as feelings, mood states, thoughts, and behaviors.

4. The therapist works slowly, being careful not to turn the discussion into a one-sided attack on one aspect of the teenager's life.

5. Change in drug use, or in feelings or thoughts about drug use, can be presented to the parents as evidence.

6. From this position, the "storyboard" may look quite familiar, as new conversations with the parent are organized through individual work with the teen. The therapist moves back and forth between working this content into sessions with the adolescent and with the parent.

Adolescents are told that their use of drugs makes them ineffective at expressing their legitimate concerns and complaints, although each teenager has some valid reasons for his or her behavior and unhappiness. These problem behaviors are related to adolescents' inability to competently explain their thoughts and feelings, such as identity struggles and past hurts, to the adult world of parents and teachers. The therapist works with adolescents to convince them that therapy can be a forum where such communication improves.

There are times when adolescents are a danger to themselves or others. In these cases, a short hospitalization or placement (such as in crisis stabilization units and short-term halfway houses or shelters) may help establish a drug-free state and/or a needed timeout from the teenagers' families (and the families from them). In some of these short-term stabilization interventions, however, family sessions can be continued while the teenager is in residential placement. However, there were few adolescents that required this level of intervention in CTRADA's ATM study.

Practical Guidelines for the Use of Urinalysis in MDFT

The MDFT therapist deals directly with the adolescent's drug use in therapy and monitors this use through weekly UAs. The UA used in the Adolescent Treatment Models study screened for cocaine, amphetamines, opiates, and tetrahydrocannabinol use and included a temperature strip to verify unadulterated samples. The results of the urine screens are shared openly with both the adolescent and the family; the understanding that drug use will not be kept a secret is established from the beginning of therapy. The results of drug screens are not, however, reported routinely to juvenile justice officials. Sharing such information with a probation officer, for example, is at the discretion of the therapist and with particular goals in mind.

Clinical charts showing the presence of drugs offer concrete proof of their actions to teens who may be in strong denial (marijuana will stay in the adolescent's system for up to 3 weeks). For adolescents with a history of cocaine use, urinalyses must be more frequent—often at every contact—because 3 days after the last use, the screen may not detect cocaine use. When the teen has a history of opiate or amphetamine use, the therapist must become knowledgeable about those drugs. It is essential for the therapist to have clear and correct information about the effect and duration of substances in the human body.

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. . ." before conducting the screen. This interaction is significant because it offers the teen the chance to be honest about his or her use with an important adult. It sets the stage for future honest communication with parents and other important individuals in the adolescent's life. A major part of maintaining drug abstinence is moving from dishonesty to honesty about drug use.

When an adolescent's urinalysis shows that no drugs are present, it can pave the way for the adolescent and his or her parents to begin communicating differently. The case example of "M" illustrates the use of a urinalysis in an MDFT family session.

Case Example: M.
M. is a teen who, because of charges unrelated to his drug use, was confined to his house after 6 p.m. unless he was with one of his parents. A major theme of his family therapy has been trust and communication between family members, especially between M. and his parents. During a family session in the home, M.'s therapist worked with them on communication skills, but M. became sullen and refused to speak. Upset because she believed he had been smoking marijuana the day before, didn't trust him, and became angry at him, he then burst out angrily at his mother. M.'s mother replied that his eyes were red and that she had little motivation to trust him. The therapist worked with mother and son, then used the urinalysis as a way to reestablish trust among the family members. The therapist suggested that M. take a test to demonstrate that he is reliable and can be trusted to go to certain friends' houses after school. In this way, M.'s therapist indicated that she trusted him, believed he was telling the truth, and advocated for him with his parents. His parents, in the meantime, worked on establishing acceptable guidelines as to where M. would be allowed to go in the immediate neighborhood—this was their way of showing trust. Here, M.'s therapist supported the parents' need to establish those guidelines and know without doubt that their son was not using drugs. When the urinalysis showed no drugs were present, his mother kissed him on the cheek and expressed her relief, and M.'s therapist showed her pride. Using the urinalysis circumvented arguments and facilitated family agreement.

When the adolescent does not want to complete the screen, it is frequently because he or she was using. The therapist may simply ask, "Is that because it will show drugs are present?" or alternatively, "Are you afraid of what the results might be?" Often teens will continue to stall by saying they cannot go to the bathroom or that they just went; usually they are afraid of the consequences when the results are known. At this point, the therapist will need to provide cups of water for the teen to drink and go on with the therapy session. After sufficient time and water, the therapist may ask the teen again, "So, what will the results be?" and encourage him or her to try going to the bathroom. If the adolescent continues to deny using and will not complete the screen, it may indicate the teen's overall distrust of relationships and a hesitancy to trust anyone in a situation where he or she may experience negative consequences.

With consistent encouragement and the knowledge that the therapist will not let up, the adolescent will complete the screen. Some teens will adulterate urine by adding water or other substances, which the temperature strip will indicate. The therapist may say, "You know, this temperature just isn't right; why don't you try again?" Once again, the teen may be reluctant, but sufficient time and water will encourage him or her to complete the screen. MDFT therapists have never had to request a screen more than two times.

When a urinalysis shows drugs are present, the therapist elicits the details of what happened: when did the teen use; what day, time, and place; how much and what did the teen

use; how many times; what his or her thoughts and feelings were before, during, and after; what friends were present; and most important, how the use could have been prevented. This detailed knowledge will help the therapist formulate ways of working with the teen and his or her family later on. The structure may include increasing 12-Step meeting attendance and/or greater parental supervision and less free time, including a more secure curfewAnother option may be more frequent check-in with a juvenile probation officer and department of justice sanctions; these are seen as last-chance efforts and often send more punitive than therapeutic messages to the teen.

MDFT therapists offer teens the opportunity to tell their parents their UA results themselves. Again, in keeping with the philosophy that secrets are not a part of recovery, the adolescent is reminded that parents will know the urinalysis results and that this is his or her chance to be honest with them. When the adolescent chooses to tell his or her parents that the UA showed drugs were present, it gives the teen a different way of being in a relationship with his or her parents. Alternatively, the therapist may tell the parents the results of the screen during the next family session with the teen present and then work through the consequences in that context. However, if the therapist believes the parents' reaction will be extremely negative, then the therapist will meet with the parents separately to process their reactions before including the adolescent. The case example of "B" below illustrates using urinalysis results to help "B" with the details of the event and his mother with processing it.

Case Example: B.
B. is a teen whose father is a chronic, severe alcoholic in rehabilitation during the time of this session. B. had not used drugs for several months but had used marijuana, which showed up in his UA the week before. Initially during the individual session when the screen showed drugs were present, B. denied using and indicated that perhaps it was because he was in a car where someone else was using marijuana. After a second test showed that he continued to lie about using, his therapist explained that the tests do not lie and that he must have used drugs. B.'s therapist then worked with him on the concept of relapse, stating simply that it meant everyone would have to work harder to help him continue to recover. At that point, B. finally admitted using and shared the details with his therapist. This therapist's nonpunitive response allowed B. to begin a different kind of relationship with his therapist and deepened the trust between them. During the next session, B. said he had something to tell his mother but that she could not tell anyone. The therapist interrupted him and indicated that if he was agreeing to be honest, he could not extract promises beforehand.

The following dialog resulted from this case example.

Therapist (T): We'll talk about that later. First, just tell her what you need to tell her.
B: [head low] I came up dirty.
Mother (M): [sighs] Why?
B: [crying, looking down] I smoked again.
M: With who?

B: ***With these girls from the pool. They were smoking. The day I had told you I was going to the pool before I met this guy. I went to the pool and they were smoking. I was getting friendly with them and then I got their phone number and they asked me if I wanted to smoke. And I told them no and then I told them, you know, that I was in a program [sniffs] and they went like that [demonstrates with his hands, someone offering] in front of me [laughs nervously] and then I was like, damn. And then I told them no again, but then like they got up and went like this, you sure? [puts hand in front of his mother's face as if offering her something] Just hit one time. [laughs] I couldn't tell them no again. So I hit it. And then they kept on smoking and then I stayed talking to them. I was like, nah, I can't smoke no more. And then when it came around again, I got it again. I smoked again. And I kept on talking to them and then I went home. And remember that was the day you saw something wrong with me. You told me, "What's wrong?" Then I went to sleep. [laughs nervously] Remember that was the day?***

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

B: ***And then I saw them again when I was with this guy. But this guy don't smoke. So I told him what happened, that I was smoking with them. And then like, cause I didn't want anyone in the family to know. You know everybody thinks I'm doing good. So in 3 weeks, they're gonna give me another drug test. To come out clean it takes 3 weeks to get [drugs] out of my system.***

M: ***You really have to want to stop smoking.***

B: ***I know.***

M: ***'Cause if you don't . . . .***

B: ***But I did. I was 3 months without smoking. Three whole months.***

M: ***But I feel that the reason you weren't smoking was being here in the program.***

B: ***That's probably true [laughs].***

M: ***I mean that's. . . . I don't know.***

T: ***Let me ask you this, Bobby. When you were telling your mom, were you crying a little bit?***

B: ***Uh huh.***

T: ***Why? What were you crying about?***

B: ***[crying] 'Cause I know she, like right now, she said I was doing good.***

T: ***So what are you feeling? Why are you crying about that?***

B: ***'Cause I was doing good.***

T: ***Hmm?***

M: ***He wants to do good.***

B: ***I was doing good.***

T: ***Okay, so why are you crying?***

B: ***'Cause now I know she don't trust me. She don't know if I'm gonna smoke again. [sniffs] I don't blame her 'cause she don't know; I don't even know. [sniffs]***

T: ***Okay. You're making a really good point, okay. She doesn't know if you're gonna smoke again or not. And so she can't trust you and you said you don't even know. Right?***

B: ***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.***

T: Okay.
B: So like, I won't. . . .
T: Be tempted.
B: Smoke. And he's, like he's nice. I. . . like him a lot. He don't smoke so I know that he won't tempt me to smoke. I don't know if like another girl will come around and make me smoke again.
T: Okay. Well, let's go back to just what you're feeling right now; that it's making you cry. I think you've let somebody down.
B: A lot of people. The whole family.
T: Who've you let down?
B: The whole family. That's why I don't want nobody to know [laughs nervously].
T: The biggest thing about addicts is that addicts use drugs, okay? But the second biggest thing about addicts is their secrets and lies. Addicts keep secrets and addicts tell lies. So my suggestion to you, Bobby, is not to get involved in secrets and lies, not keeping some big secret, okay? That won't help you.

B.'s therapist then shifted the focus and began to work with B. on how important honesty and not keeping secrets are to his recovery. B.'s therapist processed with B. the kind of relationship B. could have with his mother. As a young man, not a little boy, he would need to be direct and honest with his mother and have a mature relationship with her, "telling the truth like a man." To help B. develop empathy for his mother and to acknowledge how B.'s mother was feeling, his therapist began talking with his mother about how guilty, terrible, and angry she felt when she knew B. was lying to her. His therapist helped B.'s mother reaffirm her love for B. Both mother and son then were able to work on having a different kind of relationship, where B.'s mother screamed at him less and where B. respected his mother enough to tell her the truth and be honest. B.'s therapist helped them think of new ways for B. to stay sober and learn from the situation. It was decided to address the relapse by conducting a new urinalysis in 3 weeks, increasing the frequency of Alcoholics Anonymous and Narcotics Anonymous 12-Step work, and using sessions to focus on B.'s use patterns and sobriety. In wrapping up the session, the therapist and B.'s mother agreed to spend some time in individual sessions to focus on managing and coping with her frustrations. In this way both mother and son agreed to work on making changes within their own way of coping.

Therapist (T): Have you known for some time that he doesn't tell you the truth all the time?
Mother (M): No.
T: And what does that make you feel like?
M: Terrible. I always tell him to tell the truth. It's better to tell the truth, 'cause once you lie, you have to keep on lying, and lying and I know if I had to live like that, I couldn't.
T: Do you know, though, that he tells his dad some things that he doesn't tell you?
M: Yeah. I found that out in the meetings [the Al-Anon meetings].
T: Was that the first time you ever knew that?
M: Yeah.
T: And how did that make you feel when you found that out?

M: Terrible.
T: Why?
M: Because they don't tell me and then, I think I feel guilty because I'll start screaming and get mad and that's why they don't want to tell me.
T: I'm not sure that's why they don't want to tell, Rose. I don't know, I mean I'm not there so I don't know, but . . . .
M: That's what they always say. That they can't tell me anything 'cause I'm always screaming.
T: Well, now that's a good excuse, but I'm not sure that's the truth. Because from what I've heard, their dad can get in a real fit sometimes when he's drunk. He goes on some real tantrums, doesn't he?
M: He gets really mad.
T: So if that was the truth, then they wouldn't be telling him either.
M: I really don't know why.
T: Uh hmm. Ask him why then. Ask him to tell you why.
M: Why?
Bobby (B):'Cause we don't want to disappoint you.
T: Is that good enough, Rose? I think we need to know a little more about that. I want you to ask him to explain that to you.
B: [laughs] You're putting me on the spot today.
T: [laughs] Ask him to explain that, Rose. Please.
M: Explain that. . . .
B: [laughs] I can't explain it. It just that, that's the reason. We don't want to, that's it.
T: What? Come on, Bobby, we need a little more than that.
B: [laughs nervously] Nah, because, damn, you always give us everything we want and then we do something and we f— up, so damn, we don't want to. We don't want to tell you what we did, you know our mistakes. That's why.
T: Then why can you tell your dad?
B: Because he's always making mistakes.
T: Ah, okay, okay, I think we may be onto something now. That's a big thing that you're telling me and that you're telling your mom, okay? Your dad is flawed so you can tell him your flaws because he has flaws, too.
B: Yeah.
T: But your. . . .
B: She don't have no flaws.
T: She has no flaws. Okay, okay. So is that true, Rose? You have no flaws?
B: And if she does she keeps a really good secret. [laughs]
[everyone laughs]
M: No, I'm not perfect, but I don't do drugs, I don't drink.
T: Okay, you don't drink and you don't use drugs.
M: The only thing I think is that I scream a lot.
T: Okay.
M: Because I'm always angry.
T: Uh hmm. Why are you always angry?

M: 'Cause they're always doing things that they're not supposed to. [begins to cry] And I tell 'em do like this and do it the other way, I don't know, I'm just tired.

T: Uh hmm.

M: What can I do? I teach them the right way and then they keep doing the wrong things, so what can I do to teach them the right way? They want to do wrong, that's why I'm always screaming. And you're always screaming. No, if you would do it the right way, you'll never hear me scream. I don't have no reason to scream. And then they put that guilt on me all the time that I'm always screaming. You know you always do that.

T: So now what's making you feel so, what brought up those tears for you right now, Rose?

M: I don't know. I always feel guilty, I don't know why.

T: You always feel guilty?

M: I'm always guilty, I feel guilty 'cause they always put that guilt trip on me.

T: What's a guilt trip? That you're screaming too much, is that it?

M: Yeah, that I'm always screaming, that's why they keep telling me I need to. . . .

T: Okay, but today, he told you that's not it.

M: I know.

As the session progressed, the therapist worked with mother and son to begin to transform their relationship from one functioning around using to a healing ceremony. These interactions opened up a new way for B. and his mother to relate to each other.

Urinalysis is often a very important issue for parents. They frequently focus on drugs as the cause of their adolescent's problems and see abstinence as equivalent to cessation of problem behaviors and a return to a more "normal" life for themselves. A UA showing no drugs present allows parents to discover hope that may have been lost and assuages some of the intense fear and terror that they experienced when their adolescent's drug use spiraled. Whereas parents frequently want the problem "fixed," the therapist must work with the parents to help them understand that given the nature of adolescent development combined with the family's history, recovery is usually a rollercoaster ride, not an incline leading to a plateau of positive behavior.

When an adolescent has not used for some time and then relapses, the parents frequently believe history will repeat itself endlessly. The therapist, together with the teen if possible, must help the parents look at the circumstances that allowed the relapse to occur and to develop protective factors to prevent future drug use as much as possible. The therapist works with the parents to increase supervision and consider what other consequences may need to be enacted and give the parents hope that the situation is not completely out of control.

While in other versions of MDFT, we use 12-step facilitation, NA groups were used for clients in the CTRADA ATM study only in cases in which it was clearly appropriate for the client, and this determination was made on a case by case basis. If the client had an entrenched habit of usage and found it difficult to abstain from drug use, the therapist would recommend that the he/she attend the NA group. Developmental functioning was very important in making the determination of recommending NA, as many adolescents functioning at younger developmental levels would often find the material intimidating or too far removed from their own experience (e.g., admitting they were powerless and/or drug addicts).

Case Example: Dealing With Drug Use Directly in Session

The following transcript excerpts represent a good example of a situation in which there was an appropriate and strategic use of an immediate-results drug screen. The father in this family used 12-Step meetings to support his own recovery. When the adolescent is tempted to use, the therapist cites the father as a role model for coping. The session includes Emilio (E), age 17; his father, Mr. Ramirez (F); and the therapist (T).

T: Welcome. Today, I told your son that I need to finish by 4 p.m. so we will have a little shorter session today, all right?
F: Yeah, it is very important that we are meeting today.

The father's sense of urgency is positive; the therapist will want to find a way to use it later in the session. Urgency and motivation are related.

T: What is going on, Mr. Ramirez?
F: Well, a lot of things are going on, not so much with the house, but with Emilio.
T: Aha.
F: He's not following rules, he's not following what he needs to do, and he is behaving like a little kid, I guess.

This is a relapse. In the past few weeks Emilio had been coming to sessions. The sessions were productive. Emilio was talking about school, his struggles to flee certain peers, his positive feelings about his girlfriend, and his difficulties in coping with his parents' divorce, which was being finalized as the participants spoke in this session.

E: Didn't I go to school?
F: He was supposed to go to the dentist on Monday, we reminded him. It was very important to go to the dentist because the dentist is very mad because Emilio has already missed the appointment five times.
E: Five times? It was only once.
F: And he is very upset.
E: Five times?
F: The dentist said that if he continues to miss appointments, he's not going to treat him anymore, so we told him that day to please go to the dentist and he did not go. My wife called me to the house, the cops called her to say that he went to the roof
T: I'm sorry, Mr. Ramirez, before you continue with the description of the event, that friend is the one that was here with the blue eyes, right?
E: No.
F: Yeah, he came over here when you were here that day.
E: No, he didn't. It was another kid.
F: Well, he was with Rick; they went to the roof. They were throwing bottles, so the neighbors called the cops to say that they were throwing bottles at their house

The cops were very upset, saying that they already have a complaint against Emilio.

T: What kind of bottles?

E: We were throwing rocks at each other. It was two people on the ground and two of us on the roof, but we are all friends, throwing rocks at each other, just playing around—so I don't know why they said throwing bottles.

T: Throwing rocks? Throwing bottles!*?*

The therapist wants to make sure the father's present concerns are very much supported by developing focus and intensity about the event by recounting the small details.

E: Yeah, throwing rocks at each other, just playing. Then we went to play basketball.

F: You know every time the cops call, it is very upsetting because the cops say that Emilio has problems again, and they say Emilio is in trouble again, and thenyesterday he was supposed to come to see you right at 3 p.m.

T: Hmmm.

F: So I went by the house. He was talking to you on the phone and I smelled liquor in the house. So I went to his room and I found two bottles of vodka, and he was with his friend Mike, the friend he used to have, who is supposed to be in the hospital rehabilitation program.

E: He was the one drinking.

T: So the reason you didn't come yesterday is because you were drunk, not becauseyou were sick.

The therapist does not want to let Emilio's missed session slide, certainly not now, because it is clear why he missed the session.

E: No, I wasn't drunk. My friend Mike was drinking.

F: He wasn't drunk. His friend was the one drinking.

E: I was just chilling in the back.

T: **[to the father]** ***Weren't you supposed to authorize who is coming to the house?***

This resurrects a previous piece of work, when the father was put in charge of whom Emilio let enter the house and banning particular friends with whom Emilio has gotten into serious trouble in the past.

F: Yes, that's right.

E: Yeah, that's why we got into a big fight yesterday, because I had people in the house.

F: Not only did he have people in the house, but he went to Mike's house, and Mike told him his probation was over. So he went to Mike's house, they got the bottles of vodka, and they were drinking in the house. I'm not saying he was drinking because the one that smelled like liquor was Mike, but he had two bottles of vodka in his room in his refrigerator, when he was talking to you on the phone.

T: Also, I'm sure you don't want to have alcohol in your house due to your own

recovery, or have you already shared this issue with your son?

The father's successful recovery makes him an ally in his son's treatment. The therapist takes every opportunity to highlight the father's success.

F: Yeah, that's right.
T: So it is pretty serious, Emilio, because your father is struggling very hard to keep sober.
E: I know. I told him I'm sorry. I didn't drink, so that is why I told this kid to leave.
F: No, he left because I told him I was going to call the cops, to have him arrested, and the reason I didn't do it was because I felt bad for the kid. They would have arrested him for disorderly conduct in the street. He went running as soon as I told him I was calling the cops, but I was very upset. Emilio was supposed to be here at 3. He was supposed to be at the dentist at 4.

The father's frustration with the relapse and his son's possible escalating problem behavior is something that the therapist must attend to and use in the session. Although the therapist did not plan to request a drug screen in this session, it is clear that for the father's sake, and to cut through Emilio's relapse, a drug screen is indicated.

T: I called at 3:05 because I know that Emilio is always on time. So what in reality was happening?
F: He was entertaining his friends in the house while they were drinking. They have no business being in the house, that was what happened. Whether he was drinking or not, I don't know, I was not there.
E: Didn't I tell you my throat was hurting? My mom knew my throat was hurting all day.
F: How come your throat hurts but it doesn't hurt too much to pick up a friend from school and bring him home?
E: I was not drinking.
F: How come it doesn't hurt to go pick up Mike at his house, when you are not allowedto be with him. How come it doesn't hurt you to be in the house with Mike getting drunk? That is what I want to understand.
E: So, okay, I was at the house.
F:* [to the therapist, exasperated] *I tell him he is in complete denial.
T: Do you think your son is doing drugs again?
F: I don't know. I think he needs to take a test.
E: I'll take a drug test, I don't care. I'm not taking drugs, not for a while now.
T: But you don't sound the same as 2 weeks ago.
F: Once he starts hanging around Mike, he doesn't go with his girlfriend anymore. He doesn't do schoolwork anymore like he used to.
E: Well, I still have good grades.

The therapist has decided that this is the moment to conduct the drug screen.

T: Okay, Emilio, please, we need to know what's going on. Are you using or are you not?
E: No.
T: So do you mind confirming this with a test?
E: No, I don't care.
T: Because I think your father is preoccupied right now and I see something that changed you lately. Two weeks ago you were making plans. You were out looking for a job.

The juxtaposition of Emilio's recent progress with the need to determine whether a relapse is in progress (through the drug test) is important.

E: I was going to get a job at the fair. I was supposed to. Then they said too manypeople signed up.
T: Could we do the drug test? I think it is important for your father. Then we can move on from here. Would you come with us, please?

The therapist supervises the drug screen, and the results indicate drugs are present.

T: **[upon return]** ***So Emilio, in the last 2 weeks you said you have not done any drugs.***
E: No.
T: Of any kind?
E: No.
T: In the last month, in the last 30 days, you have not done any drugs of any kind?
E: No.
T: No heroin?
E: No.
T: No cocaine?
E: No.
T: No acid?
E: No.
T: No pot?
E: No.
T: Are you sure no pot?
E: Yeah.
T: Unfortunately, I need to disagree with you. The test is positive for marijuana, negative for methamphetamine, negative for cocaine, negative for morphine. And this is a very valid test.
E: I haven't smoked so I don't know.
T: Emilio, that is why these tests exist—it's about fact.
E: It tells you how long it's been since I smoked?
T: Within the last 30 days.
E: Aha.

T: Emilio, we have a good relationship, and I think that if you would say to your father and to me, "I didn't want to acknowledge it, but I've been doing pot here and there," we can accomplish much more together today.

The therapist tries to sidestep any debate about whether Emilio used drugs, inferring that other important things need to be talked about within the context of knowing that he, Emilio, had used again.

E: I haven't smoked in 30 days.
T: Spending time denying it won't get us anywhere. I do trust these tests. It shows that you have used marijuana. The problem for me is that you cannot acknowledge that. In my clinical experience with kids like you, I was sure that you had done it because you are not the same as you were in weeks that you have not done drugs. It would be my word against yours, but now we have a proof. We need to talk as three men here.
E: Yes.
T: We cannot be sitting here denying it. Say what is going on with you. Are you mad with your father or your mother? Are you confused?
E: I haven't smoked in 30 days.
T: I receive a training with these instruments, and I trust these results.
E: That means I smoked in the last 30 days?
T: Yes, within the last 30 days. I'm sure it happened in the last 2 weeks. Two weeks ago when we met here in this office you were by yourself, calm, relaxed, and thinking clearly.

Linking a drug use state of mind to life events that are destabilizing or upsetting is important.

E: I've been in my car with people smoking, but I didn't smoke.
F: They close the window and they fill the car with pot smoke; eventually it is going into his lungs.
T: Mr. Ramirez, every kid in America who is caught by the police says I have notdone anything, it was the other kid.
F: I agree with you.
T: If you are doing this again, why did you start? Are you mad or are you sad because of your parents' divorce? Are you mad with your mom? Do you get a lot of pressure from your friends?

Emilio's progress was noted. The circumstances that promoted his relapse need to be determined.

E: They're always fighting in my house every day, arguing, my parents and brothers.
T: That makes you nervous?
E: It is annoying.

F: Emilio, why do you carry a lighter everyday?
E: I smoke cigarettes.
F: I thought you don't smoke cigarettes.
E: Sometimes I do; sometimes I smoke cigarettes.
T: Since there are more fights in the house again, you started to feel more nervous again or more anxious, and you find that pot is calming you down a little bit? Be honest with me, Emilio.
E: No.
T: Are you attending AA meetings?
F: Yes.
T: How often?
F: I'm trying to go as often as I can, which has been only the weekends, because of my schedule and events with the family
T: Your father is also dealing with a lot of problems and stress, so he knows he can be tempted to go back to his old habit. What does he do instead, Emilio?
E: He goes to meetings.
T: In the time that we have been working together, you showed to me that there is a very clear side in Emilio who wants to succeed in a drug-free life.
E: Un huh.
T: We need to finish today. So can you clearly acknowledge your relapse?
E: Yeah.
T: It would be pointless to fight the result of this test, right?
E: Yes.
T: So be honest with your father and say, yes, I've been doing pot. That should be it.
E: I don't think it was within these 30 days.
T: Okay, but you have done it, and it is clear that we need to work together harder now not to let you go downhill, okay?
E: Yes.
F: All right. Thank you.
T: Thank you very much.

The session takes Emilio from denial of anything being wrong to a familiar zone for the therapist and family. Discussing the coping processes related to the divorce, the father–son relationship, and Emilio's ideas of what contributes to his difficult everyday circumstances are all more workable topics of discussion.

MDFT With Adolescent Girls

Female adolescent drug use has increased dramatically over the past 30 years. Consensus is emerging that the syndrome of female adolescent substance abuse is different from the well-recognized male pattern. Evidence from many sources provides a compelling argument that there are important differences between male and female adolescents, in particular, in patterns of comorbidity and family relationships. One member of the MDFT research group, Gayle Dakof (2000), is developing MDFT's approach to working with adolescent girls.

Drug-using girls referred for treatment not only use drugs and engage in externalizing behaviors as extensively as do their male counterparts but also are distinguished by a higher level of internalized symptoms and family dysfunction (Dakof, 2000). It appears that girls get a double dose of symptoms—the internalized symptoms more common in adolescent girls irrespective of drug use and the externalizing symptoms prevalent in drug users irrespective of gender. In addition, families of substance-abusing girls show more conflict and less cohesion than families of substance-abusing boys.

The family problems and internalized symptoms that characterize female adolescent drug abuse are illustrated in the following quotations from two girls. First, speaking about family relationships, Grace, a 16-year-old, non-Hispanic white teen, discusses why she doesn't feel close to and trusting of her mother:

> *When I was 14 years old, my mom came home from work early. She found me and some of my friends at home. She freaked out especially because of the guys. The next thing I know, that night I'm on a plane on my way to live with my dad. It was a lot of emotional stress. I didn't know what I had done wrong. I was confused. I didn't know. They didn't tell me. I didn't go to school for a couple of months because they couldn't get all of my records. It was hard because we lived in a place with no hot water, no shower, no kitchen. I hardly ever talked to my mom. That was over 2 years ago. Every once in a while I would call my mom and beg her to take me back 'cause it was bad with my dad. He wasn't interested in me. He had a girlfriend. He'd beat me. I ran away a lot. But my mom always said no, until this last time. Well, I was living on my own for almost 2 months. I slept at friends' or in abandoned buildings.*

Next, Hope, a 16-year-old African-American girl with both serious depression and a conduct disorder, talks about her forsaken dreams and hopelessness about the future.

> *I'm not used to smiling. Never! Everybody always say, "Why you so sad lookin'?" I say hey, that's me. I always look sad. . . . I always wanted to be a teacher. Everything changed around because I been locked up. I wanted to be a lawyer. I wanted to be a judge. I wanted to be a teacher. . . . I'll probably fail in school again. The teachers are going to fail me again. . . . I hope I make it to 20.*

These brief clinical portraits reveal why treatment should occur at both individual and family levels. Clinical and theoretical discourse on female adolescent development and psychotherapy with girls and women suggests focusing on relationships in treatment (Choderow, 1978; Gilligan, 1982; Miller, 1976). With female adolescent drug abusers in particular, this focus on relationships may be most beneficial in the realm of family relationships.

When working with girls, it is important to strike a balance between individual work on the adolescent's internalized symptoms and family work to address conflict. Adolescent girls and their parents often have differing views about which of these issues is more important (Dakof, 2000). Adolescent girls express more concern about family conflict, whereas their parents are

first concerned with the girls' internalized symptoms. It is extremely important, in attempting to maintain engagement of all family members, to address both of these areas in treatment.

Cultural Themes Interventions

In tailoring interventions to individual adolescents and families, racial and cultural issues must be taken into account. MDFT treatment development efforts have included a focus on the use of cultural themes to enhance the engagement of African-American teens. During the past few years, the we have been focusing on special engagement methods for Hispanic teens and families. The cultural theme engagement involves (1) therapist activity within multiple systems of the adolescent's life, (2) an emphasis on facilitating active adolescent involvement in treatment, (3) the use of popular culture, including the music of the adolescent's culture, and (4) extensive discussion of salient cultural themes (e.g., with the African-American teens—cultural mistrust, anger and rage, alienation, respect and disrespect, spirituality, the journey from childhood to adulthood, racial socialization, racism, and hopelessness). MDFT therapy is a means to help adolescents prepare for the next phase of life. For pre- and younger adolescents, the focus is on the transition from childhood to adolescence, rather than adolescence to adulthood as it is with older adolescence. The therapist begins this process by first accessing the day-to-day details of the adolescents' street lives. As an adolescent tells his or her story, the therapist is able to exert a positive socializing influence based on that story. The therapist is then able to involve prosocial adults in the adolescent's life as mentors, particularly males if the adolescent is also male.

African-American adolescent males are influenced by both the mainstream American culture and a traditional black or African-American culture (Boykin & Toms, 1985; Phinney & Devich-Navarro, 1997) within a youth or adolescent subculture embedded in street culture. For some adolescents this street culture has antisocial connections. The culturally specific family therapy method presented here attempts to take into account all the interconnected cultural influences that affect these youth.

Articulating personally meaningful topics and treatment aims, focusing on the self and the teenager's personal story, and taking the therapeutic stance of being an ally to the adolescent are key in-session behaviors for the therapist. For example, using the music of the adolescent's culture within the therapeutic context helps adolescents to discuss areas of their lives to which the therapist otherwise would not have access more easily.

John (J): The only reason why I used to do marijuana is 'cause I heard rappers like Snoop Doggy Dogg say they used it.

Mother (M): Are you going to listen to a record?
J: Yeah, that's how it is in the nineties.
M: You'd rather listen to a record than listen to what I've been telling you?
J: That's how it is, you can ask anybody.
Therapist (T): People are doing a lot of stuff out there. It's not just because of the rappers.
J: It's because of the rap.
M: It's because of what you want to do from the beginning.

J: No, it's rap. Snoop Dogg sounds better than you.

In this example, the adolescent revealed that the rappers "sound better" than his mother's attempt at influence. In the next case, the therapist finds that the music helps the adolescent specify aspects of his world that frighten him. The young man (M) brought in a tape of a rapper that details his stealing. This exchange occurred after the tape concluded:

M: People know that if they see a car full of people. . . well anytime you see a car full of people, and they don't look familiar, and they have music like that on, you know somebody's about to get shot up. It happened to me like that.

Following this statement, there was a discussion about the young man's life on the street. The adolescent talked about getting robbed and the fight he initiated in retaliation the day after being robbed. The music that these young men enjoy speaks volumes about their experiences and their views of life.

The therapist tries to teach the adolescent new and necessary skills (e.g., anger control, bicultural efficacy) and to build new relationship bonds (or reestablish old connections) with caring family or community members. These connections help maintain the positive socialization influence of therapy, and they also assist with the maintenance of skills the adolescent acquires in treatment.

The transition into adulthood is relevant for all adolescents, but the theme of the "journey from boyhood to manhood" is particularly applicable to the transition experienced by African-American male adolescents. The focus on the journey from boyhood to manhood helps define therapy as the context within which the adolescent inventories his skills and preparedness for manhood. The theme is explored in discussion. What is manhood? What skills does the adolescent need for survival in the mainstream world? On the street? How does the adolescent view the street as being a part of his identity as a man/black man? Central to these intentional, focused discussions are assessments of the modeling or mentoring interactions present or absent in the teen's life. For adolescents who say they have no mentors, attention moves to how mentoring experiences might be established.

In other cases in which men are not accessible, church groups, rite-of-passage programs, or job training initiatives are used to assist with the processes of emotional support, skill development, and learning values.

When specifics are uncovered about the antisocial influences in a teen's life, it is important to discuss the developmental implication of these influences. In a 1994 National Public Radio (NPR) broadcast segment titled "Jail Seen as Rite of Passage by Many" (Hinojosa, 1994), youth talk about the importance of "becoming a man" in their street subculture. The following is an excerpt from the NPR broadcast:

> For many young men in this country, it is not going to college or going to work but going to jail that has become something of a rite of passage. The United States has one of the highest incarceration rates in the world. On any given day, one-and-a-half million people are behind bars, most of them men. It's becoming a common, accepted, even welcome experience in some neighborhoods.

To counteract these street values, interveners should openly and frequently reinforce for these youths the positive developmental outcomes that may be culturally consistent but counter to traditional expectations for adolescents (Burton, Allison & Obeidallah, 1995; Burton, Obeidallah & Allison, 1996; Stack & Burton, 1993). Some of these alternative, culturally sanctioned outcomes may include taking responsibility for an older grandparent, helping community members and parents with the parenting of younger African-American boys, or simply accentuating the acquisition of skills to stay alive on the street while resisting involvement in antisocial peer culture (Burton, Allison & Obeidallah, 1995).

Tutoring and job training programs are examples of well-organized, prosocial, future-oriented, competence-producing contexts (see Academic/Vocational Training Interventions on page 145). Once adolescents of any culture have found a context to learn these skills, a core clinical challenge is to assist them with the process of learning to "role switch"—to use the skills needed to survive in one culture only in the context of that culture and vice versa (Boyd-Franklin, 1989; LaFromboise & Bigfoot, 1988; Pinderhughes, 1982). Bicultural competence training is recognized as an essential component of African-American success (Banks et al., 1996; Demo & Hughes, 1990; Fordham & Ogbu, 1986; Phinney & Chavira, 1995).

In the next example, a young man (JD) reveals an aspect of himself that he uses on the street. His father (D) insists that he "control" that side of himself in other environments. In response, the therapist (T) reshapes the idea of control into the more competence-oriented concept of role switching.

T: ***Part of why we are going into the past is so we can get out of the way anything that might be causing what we see now. JD, can you say a little more about this street side?***

JD: ***I've got to take care of myself and I just let that take over. If somebody says something to me, then I just let that street side kick in. See, I can control it sometimes, but like it just gets out of hand.***

T: ***Dad, you're shaking your head. What's that about?***

D: ***He can't control it.***

JD: ***I can control it kind of.***

D: ***No, he can't. He even said that if someone says something wrong to him, he goes off. And I try to explain to him that on my job people say wrong stuff all the time. Probably worse stuff than is said to him. You've got to learn how to use this [points to his head], 'cause when the street side takes over, one day that could be it.***

T: ***Let's try to figure out what goes on with this street side. Like how it serves you or doesn't serve you. Like how it may work for you in some settings, but not in other settings—and maybe not in the broader scheme of what you may want for yourself.***

JD: ***See, the street side works when like something happens. But when I'm in school, it don't help 'cause it comes out and I get suspended and that makes me miss some of my schoolwork.***

T: Is that something that you want to get some help on here? I mean working on how you use the street side?

JD: Yeah, and working on my attitude.

The therapist raises the topic of using these skills only in settings other than on the street where they will be useful (Schinke et al., 1988).

Risky Sexual Behavior Interventions

An overarching goal of MDFT is to promote adolescents' healthy development including their sexual behavior. Interventions in this area focus on the adolescents taking responsibility for their sexual practices, particularly in terms of protecting themselves from contracting human immunodeficiency virus (HIV) and sexually transmitted diseases (STDs). Early sexual activity and risky sexual behavior, pregnancy, and sexual acting out are common among adolescents with behavioral problems, and adolescent drug abusers appear to be particularly at risk (Deas-Nesmith et al., 1999; Langer & Tubman, 1997). MDFT 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 individual interactions with the adolescent.

The educational portion of the adolescent HIV prevention module may be provided in cooperation with an existing community program. It is essential that the educational material presented be appropriate for the adolescents' developmental level, as well as the characteristics of the particular adolescents in the MDFT program. One way to ensure such a specific orientation is to pilot and refine the workshop format and content in conjunction with the community agency. Workshops facilitated by peer leaders seemed to be beneficial, especially when the option was provided for the adolescents to later become leaders themselves. Topics of this educational component should include STDs, basic information about HIV/acquired immunodeficiency syndrome (AIDS), decision-making skills regarding sexual behavior, communication skills, discussion of love and relationships, peer pressure in regard to sexual activity, and techniques for safer sex. In the case of younger adolescents, therapists must be sensitive to the issues of pubertal onset and notice if they need extra individual work following group presentations such as is the case for early maturing girls.

Key Concept:

Therapists creatively modify local resources to meet the needs of the adolescents with whom they work.

All educational HIV prevention sessions should be interactive and contain fun activities to keep the youth engaged in the education and skill-building process. After the workshops, each adolescent may be asked to engage in outreach activities, including making presentations about safer sex to other adolescents. MDFT therapists have found that the adolescents are very engaged in these sessions and create a positive dynamic within the group. Therapists attend the workshops with the adolescents, and the adolescents do not seem to hold back any information in

their therapists' presence. One extremely powerful component of this type of educational experience can be inviting a teenager or young adult who contracted HIV from heterosexual contact and has become symptomatic to speak to the adolescents about his or her experiences. Having this individual meet with the adolescents helps make the issue more real for them and may combat their belief that only gay men or injecting drug users contract HIV.

For adolescents who are currently sexually active, it is important to make consistent inquiries about their use of condoms, reminding them of the risks involved in not using them. It is important for MDFT therapists to shift these responsibilities to parents so that they discuss these issues with their children on a regular basis MDFT therapists also help to arrange for female teens to go to Planned Parenthood for a pelvic exam and to explore birth control options.

The adolescents tend to be comfortable with these types of reminders and discussions, and they also seem to be comfortable in accepting the condoms that the therapists may distribute. These adolescents have grown up with the specter of AIDS, and they know that it is a life-and-death issue. They do not always behave responsibly, however, because of their developmental feelings of invincibility and their tendencies toward impulsivity. Another issue that contributes to the inconsistency between their seeming awareness of AIDS and their sexual risk-taking behavior is that even though they may know teens who are HIV-infected, their peers are typically not yet symptomatic. Not seeing their friends or other teenagers with the actual symptoms of AIDS makes the danger seem less real to them.

Helping adolescents move toward maturity, toward understanding and accepting the responsibility for self-care, is a key component of the MDFT model. This message—that they must take care of themselves and accept responsibility for their own health and own lives—is the same message that is communicated to them about their drug use.

Overall, the most important emphasis in terms of adolescents' sexual behavior is that it really is about life and death, as is drug use (see Parenting Relationship Interventions on page 115). The HIV issue, however, is an area in which the therapist can approach adolescents from a life-and-death perspective, and they know it is true. The therapist can then tie this work into other aspects of the adolescents' move toward health.

Multimedia Interventions

In attempting to gain access to the adolescent's world, the therapist uses psychoeducational videos, popular films, music, and written or Internet materials to facilitate discussion of both general topic areas and the personal experiences of the adolescent.

During the first stage of therapy, the use of multimedia resources assists the therapist in broaching sensitive topics with the adolescent. Because these types of media tend to be more interesting to the adolescent than simple verbal exchanges, they typically generate more interest in the subject matter. Discussion of topics raised through watching a movie or reading a story, and therefore not obviously and directly related to the adolescent, may also provide a measure of comfort. Once the therapy moves into the second stage and the relationship between the adolescent and therapist is stronger, these media can be used to help adolescents express more intense emotions and concerns in a creative, productive manner. The therapist may encourage the adolescent to bring in his or her own music or a particular movie that has captured his or her

attention. At this point, the resources become catalysts for emotional exploration and expression.

A number of psychoeducational videos are available that target high-risk adolescents (e.g., Straight Talk [Substance Abuse and Mental Health Services Administration, 1993]). Similar films that target recovering adult substance abusers (e.g., the Beat the Street series [Boundy, 1996]), as well as televised documentaries or specials (e.g., Lords of Chaos: Dateline Special [Shapiro, Pepper & NBC News, 1999]), may also be appropriate. The videos most likely to hold the adolescent's attention are those in which the main characters are teenagers who seem sincere and realistic in their portrayals of the consequences of drug use and, if applicable, the manner in which they found a way out of the drug-using lifestyle. Videos are especially helpful for younger teens, as videos give them words and the emotional context for them to discuss these issues in therapy. Videos further capture the attention of younger teens, who may be less motivated to participate in discussions that seem abstract or address difficult topics.

The use of popular films in therapy has gained increasing support in recent years (e.g., Hesley & Hesley, 1998). MDFT therapists have found such films as *Dead Man Walking* (Gramercy Pictures & Robbins, 1995), *Good Will Hunting* (Miramax & Van Sant, 1997), *Boyz N the Hood* (Columbia Pictures & Singleton, 1991), and *Basketball Diaries* (Polygram Video & Kalvert, 1995) helpful.

MDFT therapists tend to reserve the use of music with the adolescent for the middle stages, after a relationship has been established. An adolescent's choice in music, and the discussion that may accompany reviewing the lyrics, can be intensely personal. The case example below illustrates the use of music in individual work with an adolescent in MDFT.

Case Example: J.
J. is a 14-year-old teenage male whose brother has been referred for MDFT treatment. The therapist also does individual work with J., and she has noticed that J. has difficulty with the traditional, face-to-face therapy session. When he and the therapist are engaged in another activity (e.g., playing a game, eating lunch), he becomes much more talkative and seems relatively at ease. One week, J. was suspended from school and spent considerable time at the therapist's office. He asked whether 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 titled "Damien" (DMX, 1998) and described some of the temptations of street life. J. 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 pull the rapper has experienced between right and wrong and deciding which path to follow. This song was particularly poignant for J., who experiences some ambivalence about religion and faith. As the therapist described it, the music provided her with a window into the adolescent's world.

MDFT therapists experiment with a variety of creative and expressive outlets with the adolescent, including writing or journaling; the use of teen-centered books, magazines, or Web sites; and audiotaping or videotaping. The therapist encourages the adolescent to tell his or her story in any medium that is comfortable for him or her, and this storytelling can be facilitated by reading or hearing about the experiences of other adolescents. To encourage these efforts, the MDFT therapist provides the adolescent with computer access whenever it is needed. Invaluable resources can be obtained through the Internet.

One resource that MDFT therapists have used is the series "Teenage Diaries" (Richman, 2000). National Public Radio (NPR) describes this series as "a new kind of oral history." NPR trains the teens to be radio reporters and provides them with a tape recorder for a period of 3 months to a year. The adolescents then keep an audio journal, usually collecting more than 20 hours of tape. NPR editors collaborate with each teen to compile radio documentaries for broadcast on the *All Things Considered* program. NPR also maintains a Web site on which listeners can replay these stories (www.radiodiaries.org/teenagediaries.html). Instructions from NPR on how to begin a similar project with local teenagers are being compiled, and MDFT therapists have already begun encouraging their adolescents to record their experiences in a similar way.

MDFT therapists also use videotaping with adolescents, encouraging them to "tell their stories" as if they were on television. The information the therapist may glean from this storytelling is invaluable, and the telling in and of itself can be immensely therapeutic for the adolescent.

Another useful resource is the Youth Communication Web site (www.youthcomm.org) (Hefner & Brown, 2000), a fairly new site that helps teens develop their skills in reading, writing, thinking, and reflection.

The multimedia module of MDFT represents a useful, practical tool that, at its best, provides a window into the adolescent's world consistent with MDFT's philosophy of approaching and developing a relationship with the adolescent individually.

Spirituality

Spirituality (belief in a higher power, God, goodness, love, or morality) is a topic broached only after an established relationship exists between the adolescent and therapist. Many adolescents who have entered treatment following detention have had contact with spirituality or the Bible because of ministry groups operating in detention centers. Many teen girls in treatment have been involved with and attended a church in the past, whereas for most teen boys it is their families who have been involved with a church.

Based on this type of intervention, it is possible to determine where the adolescent is in his or her interest in spirituality. Some adolescents are ready to make a link to a church, others to meditation, and others to the serenity prayer and the 12-Step concept of a higher power. But in all cases, the MDFT therapist proceeds carefully, not selling church, not selling a "preachy religiosity," but inquiring into the world view of the teen.

Spirituality can be a link for the adolescent to feeling good about himself or herself rather than feeling good primarily through material possessions. The MDFT therapist can facilitate and

reframe the process, commenting that he or she sees the spirituality, the goodness in the adolescent, and asking whether the adolescent can see it in himself or herself and project it out to interactions with others. Addressing spirituality with adolescents can help them learn how to find the better life, the inner serenity, the comfort found in connecting to something bigger than they are. However, it should be kept in mind that existential understandings are difficult for many younger teens given their less advanced cognitive and emotional level.

A critical aspect of treatment with this population is establishing a set of strategies for handling crises, especially for teens who demonstrate serious deterioration. MDFT therapists should become familiar with local mental health resources so that the procedure for dealing with crises can be delineated at the very beginning of treatment. There tend to be two situations that could require more intensive interventions: suicidality and physical violence.

Any adolescent who is judged to be at risk for suicide should be transported to the local community adolescent mental health crisis unit. Depending on the crisis unit's assessment, the teen should be either returned home and taken to MDFT treatment (minimal risk), kept in the hospital for 1 to 3 days of observation (moderate risk), or hospitalized for 1 to 2 weeks (severe risk). In any case, treatment should continue with family sessions focusing on the issues that contributed to the adolescent's suicidal symptoms. The adolescent should then continue treatment when released from the hospital.

For the vast majority of drug-abusing youngsters, an intensification of the intervention dosage is sufficient to survive most crises within the family. In those cases in which the situation is exceptionally intense or dangerous, a period of respite should be arranged for the family members. One way to achieve such a respite is to work with the extended family to arrange for one of the at-risk members to stay with the extended family for a short time, although all members continue to be active in therapy and work through critical family issues. In cases in which no family members are available, therapists may use community shelters where the adolescent can stay in a nontherapeutic but safe environment. Joint therapy sessions should continue during this period of respite, providing continuity to the treatment.

Common crisis stabilization methods can be counterproductive because they derail the ongoing therapy process by pulling the adolescent and family out of treatment and into a separate crisis management facility (which has the sole aim of stabilization). The fundamental goals of the strategies presented here are to keep the adolescent and family safe through the crisis and ensure continuity in therapy.

Overall, the adolescent module is characterized by efforts to engage adolescents in therapy, enter their world through a variety of means, and form an alliance with them to better effect change.

The Parents and Other Family Members Subsystem Module

Goals

- **Build a therapeutic alliance with a parent**
- **Create a collaborative agenda**
- **Establish a developmental-ecological framework**
- **Facilitate parental commitment**
- **Facilitate and improved relationship or improved communication between the parent and adolescent**
- **Increase knowledge about and effectiveness of parenting practices (e.g., limit setting, monitoring, appropriate autonomy granting).**

Rationale

The family environment and parenting practices make unique and critical contributions to the development of adolescent competence or deviance.

Procedures

- **Meet alone with the parent**
- **Address parental frustration and despair while engendering hope, renewed commitment, and change**
- **Understand the parent's beliefs and emotions about, and philosophy of, parenting**
- **Assess competence in key areas**
- **Help the parent create a new relationship with the adolescent.**
- **Help parent address personal developmental issues, take care of himself or herself, and manage relationships with extrafamilial agencies and institutions, when indicated.**

Relationships with Parents During Early Adolescence and Clinical Implications

Young adolescents' relationships with their parents necessarily undergo a process of change and transformation (Steinberg, 1991). Developments in cognitive skills, emotional experiences, and social roles change the ways young adolescents relate to parents, and parents of young adolescents experience life transitions of their own that impact the nature of the parent-adolescent relationship (Silverberg, 1996). The relatively minor increase in parent-child distance and conflict during the early adolescent transition does not preclude the desire for acceptance from and attachment to parents. Research demonstrates that an early adolescent's well being is closely connected to parental acceptance, involvement, and support (Lieberman, Doyle, & Markeiwicz, 1999).

Poor parental monitoring is perhaps the most critical family factor in the initiation of early adolescent substance use (Steinberg et al., 1994), as much of early adolescent drug use occurs in the adolescent's own home, in the absence of adult supervision (Steinberg, 1991). Authoritative parenting, which combines warmth with challenge and supervision, is associated with the most favorable adolescent outcomes, including school achievement, prosocial peer affiliations, low levels of drug use, and a coherent sense of identity (Eccles, 1999; Steinberg, 1991; Fletcher & Jefferies, 1999). Conversely, permissive-neglectful parenting is associated with pervasive difficulties (Brook et al., 1999). Perhaps most importantly, protective factors such as consistent discipline and monitoring within the family limit access to and attraction to drug using, deviant peers (Steinberg et al., 1994).

Convincing parents of the essential premise that they can be helpful and influential in their teenager's life is a major task of subsystem work with parents. The goal is to interrupt the cycle of defeat, desperation, and distance that parents experience and to rekindle their hopes, dreams, and aspirations for their teenagers. They should not take on every issue but instead "choose their battles" with discretion. This choice involves defining the realms in which they can and cannot influence their child.

Parents are in charge of reestablishing a developmentally appropriate family environment; to achieve this, family management practices must be reviewed, as must the family's history. Concomitantly, parents must also accept their need to confirm and assist in fostering the development of their teenager. A central challenge is how to make parents emotionally available to their teenager after all that has happened. This is very difficult. A therapist tries to resurrect some of the parents' previous levels and feelings of love and commitment for their child. If these are not there or are inaccessible, the therapist tries to create them anew, most frequently by emphasizing the dire straits their child is in and convincing parents that they are vital to accomplishing necessary changes. Sometimes one's credibility as an authority or expert or citing evidence from research studies can be employed to remobilize parental commitment. Studies indicate that changes in parenting practices are possible, even with adolescents who are affiliated with drug-using peers and disconnected from prosocial institutions such as school (Bank et al., 1991; Dishion & Andrews, 1995). These changes in parenting are associated with decreases in the drug-using and antisocial behavior of youth (Schmidt, Liddle & Dakof, 1996; Steinberg & Levine, 1994). The quality of a teenager's relationship with his or her

parents has been found to be the most powerful protector against deviant behavior and problems in development (Resnick et al., 1997). As in other arenas of assessment and intervention (e.g., adolescent development, neighborhood influences [crime, drug availability]), MDFT uses research-based knowledge about those aspects of parenting that promote prosocial development (Liddle et al., 1998). A number of treatment studies have shown that modifying parents' personal and marital distress can improve their problem-solving and communication skills and that these changes are associated with reduction in behavioral problems in their children (Dadds, Schwartz & Sanders, 1987; Mann et al., 1990; Miller & Prinz, 1990). For younger teens, parents may be less close to abdicating their parental responsibilities; in contrast, they may be unwilling to grant their adolescents they autonomy they need to develop good judgment.

Therapists implement parent-focused interventions in stages, first assessing the status of the relationship between the parent and the adolescent, with particular focus on the attachment aspects of the relationship (developmentally appropriate for adolescent–parent relations, of course). Failure to maintain relatedness in the parent–adolescent relationship creates significant risk for a variety of negative developmental outcomes (Allen, Hauser & Borman-Spurrell, 1996; Greenberg, Speltz & DeKlyen, 1993). A teen's achieving autonomy while maintaining a positive relationship with parents is widely recognized as a fundamental task of the adolescent and parents (Baumrind, 1991; Steinberg, 1990). It is important to remember that adolescents continue to seek out their parents for support and guidance (Greenberg, Speltz & DeKlyen, 1993), and although the nature of their parents' influence is different from what it was in childhood, their parents continue to have considerable influence over teenagers in many areas (Hill, 1980). MDFT creates road maps for therapists who wish to work with adolescents and their families in more developmentally informed and developmentally on-target ways (Liddle, Rowe et al., 2000).

The MDFT model specifies an array of interventions with parents designed to accomplish several interrelated goals. First, therapists engage with parents, seeking to understand and elicit underlying feelings of hurt, disappointment and despair blocked by anger and resentment. They use these more vulnerable emotions and specific "Parenting Relationship Interventions" (Liddle, Rowe, Dakof, & Lyke, 1998) to help the parent to reconnect with the adolescent. Here, we highlight parenting interventions particularly important in our work with younger adolescents.

With parents of early adolescents, some of the most important work involves addressing parents' expectations and beliefs about what adolescence is all about. Parents may need to work through their own feelings of anxiety and insecurity, with therapists helping them to acknowledge that this is indeed a period of change for the whole family. In all of these conversations, therapists provide positive feedback about the parents' strengths, inspire hope for changing less effective strategies, and give encouragement that they are not going to be on this journey alone. In the following case example, the therapist confronts the teenager's mother, who has had difficulty making the adjustment to parenting Tony as a young adolescent.

Therapist: I'm concerned, because something I see you doing is you tease him. You chide him. I see you looking at him and it seems to me that you're thinking, 'you're 14! I'm not ready for you to grow up.' Do you know what I mean?

Mom: Yeah. I still think of him as little Tony that – you know – my baby. He's always just been my baby. He's not supposed to be interested in girls. I'm thinking, all he needs to do is eat and play with his little GI Joe men.

Th: Do you think it's going to be hard for you to help him through this change?

M: If I know where he's coming from, I can deal with it.

Th: And the more you can take him seriously – even though sometimes he doesn't look serious, you know, because he's 14 – but the more you can take him seriously and help him grow, the more he's going to share with you and feel comfortable.

Therapists talk to parents about how the young adolescent is changing, as well as addressing parents' expectations about what parenting adolescents involves. MDFT therapists describe how authoritative parenting works in ways that parents can understand. Later in the same session, the therapist summarized the approach to Tony's mother in the following way:

Th: I think there are two things that a parent really needs to do. One is to be there – to find a way to help him feel comfortable talking to you about what he's going through. It means talking about girls, maybe about why school is so hard, all different kinds of things. And then the other half is even when Tony is going to tell you some of these things and share them with you, you still have the responsibility of a parent who cares to decide what's acceptable and what's not, and set the rules, and be firm and be consistent with them. And that's the second part that we were talking about now – how you're going to respond when you feel like Tony's not taking responsibility. So it's really both things together, and they complement each other. Both getting closer and helping Tony tell you the story of his life and you being able to not jump on him but to decide, 'Well, here I'm not going to get crazy, but over here I am going to take a stand. And here's how I'm going to take a stand effectively.' And we're going to do both things here, together.

MDFT interventions with parents of early adolescents are based on the known parenting factors associated with drug use during this developmental phase. As in the example above, therapists convey that a close and supportive parent-adolescent relationship during early adolescence is critical because it is one of the only stable forces in the adolescent's life during this transitional period (Steinberg, 1991). Therapists in MDFT take the stand that early adolescents who are already in trouble with drugs, having problems in school, and involved with deviant peers are at an exceptionally vulnerable point in their lives, and they emphasize to parents that they (the parents) are probably the adolescent's only hope for turning things around. Parents may believe that the adolescent does not want or need their input or attention given the young adolescent's relatively new investment in peer relationships, yet therapists actively attack this misperception. Therapists also provide hope to parents who believe their adolescent is beyond their help, insisting that it is not too late.

The following segment illustrates a discussion with a parent of a 12 year old girl referred to drug abuse treatment for multiple problems, including shoplifting, drug abuse, school truancy and failure, and behavior problems. The therapist in this case instills hope by insisting that things can change for her adolescent, while conveying the urgency of the situation with her daughter and the importance of repairing the mother-daughter relationship in helping her daughter change.

Mom: At her age, I don't think she wants my time.

Therapist: I don't mean so much the way she did when she was a toddler, but I think yes, she wants your attention certainly, your interest in her and what she thinks, how she sees things, the things that happen to her. I don't mean prying. What we're talking about, what you're asking about, is how to be a parent to a kid this age. Yes, certainly you respect her privacy- that there are some things she doesn't want to talk about, but I think for you to be more in her world, or knowing about her and how she sees things- I think she thinks a lot. She's thoughtful and smart and there's a lot going on in there. And I think that you're the person- the one person- the most important person- who has to know her. However you can make that time for the two of you. And what I would want you to do wouldn't be so much to focus on the problem things- there's always time for that- but to talk about- to ask her to express interest in whatever's going on with her, and to talk about yourself if that's relevant, you know, and let her know some things about you, and to have more of an experience that the two of you would come away from that wouldn't be about the same old problems and bad feelings.

M: I've asked her to talk with me, but she doesn't want to. When I ask her things she doesn't say anything. It's frustrating…

Th: I know. I see how frustrated you get. But I want to tell you something. You're going to have to do a lot of reaching out before she's gonna reach back. There's just no question. I think that's maybe the hardest thing for me to help parents with.

Later in the session, after exploring what some of these particular difficulties might be given this parent's unique life circumstances and history, the therapist comes back to her main point concerning the importance of the mother-daughter relationship.

Th: She's kind of drifted off- she's sort of in her own world-

M: It's her self protection role that she learned to cope with things-

Th: Well, and it's not working so well, is it? Because the stuff she does to cope- like the smoking marijuana, staying out all night, not talking to people about what's bothering her, this is not good coping. You know that. And so what's happened is there is some sort of a gulf between the two of you where it seems like you don't know her anymore.

M: I'll tell you the truth. I don't know her. I just don't know her. I don't know if it's this dysfunctional family or if I just can't do it, or if it's too late…

Th: ***No. You can do this. What I'm trying to say to you is you can do this stuff. She's still at an age where things can get turned around. You really have an opportunity here, but I think it's really at a critical point. And you're the key. You're the key there. She's kind of out there getting further and further away and it's going to be harder and harder to reach her and I think that's a scary thing, and as a parent I wouldn't want you to get so out of touch with her that by the time she's 16 or 17 she's just out there going, on drugs, doing what she wants, getting pregnant, whatever- And I really think there are ways now that you could bring her back in, but it would really mean a different way of being with her.***

M: ***I know what you're trying to say. But she doesn't want it. She won't let me in.***

Th: ***You know, that's something we're going to do together. I want to help you have a different relationship with her, but it will take a lot of work from you. When you're talking with her and she's shutting down don't get pushed away. She can do that. I've seen her do that in here with you- she just gets quiet and silent, and you think she doesn't care.***

M: ***I ask her all sorts of things, about school, her friends, and I get no where.***

Th: ***And sometimes she just doesn't deal well with those direct questions. But there are ways of being interested, of saying that you want to get to know her, of hanging in there- and hanging in there also might mean just making sure that you don't get turned off. As you reach out to her, whatever that takes, she'll know that you're going to keep trying to get in there with her. I don't think she really wants to push you away, and I know that wouldn't be good for her. I think you have an opportunity here at a time that's really critical for her. Because if she feels really cut off, and that keeps going on, she's going to find other connections that aren't going to be good for her. She's young enough to respond to you. It's not at all too late. She's at an age where things can go either way for her. She's struggling with a lot of things, and she needs you in there with her to sort things out.***

The therapist in this segment is building a foundation for productive work in the parenting subsystem by resurrecting positive feelings of being together, generating hope that she can impact her daughter's life and that it is not too late for her daughter's life to turn around, while at the same time communicating the urgency of making changes in the relationship before things spiral out of control. These are all important first steps in ultimately changing the mother's approach to parenting. Future work in therapy with the mother and adolescent will focus on actively improving the nature of the relationship and increasing the effectiveness of the mother's parenting strategies.

Therapists also make it clear to parents that a close relationship is only one part of the complex equation that determines the development and maintenance of drug use and other problems. MDFT therapists insist that parents learn more about the young adolescent's life, who they spend their time with, what school is like for them, where they go with friends, and what they are doing during unsupervised time. With parents of young adolescents, therapists emphasize the continued importance of limit setting, firm and consistent discipline, and clear

communication, despite the adolescent's desire for increased independence. The clinician helps parents and adolescents negotiate the parameters of their changing and evolving relationship. In the next example, the therapist insists that the young adolescent's mother provide more structure and limits.

Therapist: She's still at an age where she definitely needs you, and she needs somebody to push her- you know, not to let her go down that path she's going down. You know parents sometimes have to pull out all the stops. You know, it's one thing to say to your kids, 'We're not going to let you destroy yourself. You know we're not going to let you get into this kind of trouble. We're not going to stand by while you do that.' It's easy to say that, but actively to stop them means something else. They may be angry at you for giving them a curfew, or for insisting that you know where they're going, and not letting them go places or be with people that you don't like, you know… If you're saying to a kid, 'I don't want you to do dangerous things, I don't like this path you're going down, I think you're doing things that are gonna get you in trouble,' then you have to stand by that and not allow certain things if you think they're not good for her. You can't afford to have her take lightly when you tell her that she has to do something.

Therapists in MDFT stand by such statements with a clear commitment to do whatever it takes to help parents and adolescents find new ways of communicating, being together, working through problems, and managing obstacles to reaching goals. Therapists know what it takes to turn a young life around, and they understand the ramifications of failing to do so. Parents need to learn new parenting strategies and implement them consistently and effectively. Adolescents and parents need learn how to talk to each other in new ways to establish open lines of communication. They are asked to take risks to reach each other, frequently confronting past disappointments and conflicts, becoming vulnerable and open to a positive, caring relationship. There is a clear sense of responsibility on the part of the MDFT therapist to help parents and adolescents do the work needed to change the adolescent's life.

Parenting Styles and Practices Interventions

Sometimes a research-based parental self-help book, such as Steinberg & Levine's (1994) *You and Your Adolescent*, is used in treatment as a reference point for parents struggling to understand their teenager and to change their parenting.

Considerable evidence underscores the link between parents' psychological functioning and their perceived and actual parental efficacy (Dadds, Schwartz & Sanders, 1987; Wahler & Dumas, 1989). Core themes of parenting are frequently related to generic issues of family life, which are manifested in a family's idiosyncratic "big questions" (Liddle, 1985) represented by the parents' beliefs about what families are and what each member expects from his or her intimates. What does it mean to be a parent, a father, or a mother in this family? What do various family members think about these roles in the family?

There are certain content themes that are frequently stressed in subsystem work with parents. These fall into three broad categories: Parental monitoring and limit setting, parenting skills, and methods and content of communication with adolescents.

The therapist asks how much parents know about issues such as the teenager's out-of-school activities, friends, inschool activities, and school performance. The therapist assesses the parents' ability to set appropriate, firm, and consistent limits and supports increased competence in this area.

The therapist assesses and discusses with parents communication, listening and responding, involving the adolescent in decision making, understanding which issues to take on and which to let go, demonstrating a sincere interest in the teenager, spending time with the teenager, showing respect for the teenager, and making useful bridges with institutions outside the family.

The therapist helps parents define what is important for them to communicate to their son or daughter. For example, what are parents trying to teach their teenagers about life, about being men or women, about life on the streets, about being an African-American in this society, about the role of school or work in their lives?

In helping parents better respond to their teenager after being hurt and angered by the adolescent's behavior, therapists can use several methods. Reformulating cognitive attributions, rehearsing behaviors, and working for increased acceptance of one another through emotional expression and clarification, for example, are seen as complementary techniques.

Parenting Relationship Interventions

The history of adolescent psychology has been dominated by the theoretically derived belief that separation or individuation constitutes the central task of adolescence (e.g., G. S. Hall, Freud, Blos, Erickson). Modern-day developmental research challenges this opinion. Empirical evidence demonstrates, for example, that positive parent–child relationships foster and predict healthy adolescent development (Hauser et al., 1985; Hill, 1980; Montemayor, 1983, 1986), and, furthermore, that families serve as a primary context of adolescent development (Grotevant & Cooper, 1983; Hauser et al., 1984).

Research in this area also relates directly to MDFT's target group of at-risk teenagers. Emotional support from one's family has been found to have a protective or buffering effect against substance abuse (Burke & Weir, 1978; Greenberg, Siegel & Leitch, 1983; Larson, 1983). Supporting these data, Wills and Vaughn (1989) found that under circumstances where there is a high level of substance abuse in the peer network, family but not peer support had protective effects. Wills (1990) concluded:

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

Outmoded and inaccurate concepts have been replaced by the idea of parent–child interdependence as the optimal developmental condition (Steinberg, 1999).

When these relationships falter or when they remain poor over time, an adolescent's psychosocial growth deviates (Baumrind & Moselle, 1985; Shedler & Block, 1990; Kellam et al., 1983; Newcomb & Bentler, 1988). Research indicates that, unlike the families of adult addicts, which are typically characterized by a disengaged family structure (Stanton & Todd, 1982), families of drug-abusing adolescents are more likely to be disengaged but still engaging in hostile conflict (Liddle & Dakof, 1995; Volk et al., 1989). When relations are strained or have been badly damaged, attachment bonds must be shored up or rebuilt before families can consider behavior changes. Such reconnection processes can be identified (Schmidt, Liddle & Dakof, 1996), and particular therapist techniques are related to these relationship shifts (G.S. Diamond & Liddle, 1996).

Given the degree of disengagement and lack of cohesion in the families of adolescent drug users, interventions that rely primarily on parental hierarchy and power (organization) can further alienate an already estranged teenager. MDFT is careful not to replicate the excesses of approaches that overemphasize parental control functions (e.g., Madanes, 1981; Haley, 1997). Rather, MDFT fosters evolution of a new developmentally appropriate relationship between parent and adolescent. Creating cohesion between adolescents and parents involves the negotiation of new modes of interdependence (Silverberg & Steinberg, 1987; Steinberg, 1999)—a relationship definition that meshes with the developmental needs of teenagers.

Although not as frequent as with older adolescents, there are instances in which MDFT therapists encounter parents who are frustrated and discouraged enough with the teen that they may be seeking residential placement for their child. These parents take on an abdicating stance and report that they are ready to "give up". In response to such situations, MDFT treatment developers have developed Parenting Reconnection Interventions to restore parents' hope and initiative to "begin again".

Key Concept:

Parenting relationship interventions are special methods used to redirect the derailed developmental tasks of the parent and the adolescent and increase the emotional connection between them.

Parenting relationship interventions (PRIs) support parental reconnection and are designed to put back into place the derailed developmental tasks of both parents and adolescents. At the heart of these interventions are the renegotiation and recalibration of the parent–adolescent relationship in a way that enables the adolescent to achieve increased autonomy within a context of continued but altered connectedness or relatedness (Allen et al., 1994; Grotevant & Cooper, 1983). These processes are designed to decrease the emotional distance between parents and adolescents.

Although some parents in the ATM study function more on the overinvolved side of parenting and have difficulty granting autonomy, research indicates that with midrange and severe drug abuse and conduct disorder samples, disengagement is the norm (Liddle & Hogue, 2001; Schmidt, Liddle & Dakof, 1996; Dadds & McHugh, 1992; Patterson & Stouthamer-Loeber, 1984; Volk et al., 1989). PRIs lessen the emotional distance between the parents and

their adolescent (Liddle et al., 1998). A clinician's attempts to change or even primarily focus on parenting behavior are often met with reluctance or resistance (Griest & Forehand, 1982; Patterson & Chamberlain, 1994). MDFT works to increase parents' motivation to consider a new kind of relationship with, and parenting strategies for, their adolescent. In part, this is done by focusing on and amplifying the urgent circumstances of and need to take action with the teenager (Haley, 1976). This can be straightforward in situations of crisis or when extrafamilial systems such as juvenile justice are involved. When parents are more emotionally distant, rejecting, or abdicating, the task of creating urgency to act can be enormously difficult. The following excerpt illustrates a therapist's (T) use of an adolescent's recent suicide attempt to create urgency in the mother (M). He encourages the mother to strike a balance between appropriate limit setting and communication of her love for her son.

T: See, this is where the real work starts now. You've been around the block withB. Come on, he's been in an inpatient. . . .
M: Well, I said that to him when I found out he was smoking pot; and I said to him, "Why are you doing this?" You know?
T: Uh huh.
M: My sister committed suicide. My son told me she was his favorite aunt. So I said, "Then why are you doing this?" This was the way she started. She started with pot. She didn't think she'd wind up killing herself. You know, and the same thing when I found out he was selling pot.
T: And what, he runs away from that conversation, doesn't he?
M: Yeah.
T: He doesn't hear. And that's why, when you have that conversation, this is the kind of conversation you got to have over and over with him. You gotta hold him still. He's gotta hear it. I don't want you just to talk about things that are issues of control.
M: I always felt like a warden.
T: And now?
M: And not a mother.
T: That's why, together, we're gonna shape this conversation that you're going to have with him.
M: I do get frustrated.
T: Okay, all right, and I know it's frustrating. And I know you love him. And you want to protect him right now. We gotta talk to him. You gotta keep going down that path. You gotta make sure that you balance that conversation. I want the majority of it to be, "Hey, I'm concerned. Yes, you've heard it before. I'm concerned about what you're doing. You're my son. Why are you in the streets? I give you a place to stay. The food's here. I'm just trying to make sure you're okay. I want to know what's happening in your life. I don't want to lose you. I almost lost you. How come you're not talking to me?" That's where we've got to go, and that's how you've got to talk to him.

Through a process called a "history of 10,000 defeats," parents appear to have given up or, in some cases, actively abdicated their parental responsibility for day-to-day influence attempts (Patterson, Reid & Dishion, 1992). These parents also withdraw from the relationship with their teenager. One study (G.S. Diamond & Liddle, 1996) indicates that stopping the slide of this emotional withdrawal is important to the creation of therapeutic in-session interactions between parents and teenagers. PRIs aim first to affect the affective aspects of parenting. The goal is to increase parents' emotional commitment and gradually their day-to-day involvement with their teenager (Liddle et al., 1998). Success enhances readiness to change one's parenting beliefs and parenting practices, even with adolescents who have abused drugs and are involved in delinquent activities (G.S. Diamond & Liddle, 1996; Schmidt, Liddle & Dakof, 1996).

The following excerpt provides an excellent example of a mother's (M) ambivalent feelings toward her adolescent (W). The therapist (T) highlights the parent's expression of love and commitment, and the mother shares her hopes that her son will have a better life than she had.

T: ***Let me ask you, Ms. M., about when W. was younger. Things were going more smoothly, and like all parents you had things that you hoped for him, and still do, and worries that you had for him. Could you talk a little about that?***

M: ***My hope for him is for him to finish school. I can give up right now like so many others have. I'm not going to do that. I'm about ready to say it. A part of me is saying it, but a part of me is saying, "Hang in there." I'd say 10 or 20 years from now, he might hate me for it, or he might like me for it, I don't know.***

T: ***You love him.***

M: ***I love him. I want to see him make something of himself. You know, with him being black—I don't want him to grow up, get older, and can't get a job, because he was supposed to get an education*** **[and didn't].** ***There are a lot of males who go out and hurt, and rob, and steal, and they blame it on the system. Now is the time—the education is out there, grab it. And half of them, to be honest, don't have the sense to go get it. And when they can't get a job, they want to blame it on*** **[someone of]** ***another nationality. I don't want my son to go through that.***

Interventions With Other Family Members

Individuals with key roles in the adolescent's life are invited to participate in family sessions, and individual sessions are held with these people as well. Cooperation of other family members is gained by their participation in treatment on an as-needed (i.e., therapist-defined) basis. Cooperation is achieved by defining and highlighting the current serious circumstances of the youth (e.g., problems in school, conflict at home, arrest, juvenile court problems). Siblings, family members not presently living in the home, and extended family members are included in assessment, case formulation, and interventions.

In the following example, Mark's grandmother (D) and grandfather (J) have been included in an in-home family session. They are part of the household in which Mark lives and are seen as vital to fostering his adaptive socialization. The therapist (T) and Mark's mother (M) and father (F) explain the current situation, a crisis where if Mark gets in trouble one more time, he will be put in detention for 3 years. The therapist then lets the grandparents know how important they are to Mark's healthy development and encourages the family to come up with appropriate household chores during the coming week.

T: ***Thank you all so much for being here tonight. We wanted the whole family here because it's very important. Mark is in a crisis and we're all very worried about him. As his father just said tonight, it's very hard because he's at Level Six. Why is he at Level Six?***

M: Level Six is where they can lock him up.

T: **So it's very serious. Bill [a therapist's helper]** ***and I are therapists in a program that Mark is attending to try to help him with anger management and all the other problems he has. So the reason I wanted you all here is because you live with him.***

M: He's 14 but on the street he acts like he's older. In other ways he's 14 but acts like a 2-year-old. He can't speak for himself and express what he wants.

T: [to Mark's grandmother] I think that you do too much for him. Because you love him. Now he really needs to start to do things for himself. So I would like for you to rest and for him to work. Is that possible? Is it difficult for you?

GM: Yes, it's hard . . . .

J: But for his own good, let him do it.

T: Mark tells me, "Oh, my grandmother loves me, she does everything for me."

F: She does everything for her [referring to Mark's mother], too.

T: Okay, so we'd like to start to think about some chores around the house that Mark should do that are appropriate for a 14-year-old.

F: **[to Mark]** ***You've gotta listen.***

Mark: I'm listening!

T: Jobs . . . .

F: For example, the garbage.

M: Homework assignments.

D: I was getting the clothes out of the dryer and I mentioned that my hand was hurting. He came and finished taking all the clothes out and brought them inside.

M: **[pats Mark on the knee]** ***That's it.***

F: One time he asked his grandfather for a dollar. He gave it to a homeless person.

T: Some time before we see Mark again, would you and Mark work out some kind of thing that you want him to do every week, a regular thing that you will stop doing? Maybe something that he does each day and then maybe something that he does once a week. So Mark, will you get with your grandmother and figure that out, what you will do to help take some of the work from her? **[Mark nods]**

T: So, thank you so much. Because you live in this house, everybody has to help him grow up and be responsible. He can't express himself, and when he can't express

himself, he gets angry. It bottles up inside him and he explodes. So we all need to help him learn how to express himself.

Many early adolescents are referred for treatment after they have been arrested for the first time. The first arrest is often traumatic for the adolescent and parents alike, as parents often have to deal with feelings of shame and shock, and both parents and adolescents often do not understand the process with which cases are handled in the juvenile justice system. MDFT therapists first work with parents and adolescents to provide them with information to demystify the process and provide them with the information they need to be of best assistance to their children. This often involves helping get parents beyond unproductive thinking, such as the common feeling that they have failed as parents. Often parents have dealt with their adolescents' behavior problems at arm's length; however, the arrest validates the seriousness of the problem. MDFT therapists work to reengage parents, using the crisis of the arrest in a positive manner to help the parents and adolescent come together, using the event as an opportunity to retrack the life of the adolescent.

In MDFT, therapists emphasize the need for others, particularly prosocial adults, to join forces with the treatment program to help the adolescent.

The Family Interaction Module

Goal

Create a developmentally facilitative family environment.

Rationale

- **The family environment, manifest in repeating and consistent family interactions, including parent–adolescent interactions, is a critically important domain of development during adolescence.**
- **Basic and clinical research has clarified the particular kinds of family transactional patterns that are conducive or harmful to adolescent development.**
- **Family transactional patterns, as a representation of current family relationships, offer an important and accessible context to block or diminish risk factors and processes and promote prosocial adaptive developmental processes.**

Procedures

- **Individual meetings focus on the content for family sessions that might change family interactions.**

- **Techniques are planned using storyboards.**
- **Enactment is the primary method for changing family interaction.**
- **Enactment is a technique, but it also illustrates a way of thinking about change (enactment is an aspect of the change process).**
- **Like the other aspects of the approach, the family interaction module is broken down into parts that are organized sequentially. One way that this organization occurs is through the orchestration of a series of meetings with individuals (family members and extrafamilial others) before as well as after enactment-focused meetings.**
- **Therapist behavior is reminiscent of the "shuttle diplomacy" concept—there are meetings with parents and adolescents separately, together, and alone again in a sequence dictated by the unfolding process and the progress being made.**
- **Important areas or topics on which to work are determined.**
- **Priorities are decided; the downsides to working one area or issue over others are considered.**
- **The therapist works gradually, using successive approximations and "personal/interpersonal best" thinking.**
- **The therapist works on skills: establishes agenda, signs on to tasks and goals, looks for openings, shifts affect, maintains focus and intensity, shapes the interaction, closes it up, and transitions out.**
- **The work must be overt; postenactment time should be used for processing, planning, and troubleshooting.**

Various kinds of family interactions are linked to the development and maintenance of behavior problems, including drug use and abuse (Hawkins, Catalano & Miller, 1992). Transaction-focused change strategies have demonstrated success in changing targeted interactions, and these techniques have become family therapy's defining feature (Minuchin, 1974). Critically, changes in interactions within families are related to changes in targeted problem behavior, including adolescent drug use and abuse (Robbins et al., 1996; Schmidt, Liddle & Dakof, 1996; Steinberg & Levine, 1994; Mann et al., 1990; Szapocznik & Kurtines, 1989) and changes in the in-session problem behavior of drug-abusing teens and their parents (G.S. Diamond & Liddle, 1996; Schmidt, Liddle & Dakof, 1996).

Change in the parent-adolescent relationship is brought about through the classic family therapy technique of enactment (Minuchin, 1974; G.S. Diamond & Liddle, 1996, 1999). A sequence of individual and joint parent and teenager sessions is used as a form of shuttle diplomacy (G.S. Diamond & Liddle, 1999). The enactment method is stress provoking. Individual conversations help alleviate the relationship dislocation stimulated in the enactment-focused sessions.

The next case example elaborates on the idea of *preparation for enactment*. The preparation of both the daughter and the mother is examined, and the rules and techniques for initiating a conversation about a disturbing family theme are dictated.

Case Example: "I Want My Daughter Back"

Jim and Marina, divorced for many years, have two daughters: Sally, age 15, who resides with her mother and stepfather, and Cynthia, age 20, who lives on her own. Marina sought treatment for her younger daughter's marijuana and alcohol use, her daughter's poor grades, and their progressively distant relationship. Sally's stepfather was decidedly uninvolved in childrearing tasks. Marina was concerned with Sally's substance use and that her daughter was drifting away from her toward what Sally called her "adopted" family, her girlfriend's family. That environment permitted drinking and other freedoms counter to Marina's values.

Abandonment was a central theme in this case. It is difficult to imagine addressing the topic of emotional or physical abandonment without dealing with issues of the past. The theme of abandonment most often emerges in session through examination of the adolescent's intense feelings that come from memories of being abandoned or neglected, as well as those that accompany the parents' experience of their own behavior. The feelings are key domains of therapeutic operation.

In this case, the daughter felt abandoned by her mother, who said explicitly that she was choosing to protect her second marriage at the cost of isolating her daughter. Marina, seemingly unaware of the impact of this on her daughter, felt abandoned by her daughter as well. Sally's emotional involvement with her friend's family, although it gave Sally attention and security, was difficult for Marina to accept. In situations like this one, in which there are powerful themes, problem-solving and negotiation strategies can easily fail.

Therapist Improvisation: Shifting Domains of Operation

The key principle illustrated in the following sequences is a shift in the therapist's focus; a multidimensional model allows the clinician maximum flexibility for in-session work. At the previous session and the beginning of the current session, Marina expressed extreme pessimism about her daughter. The clinician was aware of her pessimism and was looking for productive ways to address and, if possible, counteract it. The therapist decided to challenge the mother's

pessimism in a straightforward problem-solving way by trying to work a conversation about mother and daughter having dinner together (a rare occurrence). When the therapist assessed that this approach was not working, she shifted her focus. In the first segment, the therapist (T) was clarifying her rationale for requesting mother (M)-and-daughter conversations in the session.

T: ***What's this about? Well, it's about having a relationship with your daughter. It doesn't necessarily mean it*** **[the contact that the therapist is trying to facilitate]** ***has to be as formal as a date.***

M: **[interrupts; seems frustrated]** ***Well, it does because she doesn't want to have anything to do with me.***

T: ***What about dinner?***

M: ***She won't have dinner with me. She will not sit down. She has not sat down and had dinner with me for 2 years.***

T: ***Would you like her to have dinner with the family?***

M: ***Sure, it's normal. Sure.***

T: ***So, what do you have to do? What are the kinds of things that go into this? Let's not assume that*** **[arranging for the daughter to sit down for a family dinner]** ***is out the window.***

M: **[discouraged]** ***It is out the window.***

T: ***Mmm.***

M: ***Well, I mean, after 2 years it is.***

T: **[sits forward and addresses father]** ***Jim, can you convince this lady that she's got more influence over this kid?***

M: **[interrupts, sounding a bit insulted]** ***Well, I don't have the energy to go in and scream and yell and pull her out every day. You guys make this sound like it's really easy, and it isn't.***

The therapist makes a dramatic shift and asks Sally to leave the session for a few minutes.

T: **[to mother]** ***I wanted Sally to step out because I think you're feeling ganged up on.***

M: **[interrupting]** ***I feel really ganged up on. You guys make it sound real easy and it's not.***

T: ***I'm here to try to make life easier for you. Do you believe that?***

M: ***Well, maybe. I don't know.***

This dialog continues for about 20 minutes. It ends when the therapist makes the following statement that reaches Marina.

T: **[to mother]** ***So why are you doing this*** **[coming to therapy, trying to reach out to your daughter]*****? You're doing this because you love her and you're concerned about her. You've already lost your older daughter to drugs. And you don't want***

that for Sally. I don't want you to feel that I am ganging up on you, or Jim (Sally's father) is ganging up on you. I will do everything I can to be supportive of you.

Intentional and unintentional shifts in a session

This segment contains several important shifts (G.S. Diamond & Liddle, 1996, 1999). First, the therapist shifts the focus of the session from the daughter (e.g., "Are you interested in having more of a relationship with your mother?") to the mother (e.g., "I think you're feeling ganged up on"), and, perhaps more important, to the therapeutic alliance between Marina and herself (e.g., "Are you mad at me right now?"). By asking Sally to temporarily leave the session, the therapist signals her respect to the mother (i.e., "I sense you are upset and I want us to deal with that").

The shift from mother–adolescent problem solving attends to Marina's experience and her individual needs. When the therapist puts herself and Sally's mother into the center of the process, another shift occurs. These moments illustrate the sincerity and credibility that have been established between the therapist and Sally's mother.

The ground rules for being attentive to and reading feedback can be made explicit and depend on lucid personal judgment under difficult conditions (Liddle, 1985). In this sequence, although the therapist has a specific agenda for the session, she appropriately adapts her style, content, and focus to the feedback. Aspects of this conversation include (1) confirming the mother's anger ("I think you're feeling ganged up on") and despair ("You are really angry and frustrated"); (2) compassion for the difficulty of her situation ("This is really hard for you"); (3) normalizing the behavior ("Anyone would find this hard"); and (4) offering new explanations ("She is not used to you reaching out to her") and restoring commitment ("You love this child"). The conversation redirects the mother's negative feelings (e.g., "My daughter doesn't care about having a relationship with me") and lack of motivation for a relationship with her mother (e.g., "This kid just does not want a mother").

Before she asks Sally to come back into the session, the therapist meets briefly with her alone. She tries to prepare Sally for subsequent work with her mother. Sally is challenged to "rise to the occasion" and take her own desire for independence more seriously. Sally agrees to try, and the therapist and Sally go back to the session.

In the next segment, the mother's change is clear. The previous therapist–mother interaction had placed Marina in a vulnerable spot.

Sally originally sat on a couch with her mother, across from Jim. To intensify the mother–child proximity, the therapist moves Sally to the chair across from her mother.

T: **[to Sally]** ***I want you to turn your chair to your mom. I want her to have a chance to say these things to you directly, because I was very moved by some of what she said. Okay?*** **[The pace is intentionally deliberate and the tone is serious.]**

M: **[in a sad voice]** ***Well, first of all, it's very hard for me to talk, because I feel so bad about all this. I feel the loss of a daughter. I miss you. There are things that I want to do with you. I want you to be my daughter and you don't want any part of it. That's very hurtful.*** **[pause]** ***I see mothers and daughters enjoy each other's***

company, and I just feel like you want nothing to do with me. **[Mom begins to cry.]** ***I came from a family of mothers and daughters. That's a very special thing.*** **[becoming upset again]** ***I lost one daughter*** **[a reference to the mother's estrangement from her oldest child]** ***and now I'm losing another.***

T: ***And you don't want to lose her.***

M: **[emphatically]** ***No.***

T: ***And you don't want to have to make rules, but you don't know how to connect with Sally, you don't know what to do.***

Sally was, up to this point, not responding very much to her mother's efforts. The therapist continues to encourage her.

T: **[in a soft voice to Sally]** ***Your mother is being particularly open right now, Sally. She's not saying this to hurt you; she's saying it because she feels so sad and she loves you so much. Help your mom know how to have a relationship with you. I don't believe for a minute that you don't miss that too, Sally.***

Sally has her head down and is crying. The therapist hands her a tissue.

T: ***I think that's why you're crying right now. I don't think you want your mom hurting like that. Why is that? I think it's because you love your mom. Talk to her, Sally.*** **[Long pause; the therapist gets up and moves next to Sally. She puts her arm around the girl's shoulder.]** ***Okay, come with me.***

Sally accompanies the therapist out of the session. Shifting gears, the therapist quickly assesses Sally's feelings about what is happening, as well as her willingness to respond more fully. They return to the session with the therapist not sure how far Sally is willing to go on this occasion.

T: ***So, Sally, tell your mom what's going on.***

S: ***I don't know.***

T: **[challenges]** ***What do you think about the things she said? Sally, why are you crying right now?***

S: **[to mom]** ***Because I don't want you to feel that way.***

M: ***Well, how else can I feel?***

T: **[strong, challenging]** ***Why don't you want your mom to? Why? Why do you care?***

S: ***Because I love her.***

T: ***Then, tell her you love her. Your mom needs to know you love her.***

S: ***She knows.***

T: ***No, she doesn't know, Sally.***

S: **[to mom]** ***You don't know?***

M: ***Well, I think you sort of love me, but I think you sort of love to be away from me. You don't want anything to do with me. Nothing.***

T: That makes you feel unloved.
M: Very unloved.
T: That's why I'm saying—I don't think your mom really knows that. If that's how you feel, then let her know. **[Sally still averts her eyes.]**

The therapist nurtures this mood and discussion. Family members often need more coaching during these early change attempts.

On this occasion, several questions might occupy the therapist:

- What will it take for the daughter to respond at the same level as the mother?
- Has enough groundwork been laid with the daughter individually? Does the daughter believe that her mother really wants to hear what she might have to say?
- To what degree should the therapist encourage the daughter to express herself (rather than involving the mother in the encouragement)?
- What are some reasonable outcomes for this sequence on this occasion? And is it not possible that asking Sally to respond in this session may be reaching too far at this time?

Questions such as these inform a clinician's judgment on a moment-to-moment basis; recalibrating one's interventions in a session is one of the most complex of all therapy skills.

Given that in individual sessions Sally had not shared ideas about what she wanted in a new relationship with her mother, the therapist concludes that this sequence has progressed as far as it could on this occasion. The mother remains emotionally available and nonblaming to Sally.

In the final sequence, the therapist works to construct a useful ending to the session.

T: I don't think that we can have a sense of closure tonight on this topic. Marina, I have to say that I was very, very moved, as I think everybody in this room was. I know what you said was very hard. I think that you certainly deserve some support, and I'm wondering if there's anything that you need from Sally before you leave this room tonight?
M: I'd kind of like a hug. **[with more firmness]** ***I want a hug!*** **[Mom and daughter reach out simultaneously and embrace one another and the therapist then ends the session.]**

During this session the therapist sometimes tried too hard to engineer a breakthrough. Furthermore, the therapist, in a discussion later with her supervisor, realized that she had too many preconceptions about what the hoped-for process ought to look like. This sequence serves as a reminder that each participant in the conversation does not participate in the same way or at the same pace, nor is it important for them to do so.

Key Concept:

Bottom-line case outcomes are achieved by breaking the work into smaller outcomes.

Finally, this sequence presents another opportunity to remember the focus in this approach on an incremental view of change. This is the emphasis despite the fact that change can be defined as having both continuous and discontinuous elements (Liddle, 1982). The focus is on working on and framing change for family members as a series of small steps. These steps are defined by Mahrer (1988) as "good moments" of therapy (i.e., processes that are instrumental to change). As Greenberg and Pinsof (1986) have put it, outcome should be broken down into the "small o's" (small outcomes) that make up a ground-level view of the therapy process. Fixation on the final product, the "Big O" of a final outcome or a "Big Event," can create unrealistic expectations and a focus on the wrong level of detail. Paying attention to these Big O's would be like trying to hit a home run every time one was at bat.

In subsystem work, the therapist might well be working with a parent about acceptance or about understanding the connection between his or her own behavior and that of the adolescent while at the same time (i.e., the same session or the next session) talking with the adolescent about his or her own concerns (e.g., parental or peer rejection, disconnection from family or school). Thus, a therapist may block a parent's persistent request for information about the teenager's current drug use and related behaviors. At the same time, the therapist may help the parent continue to reach out to the adolescent by sharing with the teenager the effect of the drug use or problem behavior. This is not done, however, in a way that elicits blame and negative attributions from the parent.

Case Example: "Building a Relationship Bridge"

The following is an example of work with a mother (M) and son (R) in which the therapist (T) attempts to elicit the parent's personal meaning from statements that in the past had taken an accusatory turn.

M: Well, I can't follow R. out in the street and keep him away from the boys who are into stealing and staying out till all hours.

T: I agree with you, Mrs. Williams. There are a lot of things you can't control. But that doesn't mean there aren't ways you can influence him. I can help him listen to you.

M: Well, I sure hope so. I must have been up most of the night on Thursday. R. went out right after dinner and wasn't back when I went to bed. I don't think he got in until 3 in the morning or so.

T: And I'll bet you were worried sick. What were you thinking about when you lay there awake?

M: I was thinking, "The police'll be by any minute to tell me R. has been shot." That's what I was thinking. I don't think I could bear losing R.

T: Does R. know what you went through that night?

M: Well, he sure knows I was angry, 'cause when he did come in I went downstairs and I guess I really went off. I was just screaming and carrying on and he kind of stood there until I finished and then we both went to bed. We haven't talked much since then.

T: So, R. doesn't know really what you go through when he stays out? I really think it's important for him to know. I think it would be good for him to hear that today when he comes back in. You and he have a relationship. Don't assume that it doesn't matter to him what you go through.

The therapist must find a way to help parents tell a story about themselves and their parenting that speaks to their worries, hopes, and dreams for their child. If a mother, for example, has long been expressing caring for her son in ways he cannot take in—threatening, nagging, yelling—the therapist will want the teenager to be let in on the feelings that underlie these behaviors. This does not mean that the mother should say only "positive" things, however; it means that when she talks about her adolescent's negative attitudes and behavior, she must be helped to do it with reference to how it affects her, their relationship, and the future as she sees it. For parent and teenager, talking together will be an important means of healing their relationship and building a new connection.

The therapist prepares parents for these in-session dialogs or enactments. At this point she has a chance to help a mother come to a new understanding of what has been going wrong in conversations with her child. Later, the therapist has an opportunity to intervene during the actual discussion to keep it on course, helping mother and son see what is not working in the way they talk to each other. The therapist and parent, for example, may talk together and agree that the parent's lecturing of her son is not working and is, in fact, pushing him away. A discussion may ensue about how she can talk to him in different ways. When she lapses into her "lecture mode" during the session, the therapist may ask the teenager, "Is she lecturing right now? Is this the kind of thing you said is turning you off? What happens when you hear her lecturing?" She asks both teenager and mother to talk about how each withdraws following one of their "talks" and gives them opportunities to have a different experience in the therapy room, as she continues to help focus and shape the conversation.

This approach is extremely flexible, because, depending on a variety of factors—receptivity, motivation, and capacity to articulate the problem, among others—the therapist can turn either to mother or son to carry the weight of the discussion. Likewise, when either mother or son shows a quite natural reluctance to persist in the discussion, through discomfort born of lack of practice, fearfulness, lack of trust in the other person or the therapy process, or a need to continue to attack or blame each other, the therapist can meet alone with that individual to try to remove impediments to dialog. The following is a sample from such a discussion:

T: R., what's going on in there? You and I agreed that it was important for you to tell your mom how angry you were when she told you off in front of your friends. Don't bail out on me here. I can help her hear you, but you need to do your part, too.

R.: I know I said that, but she's not gonna listen to me. She never does.

T: It sounds as if you're feeling really hopeless about what we can do together to make things change. What do you think will happen if we bring this stuff up today?
R.: Well, she'll say all the right things when we're here, and then we'll go home and everything will be the same.
T: R., if that's so, I also want us to say that to her—that you don't really trust her yet to follow through. I want to help you with this, R., but I can't do it without you. Can we agree to go back in there and at least try?

The following is a sample discussion of the same type with R.'s mother (M):

T: Mrs. Williams, when we were in there, it seemed as if you stopped talking when R. didn't respond right away.
M: Well, I just can't stand that attitude. It completely turns me off.
T: Say a little more about the attitude.
M: It seems like I'm doing all the work, and all I get in return is Mr. Stoneface.
T: So what you mean by "attitude" is that he doesn't appreciate what you're doing, and when you sense that, it makes you really angry. . . .
M: Yup, that's what I'm saying. With all we do for him, and then he just sits there.
T: Then, underneath the anger, you would say you're feeling hurt. You feel really uncared about when he doesn't respond to you.
M: You've got it.
T: And when you don't feel cared about, it makes it hard for you to reach out in the way we've been talking about. So, let's talk a little more about how you withdraw rather than letting him know what's going on with you.
M: Yeah, I know what you're saying. You're saying I've got to hang in there, because when I don't say anything, then we just go to our corners and nothing changes. I know I've got to keep on trying.
T: Right. Now you've got it.

Facilitation of an in-session dialog between an adolescent and his parents sets the stage for further dialogs outside of sessions. In the following example the therapist uses the adolescent's willingness to share the difficulty he has in staying "on the good side" and resisting drugs; the therapist's supervisor also calls in to assist with the facilitation. This session includes the therapist (T), the adolescent Willie (W), his mother (M), and her partner Matthew.

T: This young man wants to make it, but he's always walking a fine line, right?

M: Right.

T: One part of him wants the good but there is another side, something else pulling at him, right?

W: Right, that other side wants something else.
T: But, what is it the other part wants? Messing up?

W: Bad things.

T: Bad things?

W: I'm trying to move to the good side 'cause, you know, I close my eyes and I think about what happens when the world ends. I'm still in the bad side, but I'm trying to go a little to the good side, so when I die I can go to heaven. You know, I don't want to be burning in hell for the rest of my life.

T: It's a tragedy happening in our society, that kids say "Maybe I'll die, so who cares?" I am very glad that you appreciate what life can bring you. But you're pulled on two sides. **[to mother and Matthew]** *I think it's important for all of us to understand more of what he's going through in his heart and in his mind. Let me show you today.* **[pulls a chair between therapist and Matthew]** *Bring the chair. I will ask you to tighten your hands* **[Mom and Matthew join hands]** *and then put this chair on this side, your chair on your side, your mother's side.* **[Willie moves his chair in between the therapist and his mother]** *And then I would like you to pull toward him, and I will represent the bad side for a moment, the bad kids in the street. And we will see what happens. Okay, go when I say "three." Let's see who wins.* **[Mom and Willie pull from one side, therapist from the other in the figurative tug of war in which the forces of the family and forces of the street are represented]** *Who won?*

M: I did.

W: I don't know.

T: They did. **[points to Mom and Matthew]**

W: How?

T: They pulled harder.

W: Y'all wanna try again?

Matthew: No. That was the idea, Willie, for us to win. The idea was for the good side to

win.

T: Do you want to try again? He needs to experience that again.

M: **[to Matthew]** *Why don't you sit on this side?* **[they switch seats]**

T: Let's go. Okay, you ask him to help you more and he's helping you. That's good. Okay, one, two, three. **[Mom and Matthew win again. Willie comments that the tug of war was so strong that his hand hurt in the process.]**

W: Ouch, your nails!

Matthew: Whatever it takes.

M: **[laughing]** *Whatever it takes.*

T: ***Congratulations.*** **[therapist shakes hands with Wille's Mom and Matthew]** ***You are very strong. This shows me one more time that when families pull together very strongly, they have a lot of power.***

M: Right.

T: ***And I'm sure that with your strength, you will be able to pull him in the right direction. But we need to remember that there's this other half holding strong. Right? So, Willie, your mother and Matthew will make sure to always pull you to the good side—for a good reason.***

[The supervisor calls and gives the therapist a suggestion.]

Supervisor: ***I think this is good. Just a small suggestion to finish this off and get everything out of it that you can. This family needs to understand what this other side (the bad side) is. They understood it physically through the exercise, but they could also understand it more fully if Willie tells them about the pull of the bad side. In whatever ways he's comfortable doing it, he needs to tell them about the other side, about the pull to do bad things. He could do this for a couple of minutes. And then, he could talk to them about it more during the week. This could go a great distance toward helping them prevent any slips or relapses. So they have things on the right track, and you're saying to them that part of the medicine to get things straightened out is this boy revealing to them and sharing with them what his struggle is about. You'll have him explain what's behind the physical struggle that you created. Okay? Very good.***

T: ***Willie.***

W: ***Yes, sir.***

T: ***Before we leave. . . . We still have something very important to do. Can you say one word that represents the bad side, the side that pulls you?***

W: ***What do you mean?***

T: ***You know, the tough kids, the kids who don't care for life, tell me one word that represent those guys.***

W: ***The bad side?***

T: ***Yeah, one word.***

W: ***Weed.***

T: ***Weed?***

W: ***Right. It's no good. I gonna cut down on that weed, man. It's not doing nothing to me but just hurting me, killing me little by little, killing my family little by little.***

T: **[shakes Willie's hand]** ***Beautiful. I am glad to hear you talking this way. Hopefully***

you will maintain that. **[to Mom and Matthew]** ***I would like this dialog to continue—he will be able to talk more with you. Ask him more questions about this other side, this side that he says he wants to leave behind. In your house, during the week, can this conversation continue? It will be about the other side, the bad side, from Willie's point of view. I think you need to understand his struggle, understand those forces.***

M: Right, to understand what the pull is about.

T: Yeah, what the pull is, and in more depth. And I think he will feel very good inside if he can talk about it with you. So then he doesn't need to feel all alone with that, but he will feel supported by the two of you. I know that you do support him, but he needs to know that in a more direct way. He will then be more like a 15-year-old. Not like a young child, but like a young man. So he needs to put that in words, not to behave like a comedian or an actor. But by talking with the two of you of these issues, I think that that will help a lot. That's a big part of this medicine. Okay?

M: Yes. Okay.

Key Concept:

A key therapist task during sessions is shaping and guiding the family members' discussions to keep them productive, rather than negative and blaming.

Individual sessions are used for more than providing support to deal with the stress invoked in joint sessions, however. There are prospective and retrospective aspects to the individual meetings. Individual sessions with the parents and adolescent are important opportunities and arenas of work, in and of themselves (i.e., the holon/whole-part principle). They also serve linking functions relative to whole-family sessions. For in-session discussions between them to be useful, parents and adolescents must first be able to communicate without excessive blame, defensiveness, or recrimination. Interventions with parents and adolescents aim to reduce negativity—a basic objective in all family therapy (Robbins et al., 1996)—and to position each person for more constructive discussion and negotiation. The renegotiation of the parent–adolescent relationship during this stage of the family life cycle is delicate, it is accomplished in subtle ways, and it is important to developmental outcomes (Fuligni & Eccles, 1993; Pardeck & Pardeck, 1990; Ferrari & Olivette, 1993). The therapist sponsors these conversations, shaping and guiding the discussion to keep it productively focused (G.S. Diamond & Liddle, 1996).

When parents and their adolescent come together in these ways, a teenager's competence in expressing needs and addressing responsibilities is elicited and enhanced. This process and these behaviors encourage and motivate the parents and provide an antidote to parental withdrawal and abdication. These new interactional patterns are seen in the context of other kinds (e.g., first stage) of changes (emotional accessibility or empathy toward other family members, new concrete options [new school, vocational training, job] outside the family). Their interactional patterns reveal the quality of their family relationships. Finding a successful way to

focus on and alter these interactions positively is fundamental to influencing a reduction in adolescents' symptoms and a gain in their prosocial behavior.

An example of such an interactional pattern follows. The therapist has prepared the adolescent in a previous individual session and facilitates a difficult dialog about the sadness and embarrassment both mother and daughter feel. This session includes the therapist (T), the adolescent (F), and her mother Mrs. Torres (M).

T: ***I know it hurts, but could you try to hold back the tears? Francisca, try to answer your mom when she finishes telling you how she felt. I want you to tell her how you feel and what that was like for you.***

F: ***I don't understand.***

T: ***Okay, she's gonna talk to you about how it felt for her, what you did, and then I want you to be able to answer what she is saying and how it was for you.***

M: ***How do you think I felt when they threw us out of the house, the green and yellow one, do you remember? Why did they throw me out? Because you guys were destroying the apartment there. There were gangs, and they were stealing. I felt ashamed, like the worst of the people that lived in those apartments, knowing that we were once one of the best families living in those apartments. You are dragging the whole family down; we moved into this house and it was the same thing. You brought your friends in, you and your sister. You stole from the owner of the house. It was only after you and your sister went to detention that I was able to repair the house—it was full of holes. You have stolen from me, and your friends have insulted me here in my own house. After your drinking and smoking in my own house I felt like the lowest person in the world, like I was not worth anything. I have no reason to feel like that because I have been in this country 19 years and I have raised five kids. They are not perfect, but they have been good kids, and you know that they respected me and they know how to value me as a mother. I give you guys everything. I dress in clothes that others give me so that I can give you guys the best and I want you to understand how I feel. There is no reason why I should be going through this. I feel ashamed, Francisca. You and your sister are not the same as you were before this all started. This is not who you are. You are not the Francisca that I raised or the Francisca that I gave birth to.***

T: ***So, Francisca, you had something to say about your friends and how that is. But first talk to your mom about what she just said. She told you a lot. She told you a lot about her embarrassment. . . her humiliation.***

F: ***Yes.***

T: ***She is telling you is that she has tried to have a good life here, and that what has happened with you and your sister has caused shame. What do you think about that?***

M: ***You don't feel bad about me having to go through all this—you have nothing to say?***

T: ***Mrs. Torres, could you ask her just what it was like for her? You've told her what it was like for you.***

M: How do you feel about everything that has happened? The months that you were locked up in an environment that you don't belong in, separated from your family, your mother. Are you embarrassed to speak?

T: Francisca, we made a deal, remember? This is the time we have available. This is about helping you grow up. And it's about helping you talk to your mom and tell her how you feel and what it was like for you. That's part of having a new kind of relationship with her. Francisca, this will allow you to have some things your way, not everything your way, but have her understand what you are going through. So this is, I think, a big thing. She's sincerely asking you to tell her how was it for you. How was that time, how is it now away from your twin on your birthday? How is that? Will you talk to us about that some?

F: **[shakes her head no]**

T: Why is that? Well, if you can't talk about it, then will you leave us for a little while? You can go in your room for a while. Here is what I want you to do. Go in there and get ready, prepare yourself to come back in and tell your mother how all this has been for you. Can you do that?

F: **[nods her head yes]**

T: How long do you think you need, about how many minutes? Five minutes, is that enough?

F: **[nods her head yes]**

T: So I'll knock on your door in 5 minutes, and you'll be preparing what you need to say to explain how this has been for you.

F: Okay, I'm going to the back.

[Francisca returns]

T: Do you understand that this is very serious? This is your chance to talk about how you feel. You understand, okay, it's not a joke or anything.

F: I'm not laughing.

T: I know, I know you're not. I'm trying to say, this isn't just for your mom, this is for you, too. So tell her what it was like for you going to DJJ **[juvenile detention].**

M: Look at me.

F: I don't know what to say.

M: Say it in English, and she **[the therapist]** *will tell me. Go ahead, look at me and pretend that nobody is here, only you and me.*

F: The words don't come out.

M: And how do you talk to me when we are together in the room, how do you tell me if you want a pair of pants or to watch the TV? Pretend that **[the therapist]** *is not here, then go ahead.*

T: So what was that **[DJJ]** *like, Francisca?*

F: A terrible place.

T: What was bad about it?

F: Because people tell you what to do. Of course, your mom tells you what to do, but these are people you don't know. You can't eat when you want to eat, the food is nasty, you can't take a shower when you want to.

T: What were the guards like?
F: The guards, most of them were nice; the rest were mean.
T: What were the other children like there?
F: They're straight, because some of them are nice, because they talk to you.
T: And you lived in a cell, and where did you sleep?
F: When I first got there it was on the floor on a mattress, and then after I was sleeping on that thing.
M: In the block?
T: Tell her how many people were in the room where you slept.
F: There's two.
T: Tell her in Spanish.
F: There were two people sleeping in each cell, but there are a lot of people in the unit.
T: And what time did you get up? What time did they wake you up in the morning?
F: 5 a.m.
T: Tell her in Spanish.
F: At 5 a.m., she knows, I already told her on the phone.
T: Tell her again now.
F: 5 a.m.
T: And then what did you do? Tell her what you did all day.
F: At 5 a.m. you have to get up, brush your teeth, make your bed, get dressed, and stay there for about an hour. Like about 6 or 7 a.m., you go to the cafeteria to have breakfast; then you walk back to the cell. They put you in the cell, and then you sleep. If there is school at 8 or 9 a.m. you go, and then at noon we go eat. Then we go back to the cell.
M: What about at night?
F: It depends. If the girls are behaving, we get to go outside after we shower. We watch TV, we eat dinner, and then we go back to the cell. If we misbehave, we have to stay in the cell the whole time.
T: What was it like when you had to go to court? What was it like when they brought you up to court?
F: You know how many times I've gone to court?
T: Well, when they brought you from DJJ, what was that like?
F: But that's the thing, I went a bunch of times.
T: Okay, so what did it feel like? Did they put you in the leg shackles to bring you up, were you cuffed?
F: When I was coming to court, yeah.
T: You were cuffed; what was that like? Tell your mom what it felt like to be in those shackles.
F: Well. . . .
M: How did you feel?
T: Was it good, was it a good thing? Tell her what it was like.

F: No, I felt very bad because they treated me like I was a criminal, like I was a dog.
T: So do you think you felt really bad, Francisca? I would have, I mean that must have been horrible, right? Right, so can you, I mean, do you relate a little bit maybe to how your mom felt with it all going on and the eviction and everything, getting up out of the house and everything? Does that make you think a little about how she might have felt? She wasn't in shackles, but in a way she was. Do you understand?
F: Yeah, I do.
T: When she was sad, how do you think what she felt is like what you felt?
B: 'Cause she was sad.
T: Tell her.
F: It was the same. When I was sad, you were sad. You would cry and I would cry, too.
T: That's right. Tell me a little bit about this, it's a big thing coming up for you with Julia in detention so long, but at least she got moved. Tell your mom, tell your mom we talked about that some, about how it is for you with Julia gone. Talk about that a little bit more, how does it feel to have her away?
F: It feels bad.
T: Tell her in Spanish. Tell your mom, turn to her.
F: It feels very bad. I'm going to start crying.
T: That's okay.
T: Can you comfort her, Mrs. Torres? You have all been through a lot and what you have is each other. She needs her mother very much, and you need your daughter very much.
M: It's okay, Francisca, please stop crying.
T: Mrs. Torres, maybe she needs to cry, to cry a lot. I think Francisca has a lot of tears and pain built up in her from all she has been through. She needs you so much to hold her and wipe away her tears, because she is still a child.

In this interaction sequence orchestrated by the therapist, we see the therapist helping the mother tell a story about herself and her parenting, a story about her hopes, humiliations, and past events, then helping her daughter express herself and the hurt and humiliation she, too, has experienced. This segment of the transcript illustrates enactment, the beginning of a mother and daughter reconnecting emotionally following extensive individual work with both. The Family Interaction Module focuses on a "new conversation." These are interactions, facilitated and shaped by the therapist, in which members of a family begin to hear and experience each other in new ways. These are examples of one way to work one of the pathways of change, as well as the small steps that make for new emotional connections and family relationships.

Extrafamilial Module

Goals
• **Create openings for new kinds of skillful transactions with relevant extrafamilial persons and institutions**

- **Eliminate barriers to treatment**
- **Coordinate social systems with an influence on the adolescent's circumstances.**

Rationale

- **Adolescents and families exist in multiple ecologies, and interactions with people and social institutions outside the family can be either helpful or unhelpful to development and problem solving.**
- **Changing important developmental domains such as the adolescent's life skills and family transactional patterns may be necessary, but not sufficient, to change the contextually embedded and influenced lifestyle symptoms of drug abuse and delinquency.**

Procedures

- **Assess multisystemically**
- **Search for concrete, prosocial, development-enhancing alternatives.**
- **Identify advocates for the adolescent and/or parent.**
- **Emphasize neighborhood or community influences.**
- **Emphasize connections with school or work settings.**
- **Emphasize mobilization of support systems for parents.**
- **Work intensively and with a practical outcome focus.**
- **Connect extrafamiliar work to intrafamiliar and intrapersonal work.**
- **Use extrafamilial work as leverage for familial or intrapersonal work.**
- **Schedule, school, work, and, if applicable, juvenile justice meetings during the first phase.**

This family-based intervention does not assume that changing family interaction patterns alone is sufficient to influence the symptoms of problem behavior of youth. (This was an assumption of classic family therapy.) The MDFT approach works with individuals in ways that individual therapists find familiar. In addition, however, this individual work prepares the individual family members for interactions with each other in future sessions. Work with family members together or alone is not sufficient to influence all problem behaviors. Development is influenced for better or worse by many extrafamilial and social forces, and these aspects of the child's ecology are also assessed and targeted as necessary for intervention.

Key Concept:

Extrafamilial system members are cultivated as friends of the family. Each party is motivated and assisted to work in the best interest of the adolescent.

The MDFT therapist works to develop the frequently hidden natural resources in the family and in the multiple systems in the adolescent's life. This broadened focus requires that MDFT be conceptualized as a community-based modality. Some of the systems with which teenagers and families are involved overlap and affect each other. The school, the juvenile justice

system, and the teenager's peer group are primary focuses of assessment and intervention. The therapist helps the family contact school officials, including teachers, school counselors, and administrators. It is important to maintain respect for the roles and functions of each of these systems in regard to the teen. People who are extrafamilial sources of influence, all of whom care about and are working in the best interest of the adolescent, should be cultivated as friends of the family. Using an element of coercion in a treatment program is not a negative thing, if the coercion is coordinated with therapeutic dimensions. Although the MDFT model has never operated within a formal juvenile drug court context, the treatment program is set up relative to the family or juvenile (delinquency) court in a way that has juvenile drug court features. For example, probation officers are called in regularly to bolster treatment by providing information and having input in the teenager's formulations about his or her life.

Interventions in Relation to the Peer Network: The Ecomap Method

The Ecomap (a visual representation of a social world and its influences) method involves the therapist's guiding the teen and the family in drawing a map of the adolescent's social network. Multiple maps may be drawn—one of the neighborhood, one of the school and the teen's peer network there, and one of the family and its extended family and/or system of support. The objective is to make concrete the forces of social influence in the adolescent and family's lives. A multiple systems therapy must understand the multiple sources of influence. An Ecomap offers the same idea in the sense that it is the contextual *lay of the land* that the therapist seeks to understand.

The following vignette illustrates use of the Ecomap in session to get information about core topics in an adolescent's world. It is a prompting device to help the teen talk about some of the salient features of his or her social world. This segment illustrates the teen's quest to develop a new perspective on and an ability to have new kinds of conversations about his or her world. This method facilitated the teen's communication of his interests and goals to his parents in a way that was new for him and, thus, new for his parents as well.

Present are the therapist (T); the adolescent, Mark; his mother (M); and father (F). In this segment, the Ecomap enables Mark to introduce his peer world to his parents. And, in an event not uncommon during sessions that are held in the home, two of the teen's friends come to the house to visit during the session. The spontaneous therapeutic use of this unplanned event in therapy is illustrated in the second portion of the session.

[Mark and his father are sitting on a sofa in the family's living room]

T: ***We've talked about this before and I would like to try something tonight. Mark, I would like you to get a pencil and paper and draw for your dad what you call "the neighborhood." Remember we talked about this before?***

Mark: **[nods yes, gets the paper and pencil, and begins to draw.]**

T: ***You have to tell her*** **[Mark's mother]** ***how you feel. That's how she gets to know what's going on with you. Right now you're not talking to anybody—where does that leave you? That leaves you climbing out the bathroom window, going on a trip to run away to who knows wehre. You know, your dad's right; at some point***

you're gonna run out of places to go. If you could start to tell people in your family how you feel, they could start to do something to accommodate you. That means they can do something to help you get what you want. I think that when you do stuff that gets you in trouble, it's about you trying to get what you want. Am I right?

Mark: **[nods]**

T: Do you have trouble getting what you want?

Mark: **[nods]**

T: Uh-huh. But what happens? Do you think your parents know what you want? **[she motions for the note pad he has been drawing the Ecomap on and takes it]** ***Do they know what you want?***

Mark: I told them I don't want anything.

T: Mm hmmm, but what, you want something.

Mark: No, I don't.

T: I think you do. You want to see your girlfriend. You want to go out in the neighborhood that you're drawing very carefully. You do want to be able to go out to some of these places, right?

Mark: **[nods]**

T: Okay, so that's wanting something. You want to see your girlfriend? That's wanting something. You want to go fishing sometime with your dad, is that right?

Mark: **[nods]**

T: Okay, those are all things that you want to do. When people say that you want something, it's not just things. . . .

M: Material things.

T: It's not just material things; those are probably the least important of anything in life. It's these other things, relationships, people, family. Our job here, and I think I'm failing in this so far, is to help you figure out how to tell people what you want. . . to tell them what's going on inside of you. **[pause]**

T: Let's try it this way. **[she hands Mark the note pad with the Ecomap he was drawing]** ***How close are you to being done with the map? Show me where your house is.***

Mark: **[points to the paper]**

T: Okay, is the neighborhood gonna fit on this page?

Mark: Yeah, it started to.

T: Okay, explain the map to your mom and dad. Okay, is it ready now?

Mark: **[nods]**

T: Where do you want to be able to go in this neighborhood?

Mark: **[pointing at the Ecomap]** ***Okay, I want to go to Juan's house, Billy's house, and Manny's house. Those are the only three houses I want to go to in this neighborhood.*** **[talking to his mother and pointing at the map]** ***You already know where Billy is, you know where Manny is, right? He's the one with the bike.***

M: That's their house on the corner?

Mark: Yeah.

F: Can I ask you a question?

Mark: What?

F: What were you doing all the way on East 167th?

Mark: I was catching a bus to go to my girlfriend's house.

T: Okay, so you were leaving the neighborhood at that point. Okay, they know these people?

M: **[pointing at the map]** ***Well, I know this one. I'm not sure who this one is.***

Mark: You remember, the one with the bike.

M: The skinny one?

Mark: Yes, with the bike.

T: Okay, and who is this one?

M: Mikey. That's the 18-year-old.

T: Okay. So this is one place where they don't want you to go. Is that right?

M: **[nodding]**

Mark: Why?

M: You know we told you that you shouldn't be at Mikey's house.

T: Why is that?

M: Because he's 18. . . .

Mark: There's no law saying I can't go out with 18-year-olds!

M: Yes, there is.

T: Wait a minute; you're saying there's no law, right?

Mark: Mm hmmm.

T: Okay, but the law that you live by is your mom and dad's law. They create your law. You don't just live by police law; you live by their law. That's what this is about.

F: ***Take this Mikey. I've talked to him—Mikey—about my son*** **[pointing at Mark],** ***about getting him off drugs, off pot, and all that. Mikey is 18.*** **[to Mark]** ***Did he talk to you?***

Mark: Yeah, he did.

T: What did he say? Tell us what he said to you, Mark. What did he tell you?

Mark: He said,"You're not going anywhere, you're not running away, you're staying home." He doesn't want me running away.

T: Why?

Mark: I don't know.

T: Because he thinks it would be bad for you or what?

Mark: Yeah.

T: Yeah. Did he say that?

Mark: No.

T: No, but you know, you think that's it? So, is this a place **[pointing to map]** ***where, in the past, you got marijuana?***

Mark: I'd get it from another place.

T: Okay, but is that one of them?

Mark: He has it.

T: Okay.

M: Okay, Mark, admit it. . . .

Mark: He has it! He didn't give it to me!

T: Mark, you're speaking for yourself now. It might not be the best tone of voice you're using with your mother. You've got to let them know how you feel; you're doing it right now, okay? You're doing it. So, correct me if I'm wrong but what you're trying to tell them is that all of these places are places where they have marijuana and you could use. Is that what you're saying?

Mark: **[nods]**

T: Okay. How can we protect you from that? How can we help protect you?

Mark: I can protect myself.

T: How?

Mark: They know! They know I can't smoke!

T: Okay.

Mark: They know!

F: ***I told them that, too: "If he smokes and I know he got it from you, you're gonna be in trouble."***

T: ***Okay, let's go back to the neighborhood.*** **[motioning for map]** ***You want to be able to go to some of these places on your own. Is that correct?***

Mark: **[nods]**

T: **S*o I think that there needs to be discussion in terms of how you can stay safe, how you can stay off drugs. When would you come home, what time would you be willing to come home? This is your chance. It doesn't mean you'll get everything, but we want to hear what you want. You understand? So tell us about it. Tell me, what time would you want to have to come home?***

Mark: Well, the curfew's 6; can't change that.

T: ***Okay. Okay, so could you be home at 6?***

Mark: Well, yeah, I came home at 6 today. I came home at 6 yesterday but I left again. . . 'cause I was mad.

T: ***So. . . what will you do in the future when you get mad, instead of violating curfew, what could you do instead?***

Mark: I dunno.

T: ***Can you think of anything, another way to handle your anger, than getting yourself in worse trouble?***

Mark: **[shakes head]**

T: ***It's something we need to think about and maybe work on?***

Mark: **[nods]**

T: ***So, still, is there anything you want to say about these places? Do you think any of them are safe places for you? Do you think all of them are safe?***

In the second half of the in-home family session, the adolescent's peers are included as part of his ecosystem and made aware of the seriousness of the adolescent's situation. The next session begins with the therapist, Mark, and his parents (M and F) who are joined by two of Mark's friends. The session ends with the friends agreeing to provide support to help Mark.

F: ***He's the kind of kid that, if you say "No," he's gonna do it.***

T: ***Mm hmmm, so what I'm saying is, maybe the thing is that you all will have contact*** **[pointing to Ecomap]** ***with Billy and Manny, and Juan and Mike—have constant contact with them about what they're doing and what he's doing and what their influence is. . . .***

F: ***I even told one lad's father about my son's problem: the drugs, the marijuana, what he's come here for; I told him, and in not a good way. I was pissed off.***

[Peers come to the door of Mark's house]

M: **[addressing Mark's friends, Billy and Manny]** ***He's here but we're busy right now.***

T: Wait, do they understand what's going on with Mark?

M: Yeah, they know.

T: Okay, because I was wondering if this would be a good time to explain how serious this situation is.

M: **[to friends]** ***I don't want to put you on the spot but come in here, because Mark really needs your help. You guys are his best friends.***

T: Hi, how are you?

Friends: Good.

M: Please have a seat.

T: **[to M]** ***Do you want to maybe take this opportunity to talk to them a little bit about what's happening?***

M: Mark has 6 p.m. curfew. Did you know that? Did he tell you about that?

[friends nod]

M: Okay, he drew this map. This is your house, Manny, this is yours, Billy, this is ours right here, this is Mikey's, and this is Juan's. Basically we wanted to know where he goes around the neighborhood, Okay, you guys are his best friends and he likes to hang around with you guys. Now, Mark has a problem with smoking pot. I know you guys smoke pot, too. That's your business. My business is here. Mark cannot smoke pot; he has a curfew. He's gotta be home and his urine has to show no drugs. That's what we're waiting for him to do now. He's got a legal problem, a court problem. If Mark does not follow these rules, he's gonna go in for 3 years for that car that somebody else stole. But he is charged with it, it's a felony. He had a battery charge in school involving a teacher. You see what I'm saying? His anger is getting bigger, his situation is getting worse. So Mark needs help. When he comes to you guys' houses, he cannot be smoking. If you guys have it, don't show it to him, keep it away from him, okay? Remind him, say "Remember, be clean." Because you guys don't have any legal problems. Whatever you do is your business. And I'm not going to go run and tell your parents. But I need your help because we cannot do it alone. Mark needs help because it's hard to stop smoking.

T: If you are really his friends, tell him that you will help him. Help him to not get in any further trouble.

M: And this is no joke. I'm glad you guys came by. I know you feel weird sitting here. You feel like, "Oh God, what are they gonna say or do? Are we gonna get in trouble for this?" No, I am glad you came by. Because that way we're able to tell

you. This way when I see you around and say, "Hey listen, where's Mark?" or whatever, you'll understand where I'm coming from. You see what I'm saying? **[the friends answer "yes"]** ***And like I said, if you guys wanna go someplace, I'll be the taxi. I'll bend over backwards for Mark and for you guys, but he needs help.***

T: Yes, he's in trouble. **[to mother]** ***Do you think it would be all right for them to go in his room now and talk with him? Is that all right?***

M: **[motions for the friends to go; after a few minutes, all the teens return to the session]**

T: I was talking about the 18-year-old **[Mikey].** ***Didn't they say they don't want you hanging around him? Why?***

Mark: Because he's a bad kid.

T: Okay. So that's what they said. That's what your friends are saying.

Mark: I know he used to be, but he's a lot better than he used to be.

T: Yeah, but they still ask you to not to hang out with him.

Mark: Yeah.

F: I'm asking you not to go there. We gotta do something about it, okay?

Mark: They know him, right? But you don't hang around him, do you? **[friends nod]**

T: When you were in your room, your mom did a really good job, I thought, of explaining to these guys about the legal stuff. Obviously these guys like you, so we asked them to help you stay straight, get this together so that you don't go away. And they said yes. How are you guys gonna help him? 'Cause you are his main guys, you are on his map **[pointing to the Ecomap].** ***Billy and Manny, how can you help him, what can you do?***

Friends: Hang around with him more? And not hang around with Mikey.

F: You guys know that he cannot touch marijuana. If you guys light up and he's in the group, the secondhand smoke would go to his bloodstream and show in his test.

To accomplish intervention in these various systems, the therapist must be active, persistent, and upbeat about the possibilities for change. In some cases, the therapist can work preventively, being sure that all concerned extrafamilial influences are working in a manner consistent with the therapeutic goals. Decisions about how best to work with extrafamilial persons are made by the therapist, and the family is critical in revealing and making suggestions about who needs to be included in this therapeutic intervention ring.

Key Concept:

MDFT accesses, enlists, and organizes prosocial community activities and options for teens, thereby supporting the development of interactive bridges among and within

extrafamilial systems.

MDFT explores how multiple systems can be used by the family or individual when developmental, relational, or structural challenges emerge. Essentially, MDFT catalyzes positive relational and systemic resources that were previously unavailable and/or unrecognizable to the individual or family. Therapists must establish and maintain therapeutic alliances with the adolescent, the family, and multiple nonfamilial subsystems. The emotions within and between these multiple systems—stemming from environmental stressors, past or current conflicts, and developmental shifts associated with the transition that is adolescence—require the therapists to operate flexibly. Therapists employ assertive engagement strategies while an agenda is established that supports development of an interactive bridge between and within systems. MDFT therapists meet individually and jointly with systems that support the clinical agenda. The community-based focus of the model supports meeting with these systems in their environment (unless clinically it is contraindicated). Clinical services are framed in sessions with nonfamily systems to promote bringing them on board. MDFT goals are presented in terms that highlight how these services can be conducive to their organizational objectives.

Interventions To Improve School Behavior and Academic and Vocational Functioning

A primary focus in the extrafamilial module of MDFT is on the adolescent's functioning in school and/or job-related activities, including vocational training. Teens receiving treatment for drug abuse and associated behavioral problems frequently have few academic successes and tend to have low commitment to school (Chatlos, 1997; Hawkins, Catalano & Miller, 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). Improving the teen's school performance and behavior and increasing his or her participation in vocational or job training involves therapist interventions with the youth, the parents, and the extrafamilial systems to support these efforts (Rowe et al., in press). Reconnection to school and success in academic pursuits 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. Success in school or jobs or both gives teens a sense of accomplishment, a powerful experience of competence (and frequently of reversing a spiral of failure), and a tangible developmentally adaptive product or outcome (either a GED or high school diploma) that set them on a positive life path and provide new relationships with healthy peers and positive adults. Therapists work closely with school personnel to institute changes in the youth's school functioning, including integration of special programs, tutoring, and vocational training.

These changes necessarily involve cooperation from school officials—a challenge because school personnel frequently become disheartened with and unmotivated to help problem students. School officials may have already tried to support and change aspects of the school environment to accommodate a problem student; when a therapist enters with a request to do more, he or she may be perceived as demanding or unreasonable. A therapist's clinical skills are

not reserved solely for interactions with the family and teen. They are also instrumental in working with extrafamilial sources of influence, including school and juvenile justice personnel. Therapists are taught to think of their actions with these influential others as no less important than, and as requiring the same kind of clinical expertise as, their actions with the teen and parents.

To achieve gains such as reconnecting the youth to school, improving the teen's behavior in school, and improving his or her academic performance, several interconnected interventions are linked to and integrated into the overall treatment plan to address school problems. These interventions reflect the MDFT philosophy and treatment modus operandi—multiple system assessment, strategic thinking, and a formulation of multiple target behaviors, each of which may require several steps, different methods, and contact with different people involved in the problem. Research in this realm is guided by at least two working assumptions.

First, there is the fundamental belief in the importance of and commitment to working in the developmentally important realms of school performance and vocational preparation. These focuses are considered instrumental aspects of adolescent substance abuse treatment, given the interconnectedness of dysfunction as well as the need to help teens succeed not only in transforming a drug-abusing lifestyle but also in creating a pathway away from negative influences. School achievement and job competence have direct implications for helping a teen reduce or stop his or her drug use. These activities are part of the new social and relationship fabric that is woven into therapy. This new context creates new social structures, capabilities, and relationships that are incompatible with drug use. School achievement and job competence are examples of outcomes that protect against relapse and affiliation with antisocial and deviant peers.

Second, the therapist must realize and accept that this work will be difficult, may not be met with enthusiasm by most school officials, and will make the treatment of the teen much more complicated than is the case with more simple, intrapersonally focused family- or teen–peer-focused models. School officials frequently are demoralized by or sometimes are actively hostile to or reject a clinician's efforts to advocate for the problem teen, to ask questions about him or her, and to request accountability from the school to help the student succeed. MDFT therapists are knowledgeable systems interveners. They are able to negotiate within and among the boundaries of multiple systems including juvenile justice, school, and family and peer cultures. The clinician's work in the school arena is an attempt to facilitate change in a system of developmental influence that too frequently fails those teens who need the most help. A therapist's advocacy position, assumption of leadership, creation of motivation and urgency, facilitation of good communication and problem solving, and emphasis on positive week-by-week outcomes, in the context of demoralization and previous failure (of the school vis-à-vis the teen and the teen in the school context), can create stress. The therapist realizes that he or she is not setting out to change the school policies per se but is simply working to achieve new outcomes relative to the particular case. Several elements are emphasized with the school officials:

1. Reasonable and possible practical outcomes for the teen
2. The belief in and support for the influential nature of the school context in

achieving prosocial outcomes with each teen

3. The notion that the therapist takes the teen's school performance seriously, understands interventions in this realm to be a key part of drug treatment, and intends to actively promote outcomes for the teen in school.

These emphases help soften and make more tolerable the perceived and actual demands made by the therapist's assertive stance to improve a teen's school outcomes. If school officials think of the therapist as an advocate for some other cause, such as changing school policies relative to all problem students rather than a motivation that stresses demands being made on behalf of the therapist's client, they are likely to dismiss the therapist's efforts and not cooperate.

The balance that the therapist is trying to achieve is not unlike those in other areas of MDFT intervention and change. Support is always mixed with challenge and requests for change in one or more arenas. Change in one realm is used to prompt and bolster change in others. The following section gives the concrete steps taken by the therapist who would like to improve the teen's school or job functioning in the most direct, expeditious, and effective way possible—by intervening on the family's behalf relative to the school.

First, a staff meeting with all relevant school personnel is arranged as soon as the adolescent begins treatment to determine whether the teen is in the most appropriate educational placement. The therapist gathers information about the teen's school history and current performance from all relevant sources. Such information includes grade reports, feedback from teachers, and the adolescent's own impressions and may include the exceptional student education (ESE) program, psychoeducational testing, and the individualized education plan (IEP). All available school resources (e.g., dropout prevention programs, vocational rehabilitation, alternative school programs) are assessed and if necessary used to provide informed feedback to the school and family regarding the most appropriate course of action (e.g., transfer to a new classroom or alternative school) for the adolescent. Although the school retains official responsibility for acting on recommendations, the therapist's close tracking of these matters is often helpful in achieving the best fit for the adolescent. Sometimes the therapist provides links with services that the school in not able or willing to offer. One example is using teachers in training at a local university for free individual tutoring services. Other agencies may assist in providing resources for academic remediation. For example, the family service planning team at the county community mental health center often has discretionary funds available for such services.

Relationships with teachers, counselors, and administrators are developed and fostered throughout treatment. Therapists actively encourage and coach parents on how to connect or reconnect with the school. For some parents, this contact is the first time they have interacted with school authorities. Case Example E. illustrates some difficulties the therapist may encounter and the proactive stance that is necessary to facilitate positive, adolescent-focused activation of the extrafamilial school environment.

Case Example: E

E. is a learning disabled (LD) student in middle school, who at age 14 was 2 years behind in grade level and reading at the third-grade level. When he entered the MDFT program, he had recently been transferred from juvenile detention into a mainstream high school classroom serving emotionally handicapped students with high reading levels. His educational records, however, had not been transferred from the middle school. He "hated school" and was failing, but he attended despite his deep frustrations. E. understood that something was wrong with his academic placement and 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, E. 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 E. was, in fact, functionally illiterate, and obtain records from all his past schools to corroborate his difficulties and get information on what avenues had been pursued to facilitate school adaptation. Present at the meeting were the head of the 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 E.'s records, offered only negative feedback about his behavior in class and lack of responsibility for his assignments, had minimal information about his reading and writing levels, and pessimistically rejected the therapist's requests for changes in his educational plan.

Because the school had clearly not met E.'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 program. In response to the therapist's systemic activation attempt, the regional director convened a multidisciplinary team (M-Team) meeting, including all school, county, and regional personnel mentioned, as well as his therapist, to assess E.'s needs. The regional director ordered a psychological assessment, a complete vocational interest inventory, a reading tutor, and a private reading program to meet E.'s educational needs. His Individual Education Plan (IEP) was reviewed as part of the M-Team meeting, and the therapist pointed out that all 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 Americans with Disabilities Act. Several changes were made to the IEP, and the outcome of the meeting was the decision to enroll E. 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 E.'s educational plan would not have been accomplished without the therapist's strong and effective advocacy. Fundamental

to that intervention, however, was the therapist's knowledge of how the school system works and her experience in advocating for teens. We define therapists' knowledge base of school system procedures and policies (which parallels the procedures and policies in juvenile justice work) as clinical skill in the same way that their work with the teen or parent constitutes therapeutic expertise. These skills are no less important than any others in MDFT. This case illustrates how advocacy provides an effective way of combating the hopelessness and helplessness that permeates these families' lives. The responses of the school system to the therapist's advocacy engendered a sense of optimism that empowered this family to believe it could have effective interactions with school and other systems leading to changes in E.'s life.

The clinical team also explores the option of tutoring adolescents struggling in certain classes or those with obvious problems in learning. Success in this area can have positive effects by boosting the teen's level of academic or scholastic functioning, reconnecting the teen to the school, providing a sense of pride and accomplishment in schoolwork done well, 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). Again, this intensive work is done because school disconnection and failure are consistent predictors of chronic antisocial behaviors and substance abuse (Flannery, Vazsonyi & Rowe, 1996) and because success in these realms in an important correlate to creating a drug-free lifestyle. MDFT therapists have been creative and resourceful in procuring tutoring services at no cost. Case Example S. illustrates the use of tutoring in MDFT. In this case, a practicum graduate student was recruited from the University of Miami School of Education's Learning Disabilities program.

Case Example: S.
S. was an intelligent teen who failed a grade in school because of involvement with drugs. She was held back and became concerned about completing high school, passing her State competency/achievement tests, and keeping up with her course work. She very much wanted academic help. S., her therapist, and S.'s family discussed her options, and all parties agreed on tutoring. The therapist spoke with the tutor, describing the situation and explaining S.'s needs, and the tutor agreed to work with the teen. The therapist and tutor went to S.'s house, and the tutor quickly developed a bond with the family. S. and her tutor began meeting twice each week for 3 months to prepare for her competency tests, and the tutor checked in weekly by phone with S.'s therapist. The tutor responded well to S.; she was sensitive to her but firm about her work. The tutor's continual affirmation enabled S. to achieve a sense of proficiency. By the end of the semester, after 12 weeks of work, S. passed her competency tests, receiving her highest grades since elementary school.

Intervention Guidelines To Improve School Behavior and Academic and Vocational Functioning of Drug-Involved Youth

1. The therapist must be clear about the fundamental importance of assessing, focusing on, and obtaining outcomes in the school or job domain of the teen's functioning. Positive changes in these realms are important supports and motivators for changes in drug use.

2. The therapist must be clear with the teen and parent about this treatment focus and explain why it is related to the teen's success in the program and how success in school or with a job connects to establishment and maintenance of a drug-free, prosocial lifestyle. Obviously, these are not one-time communications. They are stated and discussed at treatment's outset, as well as throughout the process of the program.

3. Family members and teens need help in understanding, negotiating, and navigating school, academic, and vocational systems. Most clinically referred teenagers have experienced frustration and failure in school and job realms. Many have given up hope that any new effort on their part can yield new results. A therapist should not assume that adolescents and parents are knowledgeable about school policies or procedures or are able to interpret correctly complex or cryptic messages from schools. Just as therapists intentionally mediate and position themselves between the juvenile justice system and the youth and his or her family, therapists adopt the same stance between the adolescent and his or her family and the school system. Although the ramifications and implications of each set of these systemic transactions are different, they have similarities. Therapists conceive of themselves as part advocate, change agent, and facilitator in their work with schools and legal systems. Their bottom line, as always, is the youth and his or her family—the therapist in each context is trying to promote positive prosocial behavior, facilitate a fair and facilitative process between the social institutions and the youth and his or her family, and help the family keep its focus on how to achieve positive and healing outcomes and concrete alternatives and success in each of these realms.

4. School personnel will not necessarily be motivated to cooperate with the therapist's efforts to determine how to make the teen's school experience more successful. Therapists walk a tightrope between too much and too little advocacy and between too much and too little understanding of the parents' and school's previous experiences with a particular teen. A therapist's clinical skill and systems knowledge are instrumental to successful work at the interface of the family, teen, and school systems.

5. The therapist is an advocate vis-à-vis the school and a coach vis-à-vis the teen and parents. The therapist works with each subsystem to prompt new attitudes and behavior relative to the other subsystems. Just as the therapist works with the teen alone to mediate and prompt new behaviors with the adolescent's parent and intervenes with parents individually to help broker a new relationship with their teen, the therapist also works with the teen and parents about becoming more involved at school and preparing the family for school requests and meetings. The therapist directly interacts with school

officials to advocate for the family's needs and facilitates contact and adoption of a positive attitude toward the teen and parents. Therapists also help parents and teens develop more positive attitudes and action plans regarding school.

6. Emotional reactions by school personnel, such as fear of the teen's continuance in a particular school or on the youth's or parent's part as well as schoolwork/academic ability demoralization issues, are commonplace. Strong reactions to a therapist's efforts by the family, adolescent, or school should not deter a therapist from a thorough multiple-system assessment and formulation and implementation of an action plan (e.g., testing, tutoring, behavioral management, job training, alteration of classes taken).

7. As the leader of this therapeutic effort, the therapist must convey an upbeat attitude to all parties. This positive energy must be accompanied by a solid, reasonable, and workable plan, in which everyone's roles and responsibilities are enumerated, as well as statements about the amount of time that can be committed by each team member.

8. Well-articulated plans can still fail. Knowing how a plan may fail is an important part of being a therapist. Knowing how to minimize slippage or outright failure is vital. Enlisting and motivating family members and the teen in the daily behaviors required to help the teen succeed in school are key to success. Good plans that are underorganized or not sufficiently attended to on a daily or weekly basis are likely to falter or fail.

9. Titration of a therapist's involvement in these organized therapeutic plans is always a challenge. Early on, the therapist is active and directive in setting up a plan, and although the family members and school officials are involved in crafting suitable alternatives, the therapist must be prepared to supply considerable energy and ideas to the new plan. Over time, of course, the plan to help the teen reconnect to school and succeed academically is something for which the youth, parent, and school must be responsible (relative to the individual roles each has to play). Thus, as the weeks of treatment unfold and the teen's new plans for school or a job are implemented, the therapist becomes more of an outside consultant rather than an inside player.

10. Finally, as is the case with MDFT therapists generally, the therapist watches and calibrates school functioning change relative to other areas of work. Gains in other realms, in the family environment or parent–adolescent relationship, for instance, are used as supports and motivators for new discussions and plans in other, related realms of functioning. The MDFT therapist, in collaboration with the family members, orchestrates the focus and effort in the therapeutic system according to the overall individualized treatment plan and in the unfolding of problems and successes in each area of work. Changes in school functioning facilitate access to and work on the self of the teen, helping him or her, for example, develop an identity that includes self-efficacy, competence, and the capacity to overcome previous failure and obstacles. Changes in school behavior or academics also can be used in a therapist's work with parents. Parents of clinically referred teens can be pessimistic and negative in their view of their teen's

abilities and potential. Therefore, when change in school behavior or academic involvement begins, this evidence of possibility and hope for a new, prosocial, non-drug-using future is brought to the parent and family sessions.

Decision making

A challenging aspect of the academic or vocational module for the therapist may lie in determining the combination of academics and vocational training that would be most beneficial for the adolescent. Case Example M. illustrates this decision-making process.

Case Example: M.
M. is a 14-year-old who was not attending school when he began treatment. M. would either skip school entirely or walk out of class on nearly a daily basis. He had been referred to an alternative school because of truancy, selling marijuana on campus, and other behavioral problems, but he had not begun attending the school. He was in 9th grade and had been held back once. Although M. was demonstrating deviant behavior, the therapist preferred for him to attend a school other than the alternative school, as her determination was that he was not "as hard" as other students at the school and she feared for his safety and further delinquency induction. The therapist decided that the most immediate concern was that L. attend school during the day so that his time was structured. As a result, she held several meetings between the school and parents to get them working together to ensure that M. was in school. The school was reluctant to accept him back due to his previous behavioral problems, so the therapist's goal was to work with the school to find a viable alternative. This necessitated bringing the region administrators on board, and when the school officials understood the therapist was not "lobbying" to get M. into the same school, they began a collaborative effort to find a school that would provide M. with more structure but would be a more healthy environment for him. While the therapist and school were able to reach an agreement on a school placement that provided M. with more structure and individualized attention, the therapist needed to have several meetings with the parents and with M. to prepare him for the school interview process. M. was able to convince the new school officials that he was ready to turn his life around and saw that his regular school attendance was a big part of this. M.'s reaction to the intake meeting was positive, and he has responded well to the new school environment.

In conclusion, the academic portions of the adolescent's world are complex and multifaceted, and the therapist must be adept at negotiating extrafamilial systems and advocating for the adolescent to address these areas comprehensively. When the therapist is successful in this endeavor, as illustrated in some of the case examples, the effect on the adolescent can be extremely positive and contribute to improvement in his or her overall functioning.

Interactions with teachers and school counselors identify and promote goals that are mutually supportive—that is, enhance parental investment in the adolescent's development and the school's desire to be supported by parents. MDFT clinicians work to identify ways that they

can be supportive of the school's goals (just one of multiple nonfamilial systems) so that potential boundary and role definition sensitivities are transcended. The objective is to facilitate positive interactions that embody a common focal theme—pulling together for the teen and family. Supportive and followup efforts by clinicians in their interactions with families and schools determine how sound this newly developed resource bridge will be. To help adolescents and families be more connected and involved with multiple subsystems, MDFT clinicians meet at a variety of locations and with various combinations of family members and extrafamilial systems. Decisions regarding with whom and where to meet are made in accordance with the overall clinical objectives and the individual features of the case.

As relationships are reinforced or built, traditional relationships between and within family and nonfamilial systems are challenged in a manner that is intended to promote positive change. The challenges promoted through MDFT are often experienced by the family and nonfamilial systems with some hesitation. This situation is true at the outset of MDFT as well as during ongoing contacts. Avoid attributing hesitation (in familial, individual, and nonfamily systems) to resistance to change or resistance to alternative interactions, for example. Rather, this hesitation should be understood in terms of the natural difficulty of facing and experiencing challenges arising in this kind of work (Liddle, 1995).

Key Concept:

A teen's or parent's hesitation about involvement in a treatment program is normal. The therapist's job is to facilitate the growth of motivation in treatment.

Collaborating With the Juvenile Justice System: Diversionary Programs

In collaborating with the juvenile justice system, therapists work hard to develop a relationship with juvenile justice personnel. Sometimes this will entail work with juvenile probation officers, but more frequently, in the case of younger adolescents, this involves work with diversionary programs. Miami-Dade Juvenile Assessment Center has a Pre-Arrest Diversion Program (PAD) in which youth arrested for the first time with misdemeanor charges are referred for counseling rather than entering the court system. If the adolescent successfully completes the program, the arrest will be removed from his/her record. This is extremely important work. PAD personnel have a certain amount of influence over the disposition of a teen's case. They can recommend for or against placement. If a teenager needs to be placed, probation officers can recommend a treatment facility over detention. The relationship with juvenile justice personnel is also important because they will have access to valuable resources that the therapist and family may need—connections with training and job programs or with school personnel and treatment facilities.

In the cases in which the adolescents had probation officers, the following procedures describe our intervention efforts. The relationship with the probation officer begins when a therapist places a call to a probation officer at the very outset of a case. The therapist asks about the probation officer's experience with and knowledge of the teenager, whom he or she often has known long before the therapist met the teenager. The therapist asks for the probation officer's "take" on the teenager; does the probation officer have any opinions or insights into what has

happened with the teen and family? The therapist introduces the subject of collaboration early in the conversation, making sure the probation officer realizes that the therapist is taking into account the pressures of the probation officer's caseload. The therapist asks the probation officer what times are convenient to check in, because the therapist knows that the probation officer is always busy and often out of the office. The therapist inquires about the nature and frequency of the probation officer's meetings with the teen, the frequency of urine drug screens, and the expectations for the teenager's cooperation. The therapist assures the probation officer that the clinical work is, in part, oriented to helping the youth and his or her parents meet the requirements and obligations of the juvenile justice system.

The emphasis is on what the therapist can and will do and only secondarily on what the probation officer may have to offer. The therapist stresses not wanting to add to the probation officer's burden and that the therapeutic or program focus is on the family and coordination of effort. The therapist asks about upcoming court dates and gets the probation officer's take on what may happen there. The therapist explains the philosophy and parameters of the treatment program but is careful to avoid clinical buzzwords and elaborate analyses. Some probation officers expect to find treatment programs are not practically oriented. The therapist looks for common ground and points of connection.

All efforts in this early phase of a case are aimed toward the collaborative relationship to follow. "Can I count on your support of our program's efforts?" the therapist may ask. "Is it okay with you if I call you and check in regularly, so we can share information and make sure we're on the same page?" Beyond alliance-building, however, the clinician must work to build and maintain a working intervention-oriented relationship with the probation officer.

Therapists and probation officers may represent radically different orientations and ideas about what is needed to help the teen. Clinicians often must convince probation officers that the focus on parent–adolescent relationship dynamics will pay off in practical terms—in better parental monitoring and the development of greater emotional resources in the family. It is best to avoid abstract language, to use dialog (conversations between colleagues with a common purpose), and to collaborate in the best interest of the youth. These conversations must inform the probation officer of the parameters and intentions of the program.

Therapists and probation officers focus on actual case material, using it to forge a relationship and build collaborative bridges. "You know, I agree with you about how hard it's been for Mrs. Williams to manage things, and she's done a pretty bad job in the past setting limits with John. I think she's depressed, and we're getting her some help with this so she feels less overwhelmed. One of the things we do a lot here is help parents see how they can take care of themselves and their kids at the same time. It would be good if we had a little time. Is there any way we can slow the placement process down? I think we've just gotten started."

It is important for therapists not to let the relationship languish during periods when things are going well.

The interaction and interdependence of MDFT and the juvenile justice system

Most probation officers focus on the teenager as an individual; MDFT has a family focus. The MDFT clinician is interested in identifying the internal logic of teenagers' choices and difficulties while helping the adolescents identify their motivations, enhance their options, and

improve their problem-solving skills. Even the probation officer who is highly motivated and involved "pulls the plug" on treatment. Therefore, the therapist must assess carefully the probation officer's motives and style before proceeding.

Likewise, the therapist must evaluate how close parents are to abdicating total responsibility for the teenager, how disillusioned they are, how angry. What resources—external and internal—do the parents bring to building a more reasonable relationship with their teenager?

The probation officer most likely will be confronting a teenager whose attitude toward authority is distrustful and who may behave in an outwardly defiant manner. The notion of being monitored by an outside authority—the juvenile justice system—that has the power to influence events in her or his life is likely to stir up any and all of the adolescent's current or lingering resentments toward systems in general. Pride and self-respect may demand that an adolescent not submit to systemic authority as a matter of honor. "Beating the system" is, for some teenagers, an ingrained response. For some teenagers, there may be a family legacy of hurts, disappointments, and slights meted out by the systems with which the teenagers have been compelled to interact.

A collaborative, purposeful, youth-oriented alliance

Every new relationship with a probation officer contains within it the seeds of either advancement of the teenager's agenda or a potentially disastrous and premature ending to his of her hopes of advancing that agenda. If the teenager is able to perceive both the necessity for and the possibility of a collaborative relationship with the juvenile justice system and the probation officer as that system's representative, then the teen's attitudes toward the system will change. The therapist lets the teen know that if he or she participates in the treatment program, the therapist will work hard to slow things down with the probation officer and try to affect any court action. Most teenagers are happy to have the therapist working with them in this manner, but a number continue to have urine screens that show drugs are present, miss appointments with their probation officer, or get into more trouble.

The therapist responds to missteps in a challenging but supportive way as well: "Look, I need you to be doing your part in this. I can't help things change or slow things down if you're doing this stuff." In addition, the therapist may be able to help a parent support the necessary actions on the part of the teenager. The therapist at all times encourages parents to work together with other adults—therapist and probation officer—out of love for and commitment to their teenager.

Sometimes parents are reluctant to state their disagreement with a probation officer's plan for their teenagers, and the therapist must help them articulate such differences so that a reasonable plan can be agreed on. Sometimes parents feel their teenagers do not deserve a second chance when they have gone to bat for them so many times before; sometimes, however, it can be equally difficult to convince parents to do things that are not purely in support of keeping the teen in the probation officer's good graces. Therapists may have to encourage parents, for instance, to inform a probation officer about violations of probation when this is in the service of

helping a teenager confront the consequences of his own actions. These dilemmas offer opportunities and are at the core of the therapist's work with parents.

A therapist needs to discuss what underlies a "bad attitude" toward the legal system and the ramifications if this attitude toward the probation officer persists. The therapist needs to talk about how hard it is for teenagers to be monitored and how the teen may be tempted to chafe at such an oversight, with a view toward problem solving together. These statements are put in the context of the potential influence that the teenager can have over the outcome of events.

More concretely, the therapist monitors the adolescent's attendance at appointments with the probation officer, shares contacts and resources with the probation officer, helps the teenager prepare for court appearances, discusses how to use the probation officer as a resource, and encourages parents to do these things for and with the teenager.

Repercussions of Lack of Involvement in Extrafamilial Subsystems

Because there was less juvenile justice involvement in this sample than in previous studies, the majority of cases in the CTRADA ATM study did not necessitate working with judges. However, consistent with MDFT's interventions in multiple systems, we applied methods for working with judges as appropriate. The case example below illustrates the intense repercussions that occur for both adolescents and families when therapists are unwilling to follow MDFT protocol and maintain contact with both the family and the extrafamilial subsystems.

Case Example: B.
Throughout B.'s case, the therapist had not been involved with or in contact with key persons outside the family. In an early session, he was unaware of the involvement of a "tracker" from the probation office. Once he became aware of the tracker, he gave no indication to the family that he wanted to get in touch with the tracker. In a later session, the therapist suggested the mother deal with legal aid and also get the adolescent examined by a psychiatrist. The mother responded with harsh resistance and criticism: "I come here, I ask for these things. Time goes by, nothing's done. There are no recommendations." The mother then criticized the therapist's efforts as superficial, prompting a defensive response by the therapist. The therapist finally agreed to call the school and attend a meeting with the mother.

Later a supervisor discussed what had occurred with the therapist. The therapist was quite resistant to becoming involved with systems outside the family. He believed that the support he provided directly to the family would enable the family to deal with external systems on its own. During the first sessions, it became clear that B. was involved with a probation officer, the tracker—a school counselor who talked with the mother frequently—and, of course, with teachers on a daily basis. It now became apparent that legal aid would be brought into the case. The therapist had also been absent for a month; during that time, B. had broken into an apartment with some friends

and vandalized it, as well as stealing $10 from a family member's car. It became obvious that this was a crisis; eventually B. was placed in residential care.

It is imperative that the MDFT therapist maintain close contact with key members of these systems. It is unrealistic to expect families to be able to navigate these complex and at times resistant systems on their own, much less attempt to coordinate efforts across systems. Moreover, members of external systems can provide valuable information and resources for the therapist. Conversely, an impasse within an external system can undermine work the therapist is trying accomplish with the family.

V. Working the Model:

Transforming Negative Processes into Key Therapeutic Work

V. Working the Model: Transforming Negative Processes into Key Therapeutic Work

This section illustrates important aspects of the working phase of MDFT using a critical topic—transforming negative processes into something therapeutic—as the backdrop for how to work core themes.

Negative Emotions and Problem Behaviors

Theory and data have converged to form a picture of the role of negative emotion and the development of problem behavior (Dodge & Garber, 1989). A major review underscored the "centrality of positive affect in the organization of prosocial behavior" (Collins & Gunnar, 1990, p. 393). Blechman (1990) described the relationship between moods of individual family members, their contact with each other while in these moods, and individual and family functioning. Blechman believes that "family members who are often in good moods are primed for competence and shielded from psychopathology, despite cultural, biological, and socioeconomic handicaps" (1990, p. 221). Similarly, Wills (1990) discussed how supportive relationships among family members influence the emotional states of adults and children and how emotional states and processes affect the health status of family members (i.e., through stress buffering).

Along the same lines, Carlson and Masters (1986) demonstrated how positive affect buffers children against some of the effects of negative affect. Ingersoll and Orr (1989) theorize that certain emotional patterns (e.g., being upset, lonely, tense, sad, nervous; having problems sleeping or making friends; self-destructiveness) predispose adolescents to risky behaviors. "It may be that individual styles of coping with social stresses are the primary moderating variables that increase or reduce the risk of engaging in problem behaviors" (Ingersoll & Orr, 1989, p. 405).

The regulation and expression of negative emotion have been critical topics in the clinical literature (Hooley, 1985; Koeningsberg & Handley, 1986; Leff & Vaughn, 1985) and basic research for some time. Affective processing ability has been linked to social competence in children and adolescents (Sroufe et al., 1984). Gottman's work with children and married couples emphasizes the link between negative emotion regulation and effective functioning (Gottman, 1983; Gottman & Levenson, 1984). Lindahl and Markman (1990) believe affect regulation to be a critical developmental task with couples and families. They hypothesize that a couple's ability to regulate negative affect in their marriage is linked to marital quality, which itself is related to the parents' ability to regulate negative affect in their interactions with their children. The parents' emotion regulation in interactions with their children, obviously, plays a central role in their children's predominant affective tone.

The predictive power of negative affect on parent–child interactions and child outcomes is well documented (Patterson, 1982). Frequent and intense negative emotional expression is connected to a variety of clinical problems, including delinquency (Rutter, 1980) and drug abuse (Kandel, Kessler & Marqulies, 1978). The connection of emotion systems to the development of drug abuse is a core construct in a promising line of research by Pandina and colleagues (1992). Their early studies have found that adolescents with an emotional profile of pervasive and

persistent negative affect, energized by a context of prolonged and heightened arousability, progress from experimental drug use to abuse.

Emotion regulation has also been discussed in terms of its adaptive functions, for instance, as a way of coping with negative self-feelings or stress (Saarni & Crowley, 1990; Wills, 1990). Three critical factors influencing emotion regulation (each with different implications from a target-of-intervention perspective)—temperament, cognitive development, and socialization (Saarni & Crowley, 1990)—are present in the case of Chris, which follows.

Emotions and Problem Solving

Clinical theory, in accord with empirical work by investigators such as Pandina and colleagues (1992), suggests that chronic negative emotion detours problem solving and, over time, erodes relationships (Minuchin, 1974). Forgatch (1989) believes that negative emotion can affect the problem-solving process in several ways.

- It may affect the representation of the problem, making solutions seem improbable.
- When a person is too focused on negative experiences, it can impede his or her ability to generate helpful solutions.
- It can affect interaction because negative emotions create a climate in which people are less motivated or able to come up with a solution.

The clinical example that follows illustrates these processes. In a study with important clinical implications, Forgatch (1989) established clear links between negative emotion and ineffective problem solving involving parents and adolescents.

Emotions and Dysfunctional Family Patterns

Earlier eras of family therapy focused on overinvolved parent–adolescent relationships (e.g., Kaufman, 1985; Minuchin, Rosman & Baker, 1978). Today, in a trend that may reflect some societal processes (see postmodernism's charge of fragmentation; Gergen, 1991), increased attention is given to disengaged family systems. Research teams see patterns of parent–adolescent disconnection and disengagement in their clinical samples (Liddle, Dakof & Diamond, 1991; Volk et al., 1989). These relationship problems, often characterized by intense negativity and longstanding resentments, have been very difficult to treat (Liddle et al., 1992).[4]

[1] Although the focus is on adolescents, we cannot conclude this section on emotions and dysfunctional family patterns without mentioning the importance of parents' emotions as a major determinant of the adolescent's emotions. In a comprehensive review of emotions in the parenting literature, Dix (1991) concluded: "Perhaps more than any other single variable, parents' emotions reflect the health of parent–child relationships" (p. 4). Dix presented a systematic, clinically relevant framework for understanding emotions' role in parenting. His model emphasizes (1) child, parent, and contextual factors that activate

Case Example: Escalating Negative Emotion

The clinical illustration below examines one of the most difficult and, according to some (Doane, Hill & Diamond, 1991), most change-resistant problems faced by clinicians—chronic, stable, and quick-to-escalate negative emotional exchanges between family members. Interactions of this kind have been identified from several theoretical perspectives and linked to the development of child and adolescent problems (see review by Loeber & Stouthamer-Loeber, 1986).

Segment Introduction

The first segment of this case gives a "baseline" of a typical, negative emotional exchange. It illustrates progress achieved during the session. The last segment presented (segment 6) occurred 30 minutes after the baseline segment. The segments show different kinds of clinical techniques; however, at a macrolevel, they are consistent in showing a single therapeutic strategy central to MDFT. Known as the *shift strategy*, this technique is used to change in-session impasses between parents and adolescents (Liddle, 1991). These emotional stalemates are broken by changing the focus of the discussion during the session. Frequently this involves moving the conversation to a more personal level. This method accesses certain emotions (e.g., the parents' commitment and love, an adolescent's hurt feelings) while blocking, at least temporarily, others (e.g., resentment) (G. S. Diamond & Liddle, 1996). Emotions are targets of work as well as mediating variables. In this sense they are intervention focuses that can potentiate entry into other domains of functioning. For example, a focus on emotion may be helpful not only for motivation enhancement but also for intrapersonal or interpersonal processes that can lead to the cognitive or behavioral domain. All the segments, from the baseline to the final segment, are presented in the order in which they occurred.

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parents' emotions; (2) the orienting, organizing, and motivating effects that emotions have on parenting once they are aroused; and (3) the processes parents use to understand and control emotions.

The case[2] involves Chris, a 16-year-old boy who is the youngest of three siblings (the older two live outside the home). Chris lives with his mother. Although his parents are separated, his father is involved in his treatment. Chris is currently on probation for drug possession and violence toward school personnel.

Segment One (Baseline): Negative Emotion in Action

Mother (M): I'm sorry.
Chris (C): What? At least I admit when I'm wrong. You never do. F___ you.
M: Well, I don't remember it that way. What I remember. . . .
Father (F): [to Chris] All right, all right, don't talk that way.
C: [to his father in a very explosive manner, sitting up in his chair, arms waving, finger pointing. The therapist sits forward, ready to intervene.] Just shut up. You don't live at my house, you don't have nothing to do with this at all. So, why don't you just leave? Just shut the f ___ up. You're never f___ing there, you're never f ___ing there. . . .
F: I'm supposed to be there.
C: Even when you lived there. . . you were never in anything. So, just shut up.
F: I come here every Monday night.
C: You think I want you to be here? No.
F: No, but I come here anyhow.
C: I don't want you to be here, so don't f ___ing lay that on me.
F: I'm not laying it on you.
M: Chris, he is your father.
C: He never acts like it, never. He's my biological father, but he's never acted like my dad ever in my whole life. I don't need a father now.
Therapist (T): Is that true?
F: I guess it is. If he says it is, I'll go along with that.

[2] These particular sequences were chosen for this section because they are good examples of (1) the selected clinical problem, (2) the therapy interventions used, and (3) the change process as it is currently understood.

This segment illustrates two important points made by Safran and Greenberg (1991) in their discussion of the role of emotions in psychotherapy. First, it shows how "emotions provide action disposition information" and, second, how "emotional responses are mediated by anticipated interpersonal consequences" (Safran & Greenberg, 1991, p. 7). Cumulatively, negative emotions of this kind are developmental threats to the adolescent's self system (Grossman and August-Frenzel, 1991). Particular knowledge like this, along with the developmental sensibilities guiding MDFT (i.e., that treatment retracks normal individual and family developmental tasks), is essential. The following passages give numerous examples of negative emotion in the life of this adolescent.[3] Some family treatment models emphasize process over content (Hoffman, 1981). In MDFT, however, the particular content of the discussion is understood as critical to the elicitation and exacerbation of the intense, negative emotional arousal. This understanding includes historically significant and contemporaneously enacted intrapersonal and interpersonal relationship themes. Themes of resentment about past hurts and the adolescent's nonacceptance of the parent's attempt to adopt a parental role are frequent in-session topics.[4]

Knowing about emotions as action tendencies (Fischer, Shaver & Carnochan, 1989) gives a therapist the confidence to intervene in a conversation progressing down a disastrous path. During an interview or session, a therapist's behavior is informed by this knowledge. Therapeutic goals include reinstitution of the attachment between parent and adolescent. Changes in this relationship serve historically relevant purposes (e.g., healing past resentments) and present-focused purposes (e.g., successful problem solving of everyday conflicts is one area in which the renegotiation of the parent–adolescent transition occurs).

Segment Two: Focus and Framing

T: Chris, right now, it seems to me that it's as if your whole life with your father is flashing before you. You've been mad at him for years; I mean, is that accurate?
C: Yeah.
T: Right now, every inch of this guy is tight and really angry, right?
C: Yeah.

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[3] Although we have yet to analyze these data, our clinical research has been concerned with characterizing the emotional processes and characteristics of the adolescents we see in treatment. In one of our studies, for instance, we used the Millon Adolescent Personality Inventory to assess the emotional self system of adolescents.

[4] Parenting is a complex area of the field experiencing a renaissance of attention and systematic study (Dix; 1991; Sigel, McGillicuddy-DeLisi & Goodnow, 1992). Elsewhere, we have described methods designed to help parents reclaim their parental role (Liddle, Dakof & Diamond, 1991). Unfortunately, these assertions of parental responsibility frequently come in the role of increased attempts at control (i.e., introduction of more control attempts into a system of relationships that already has an overabundance of control issues and attempts). Not surprisingly, our research found these behaviors to be some of the very ones that lead to greater estrangement on the adolescent's part (G. S. Diamond & Liddle, 1996; Schmidt, Liddle & Dakof, 1996).

One aspect of dealing with emotional reactions is to focus on the appraisal of events or relationships (Lazarus, 1991; Shaver et al., 1987). Therapists' characterizations of situations are intentional and precise, selecting certain elements of the drama for focus. Understanding emotional reactions in MDFT is not an objective per se (although this may occur). Characterization or, in family therapy terms, creation of new realities (Minuchin & Fishman, 1981) or frames (Alexander et al., 1983) is a practical and at least temporarily useful accomplishment. These realities or frames are also new in-session territories of operation, as they are called in MDFT. They are intended to serve as a more workable foundation on which new work on one's self and one's relationships occur. In the previous sequence, the therapist first reestablishes the longevity of the problems—thus presenting the historical reason for why Chris' emotions would be so strong. This construction is preferable to pathological personality ascriptions that perpetuate beliefs about the other's incompetence and contribute to a chronic negative emotional tone. Then the intensity of Chris' experience is acknowledged and named. The intent is to reduce the fears associated with this experience (both his father's and Chris' own concerns about his lack of control).

T: And, Chris, you're angry at your father.

The interpersonal aspect and target of the behavior also are named.

T: [continues, to Chris] You have to help us figure this out. When you get angry, what's the best way to handle this?

This attempt to establish a particular reality first aims to demystify and disprove the apparent inevitability of emotional reactivity and failed problem solving. Second, it asserts that Chris can and should have some responsibility for communicating his concerns more effectively and helping to devise a therapy plan. It is important to affect the adolescent's participation in treatment in the presence of a parent to counter the frequently heard remark of parents that some treatments require too little of the adolescent.

C: I usually just tune out and try to forget about it.
T: All right, but you know that's no good. That's why you're here, Chris. [to his father] As you know, you're trying to find a new Chris.

Although it may have clear adaptive functions (Wills, 1990) and represents this adolescent's emotion regulation strategy (Saarni & Crowley, 1990), Chris' "tune out and forget" method is defined as ineffective problem solving. The "big picture" (Liddle, 1985) aspect of the work is invoked. This is an attempt, among other things, to help Chris express himself more effectively. Mastery and competence are important tasks of adolescence and protect against the development of problem behaviors (Dodge, 1989; Newcomb, Maddahian & Bentler, 1986). They are fundamental treatment goals.

In this situation several things are assumed. First, part of Chris' problem behavior relates to his failed attempts to communicate about various aspects of his life. Second, related to this, Chris needs to articulate his concerns more effectively (Liddle et al., 1992). The therapist works within and between two levels of focus and targets of change. Sometimes a so-called big picture of relationships is emphasized. These might be broad-level conclusions about one's son or daughter or parent. Particular day-to-day or past relationship events are the components of the big picture central to all therapies. They represent the recollected history and continuing events that have led to the conclusions portrayed in a big picture analysis.

The language in the previous sequence typifies how problems are framed, construed, *and* constructed. Because of our environment and interpersonal relations (Strupp & Binder, 1984), interventions must take into account these complementary processes. Safran and Greenberg's (1991) interpersonal schema (an internal model of relationships derived from experience) is also a clinically practical generic representation of self/other interactions. The interpersonal schemas of Chris and his father are intervention targets. Although the aim is to reduce the problem behaviors of the adolescent, as in all family treatment models, the relationship context (parenting, if we are referring to the father) is related to the adolescent's change.

Although it may appear to be the case, the quest to develop a new Chris gets at something that is not solely intrapersonal. It is important that his father recognize Chris' changes and construe them positively. This begins[5] a cycle that can shape the father's attributions, emotions, and behavior. In family treatment terms, the creation of new relational realities infers that his father's experience of his son changes when Chris' behavior is different, even if only slightly, for a brief time, or on a less-than-consistent basis. These new or altered perceptions and feelings are ingredients for changing family members' behavior toward each other.[6] Chris' father's emotional reactions to and cognitive appraisal of his son predict future action (e.g., his maintenance of emotional disengagement, his beliefs about Chris' inability to change, and his feeling that he cannot affect any positive change in his son). Hence, they are key intervention targets.

The call for a new Chris relates to how problems are recast in developmental terms. The concept of "possible selves" (Markus & Nurius, 1986) is useful in this regard. The metaphor of multiple aspects of the self and reinvented selves (Cross & Markus, 1991) are common in clinical work (see review in Mahoney, 1994). The metaphor can be an umbrella concept used to

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[5] Because this approach is representative of the broader class of systems interventions, it is important to note that the reverse of this conceptualization also is possible (reminiscent of the multidirectional nature of change in intimate relationships). It is equally important for Chris to begin to experience his father in new ways. And altering his father's emotional reactions to and negative predictions about his son's behavior (or even about Chris' lack of trustworthiness or probable unsavory motivations) is key to providing Chris with just such a new experience.

[6] All changes do not lie in the (self-reflexive) network of perceptions one has about oneself and others. Although it is the dimension of the change process that we emphasize here, various other contextual (e.g., extrafamilial, ecological) factors, as well as other intrapersonal factors not emphasized here (such as the role of skill development [communication; problem solving, both cognitive and affective; and general life skills]), affect change. They are omitted because they do not embody the therapy model represented.

orient goals and structure therapy. Therapists talk with teenagers about their possible selves, trying to counter the narrow role in which the teenagers have defined themselves and have been defined by others.

Segment Three: Emotions Inform Theme Development

> ***T: [to Chris] Let's try to figure one aspect of this that I really don't understand. There's something weird that you do with him that is, well . . . it's like "egging him on" to hit you. How do you understand that?***

The therapist works with Chris to articulate an understanding of his behavior. The therapist realizes that specifying the "facts" of the story is a central therapeutic task.[7] Reestablishing some degree of attachment between father and son takes time and has several dimensions. Clinical families often reside in a chronic emotionally negative environment. MDFT uses multiple channels to change this multivariate network.

> ***C: When I was a little kid, he used to hit me, and now, I would hit him, and then, ah, I would say, "Yeah, you won't hit me now, you say the only reason you don't hit me is 'cause you love me and you're afraid of child abuse. Why didn't you do that when I was a little kid when I couldn't hit you? Hit me now, go ahead, go ahead."***

Factors such as their temperament, cognitive development, and socialization influence emotional regulation in adolescents (Saarni & Crowley, 1990) and guide a therapist at a time like this. Perceptions of and attributions about one's own or another's temperament may be changeable. Indeed, temperament is now believed to be modifiable as well (Collins & Gunnar, 1990; Goldsmith et al., 1987; Matheny, 1989). Cognitive development may be more difficult to address. Socialization (i.e., parenting) practices are intervention targets, as are an adolescent's perceptions of these practices.

In the previous sequence, one can see movement between descriptions of the past and understandings about someone's motivations in the present. Chris reveals his father's abuse many years ago. Chris' challenge and its insight are profound. What his speech lacks in coherence is redeemed by its intensity.

> ***T: So it's as if you're saying, "I'm paying you back. I remember when you hit me when I was small."***
> ***C: And you won't hit me now.***

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[7] This aspect of treatment relies on the interaction between individual sessions with a parent and the adolescent and sessions with both the parent and adolescent. In individual sessions, the "positions" of each person are discovered or constructed, within the context of a supportive working alliance. These individual sessions serve as a foundation for joint sessions. At the same time, they have value in and of themselves. Change is understood in a multifaceted way, just as problems of adolescence, such as drug abuse, are understood multidimensionally (Newcomb, 1992).

Gaining retribution for another's past behaviors (Liddle & Diamond, 1991) is a familiar theme in clinical work. Working for forgiveness[8] is the clinical goal with persistent retribution themes. Some clinical researchers have termed materials of this nature core conflictual relational themes (Luborsky & Crits-Cristoph, 1990). The conflict in segment three is an example of how conflict among family members involves multiple layers of content (Vuchinich, 1987).

Conflict resolution has been found to vary as a function of, among other things, the topic of discussion (Smetana, Yau & Hanson, 1991). Clinical experience suggests the content area pertaining to retribution and its antidote, forgiveness, is a complex discussion topic and not amenable to straightforward resolution. However, these areas get a high priority in the clinical model.

Segment Four: Working an Emotion-Related Theme and the Interrelationship of Empathy and Constructivism

T: [to Chris's father, F.] Ray, I realize that you're goin' through hell right now.
F: Not really, I'm coming back.
T: Okay. Good. When this hits you, according to the best way that he has this stuff put together in his head, with every punch and every kick he is saying,"this is a payback."

Identifying the retribution theme is only a first step. The following shows how these first-level constructions are transformed and worked in a session.

F: Yeah, it probably is.
T: So how do you make sense of that?
F: I don't make any sense out of it.
T: He may never say it, but it's like. . . this kick is for when I was 7, this punch is for when I was 8. He remembers. . . some bad things have happened between you and him. He's saying, "That hurt me when that happened then." And he's saying, "It still hurts me now." [Pause] I'm not justifying what he's doing, but I am trying to make your son's language clear. Many times, he speaks a different language than we speak. No?
C: It's not a good language, that's what I was sayin'.
T: Well, no it's not. . . Do you know what I'm saying, Ray?
F: Yes. I know what you're saying.
T: When he kicks you, he says, "Screw you," but he also says, "I'm hurt. And you hurt me. And I'm gonna hurt you back. And I'm a big boy now, really big."
C: I'm not that big. He's bigger than me.

[8] There are degrees, stages, and multidimensional aspects of forgiveness. Forgiveness is less an event and more a process that must be understood in a developmental, temporal context.

T: [again to Chris' father] So see what I'm saying here? What I'm trying to get at is, "What is your son's way of talking, what is his language?"

These passages reveal deeply felt emotions. One clear target of change is the adolescent's behavior itself. However, another target focused on in this sequence, Chris' father, is equally important. It is important to use Ray's role as a parent to reach him. Adolescent participation in decision making (Smetana, 1988), development of the responsiveness (Baumrind, 1991) or empathy (Dix, 1991) dimensions of parenting, and the role of communication of respect to one's teenager (Steinberg, 1990) are other examples research literature identifies as having rich clinical implications. In this vignette, establishing different meanings about Chris' behavior are used to instigate processes that can "unfreeze" his father's perceptions and feelings. This would position Ray to perceive his son's new behavior.

Distinguishing between creating a new understanding of Chris' behavior and appearing to take a position that might be construed as excusing the problem behavior is primary to this process. The seriousness of the problem behavior must not be diminished.

The therapist interprets his son's remarks to Chris' father: "He says screw you, but he also says I'm hurt. And you hurt me. And I'm gonna hurt you back." Chris was frequently described as a time bomb ready to detonate. Therapy involved debunking these dramatic notions, making Chris' behavior more functional and understandable (but still not an acceptable response to the circumstances).

Both the adolescent and parent are told that their current way of trying to get what they want and expressing complaints is ineffective. Adolescents in particular are then able to sign on to an agenda that avoids "fixing the teenager."

Segment Five: Using an Out-of-Session Crisis To Work a Core Interpersonal Theme

This segment shows how a recent between-session crisis is employed to work key themes. The event is used to reintroduce a primary theme—belief and trust. Inherent in this discussion is the role of the family's past as an influence on emotions and thoughts in the present.

This event is addressed with several goals in mind—the need for (1) reattribution work, (2) a different emotional reaction, and (3) development of behavioral options for the future. The out-of-session event, despite its high emotionality, presents an opportunity to rework the ineffective problem solving. A thorough understanding of the terrain of how negative emotion inhibits problem solving, as Forgatch (1989) and Patterson, Reid, and Dishion (1992) provide, for example, is helpful for a clinician entering into a sequence of this nature.

T: So, part of what I'm getting at here, Ray, is that I want to clarify Chris' language. Do you think there's anything else that he's saying to you?

F: [to Chris] It's just that I don't believe what you were saying to me yesterday. [sarcastically] That you owe some drug dealer $135.

C: Why do you think my mouth was bleeding for 4 days since I got hit, man? I won't pay him; I already had somebody take care of him so it's no big deal now.

F: Okay, but the thing is, I don't have $135 I can loan you . . . .
C: Yeah, it's all right.
T: [to Chris' father] Stay with what you were saying. See, you're onto something good.
F: The fact is, I did not believe him.
C: All right.
F: You have conned me in the past. You've even admitted this.
C: When?
T: [to Chris, who is becoming agitated.] Here, sit back. He's not finished. [Therapist moves closer to Chris, puts arm around his shoulder.]
C: He was done talking.
T: No, he's not done talking. Wait. [to Chris' father] You do not believe him because of. . . [The therapist offers an incomplete sentence for father to complete, as a way of drawing him back into the conversation]
F: Past experience.
T: Past experience.
F: Yeah.
C: I . . . .
T: [to Chris] Not yet. [to his father] Keep going.
F: I make my decisions from past experiences.
T: Right. Keep going.
F: I thought, to tell you the truth, that you were conning me again to buy some drugs, since you have done it before.
C: Can I say something? You want to give me a drug test right now so I can prove to you I didn't do no drugs? And I was scared, man, I didn't wanna come to you, man, because I knew what you were gonna say. You already kicked me out of the house. [Chris' mood is changing and he becomes more agitated and angry] Only reason I came to you, I was scared. I'm sorry I stooped to your level because I was scared, but I was. I won't come to you anymore . . . .
T: [Trying to slow the pace down and looking for a way to use the new details that have emerged] Okay, that's interesting.
C: I don't like to admit I'm scared, but I was.
T: [to Chris] Do you understand what your father's saying, I mean, is that so unreasonable?

It is important to help Chris understand and gain perspective on his father's point. In a clinical population, perspective taking is a prime goal. Next, with Chris' acknowledgment ("I don't like to admit I'm scared, but I was"), the conversation shifts.

C: No. He . . . .
T: Do you understand that he said, "My first take on this was that this kid is conning me."
C: Yeah, I can understand that.

T: ***Okay, you can understand that, good. The thing that you said that was interesting is that you were afraid because . . . .***

C: ***I don't like to admit I was afraid, but I was.***

T: ***Okay, why were you afraid. . . because there are people who can be pretty weird when it comes to owing other people money, and you could get hurt, and these people would make it clear to you that you are gonna get hurt?***

C: ***They already did.***

T: ***Ray, I know you didn't hear it this way, but what this kid is saying. . . now admittedly, let's take this with a grain of salt, but let's say he's telling the truth right now. I want to get back to this thing of "what's Chris' language?" okay? If he is telling the truth right now, his language is telling you, in a not-so-direct way, "I came to you for support." Let's assume, again, that he's telling the truth, he was fearful, he was afraid. He came to his father for a form of support and help, and in a sense, protection.***

F: ***And I let him down. . . again.***

T: ***Is it possible that he is telling the truth about this?***

F: ***Oh, it's possible.***

T: ***Where are you right this instant with this issue?***

F: ***I think he probably was telling the truth.***

T: ***Really?***

F: ***But at the time, I didn't.***

T: ***I know. But, I want you to think deeply about this. I want you to really search your soul right now. I don't want you to be afraid to say, "Well, 90 percent [of me] says 'truth,' but 10 percent. . . I'm still unsure." What do you think: 90, 10?***

F: ***[to Chris] Let's put it this way, I always want to believe you. I've always tried to believe that what he's saying is the truth. But then I see the facts afterwards, and how things weren't true.***

T: ***Right.***

F: ***So, I'd say. . . I'd say 80-20 that I do believe him.***

T: ***Good. See, this is an important lesson for Chris. I think it's very important for him to have an understanding of what your position was. Why shouldn't he understand that you will find it hard to trust, you who have been burned. When he was doing a lot of drugs and was really screwed up, he wasn't the same person; he was lying, he was kidding you, other people, himself most of all. But yesterday, that was an interesting event to try to make sense of. I mean the tragedy of it was that, again, the language was so unclear. I really hear him saying, "I came to you for help. I was afraid."***

F: ***Yeah.***

T: ***I think it's interesting that he did come to you.***

This segment highlights how to modify extreme stances—all-or-nothing thinking and feelings characteristic of a parent–adolescent impasse (G. S. Diamond & Liddle, 1996).

T: You flashed back in time, you've heard this before . . . .
F: Exactly.
T: You thought of half a dozen other incidents where this boy came to you and you reacted. It was like if a person hits his knee like that, see [therapist hits his knee], it jumps, it's a reflex. You had no control when he asked you for the money, especially given the way that he asked you—it was absolutely terrible. Again, his language was lousy. See, he was stuck in the past too. You were stuck in the past with that reaction, but he was stuck in the past too. Because he couldn't make clear what was going on with him when he asked you that.

Here both father and son are portrayed as having had a "relapse" in the way each handled this event. Ray is challenged to not be a prisoner of his past perceptions and feelings about his son. Chris' challenge applies to his timing and methods of accessing his father.

These processes are difficult to change. The therapist is intervening at the intersection of emotion-appraisal, -experiencing, and -expression. Various researchers have described the predictability of these processes. For Shaver and colleagues (1987), "Once one of the basic emotions is elicited, its characteristic action tendencies, cognitive biases, and physiological patterns seem to arise automatically unless they are countered by self-control efforts" (p. 1080). In the clinical situation described here, the self-control and interactional control mechanisms have not functioned for some time. It is this process that the therapist seeks to interrupt and replace.

The following sequence again employs relapse framing as a platform for change.

T: So, where did the fight end between the two of you?
F: You mean today?
T: So yesterday there wasn't any fight?
F: No, there wasn't any fight yesterday. Today's when we was comin' on the freeway. He was . . . .
T: And that was about the money.
F: . . . goin' off about his hair and stompin' the car . . . .
F: But pullin' somethin' like that when I'm pullin' onto the freeway, I'm lookin' for merging traffic.
C: I'm sayin', even if we're stopped I shouldn't of did it. I'm sayin' I'm wrong, but I'm sayin' that's how it happened.
T: Okay, that's good. [Pause] It's too bad things don't happen the way we really think they ought to happen. Things like change. [To reengage Ray in the dialog, the therapist looks to Ray, and again uses an incomplete sentence, cueing Ray to complete it] Because we would like a world where when somebody says they're gonna change . . .
F: They change, right . . . .
T: [to Chris' father] They change. So today, you have to live through something that triggers some terrible things for you, really terrible things. It sends you back. See,

he had a relapse today. When he goes off like this, gets angry, stomps on the car . . . [to Chris] Do you know what a relapse is?

C: Yeah.

T: It's like you got the flu, you're feelin' a little bit better, then all of a sudden, you feel sick again. Okay, you know what it is. [now to Chris' father] So, today, he had a relapse. But, you had a relapse too. Because your relapse is characterized by tremendous doubt about him. Right? What are the elements of the doubt? The most basic of it is, he hasn't really changed. What else? That he can't change?

F: No, I think he can change.

T: What else? You're in a relapse, you're really feeling bad, and he's just gotten finished giving you a good whack. So what is it characterized by? What else?

F: I don't know what you're gettin' at.

T: You didn't believe in him in that moment.

F: I didn't believe in him when he kicked me in the arm?

T: Yeah, you didn't believe that he could be different, that he was gonna be different, here's the same old Chris, he's just conned me out of money . . . .

F: No, what I was gettin' at is I've seen [pause], okay, now I'll tell you what I mean by a relapse.

T: Okay.

F: I've seen this building up in him. When I picked him and his mother up, and he got in the car, he starts, "I hate this haircut, I hate this car, I don't like this haircut," and he's goin' on like this, and he's goin' on, and I was havin' trouble findin' where you get on the highway. So, I finally figure out and I go around, and then all of a sudden he starts on the car, and he's really goin', he could put his foot through that thing. I said, okay, here we go again, 'cause I've seen this same . . . .

T: Right. Okay, good.

F: . . . the same routine, how it all builds up.

T: Okay, good.

F: And it builds up, and then here I'm just lookin' to merge and he blindsides me.

C: I'm not sayin' I was right, but soon as he said, "Here we go again," I went, oh, okay, he thinks it's gonna go again, might as well.

T: Might as well then, right?

C: Right.

This sequence relates to observations about the role of emotions in interpersonal events. From the perspective of emotions as influencers, "emotions have script-like properties that direct the organization of behavior" (Fischer, Shaver & Carnochan, 1989, p. 123).

Kelley's (1984) concept of intersituational processes is also illustrated in this vignette. For Kelley, "By their very location, the intersituational processes must, like Janus, the god of doors and gates, face simultaneously in two directions, toward the just-ended and the about-to-begin" (p. 92). This sequence shows the retrospective, present, and prospective implications of emotional expression in sessions. Knowledge of this kind helps the therapist broaden the discussion of the negative incident. The relapse notion is given a specific meaning. Both father

and son contributed. Chris' part of the relapse was his return to a problematic way of dealing with feelings about his father. His father relapsed, too. His negative beliefs about Chris were automatic, triggered in the heat of an escalating conflict. Ray's belief in his son's ability to change is, theoretically and in practical terms, important to Chris' change.

The therapist interrupts the automatic nature of the processing ("schematic emotional memory mediates emotional responding" [Safran & Greenberg, 1991, p. 8]), as well as its pace, by developing different appraisals and responses.

A specific incident helps the therapist track down, give new meaning to, and rework the emotions around a core relationship theme. In this situation, there are four subtexts to this conversation/intervention.

- Dealing with emotional events is possible. (This is distinguished from control of one's emotions.)
- Extreme positions can be avoided.
- The consequences of negative events of this magnitude hurt everybody.
- There are advantages for each person in not letting negative interactions escalate.

Segment Six: In-Session Outcome

This segment occurs about half an hour after the baseline segment. The therapist plays a central role in changing the flow of emotional negativity. In these situations, a shift to a cognitive realm is not uncommon.[9] The therapist says that he is "translating" for Chris. This method gives complex emotional themes a reference point in future discussions.

The next segment illustrates something important about the nature of the therapist's subsystem network with the adolescent. The therapist must be careful not to do the adolescent's or the parent's work for him. At the same time, particularly at the beginning of therapy, parents and adolescents cannot be expected to have the ability to bring up sensitive topics with great skill.

> ***T: I'm doing something that, ultimately, should not be needed, and I think, will not be needed—and that's translating for Chris. [to Chris' father] Do you know what he was telling you with his very immature behavior? One thing that he was telling you was, "Yo, Dad, it really sets me off when I hear your lack of belief in me."***

[9] This basic intervention strategy, known as a shift intervention (Liddle, 1991), has been identified empirically through a discovery-oriented process research method (G. S. Diamond & Liddle, 1996).

The word *translating* labels an important stage-specific therapy operation. The therapist first attempts to help Ray shift his view about the event and about his son. Sometimes, processing negative emotions yields more negative emotions. So, when negative emotions run high, it is necessary to begin work on important content of this nature from within the cognitive realm. The therapist ascribes a positive motivation to counter the narrow negative attributions and emotional response of Ray to his son. This treatment establishes complex frameworks about each family member's behavior. From this base, emotions contextualize the past and provide motivation for the present and future.

T: He seems like such a bully sometimes, but there are obviously other sides to him . . .
.
F: He has a very good side.
T: [to Chris' father] It doesn't come out sometimes. He'll get better. But at that moment, what he basically says to you is, "It shattered me that you didn't believe in me, that you thought the bad stuff was coming again." And then, from that point forward, he loses it, and gets very childish: "Oh yeah, so you think it's gonna happen, I'll show you it's gonna happen." Then it's too late. But it's very interesting what he said. That should make you feel that your opinion is important to him. Certainly, your support and your belief in him are important to him. [to Chris] Are they not important to you?

This content elaborates on the "translating" theme. Attachment theory and research inform this intervention. To Chris, the importance of his father's emotional connection to him is stressed. The final statement intensifies and focuses the issue, making sure the father and son understand the new meaning being developed. The therapist's question to Chris, referring to Ray's belief in his son, "Are they not important to you?" creates a personally meaningful and interpersonal in-session experience.

As to whether his father's overt concern is important to him, Chris says:

C: It is. . . but a lot of times I act like it's not, and [I say] "f___ you, I don't care what you say." I really do care, the only reason I say that is because, you know, I feel like you don't [support or believe in me] so I just. . . I don't do what you want.

Chris acknowledges the importance of his father's support and belief. He reveals something critical—sometimes he acts as if this connection is not important. Attributing rejection and disconnection to his father (a common interpretation), Chris protects against future hurt and disappointment.

F: You know I do care. . . right?
C: Yeah, most of the time.
F: Sure I do.
C: I'm not gonna say always, because I don't feel like it's always.

Although Chris acknowledges some of the father's support, he does not withdraw his complaint. Father and son experience the possibility of negative and positive feelings coexisting. The father reiterates a clear statement of caring for Chris. This is important to note because, although these segments showed cognitive aspects of emotion, MDFT deals with a number of realms of human functioning.

Good moments[10] in therapy (Mahrer, 1988) are way stations, returned to later for elaboration and further work. As is the case with aspects of MDFT, these achievements are wholes and parts. This segment shows how escalating negative interactions and relationship themes can become more complex and be dealt with directly and positively with a therapist's help.

[10] The "good moments" method seeks to answer the question: "Given certain in-session patient conditions or states, what therapist operations or methods are useful in helping to bring about what kinds of very good moments of in-session patient change, improvement, movement, progress, or process?"

Procedural Steps: Implementing MDFT - Facilitating Key Therapeutic Processes

Establishing Priorities and Making Decisions

Making priorities regarding which sequences, steps and content are necessary to help therapy progress is accomplished as the therapist engages in a process of thinking with clarity about the events of the session as they unfold. Key guiding questions orient the therapist's conceptualizations and interventions. Questions such as "Am I focusing on the right content here?" or "Is the affective realm in which I am operating on target?" help the therapist develop an intentionality and criterion-driven methodology for moment to moment decision making in sessions. Therapists enter each session with a specific agenda. Throughout the session, therapist style, content and focus are adapted to accommodate feedback about family members' reactions to the session's events and to the therapist. The ground rules for being attentive to and reading feedback, can be made explicit and depend on lucid personal judgement under difficult conditions (Liddle, 1985).

Therapeutic Alliance

Reformulated to fit the developmental period of the second decade of life (i.e., adolescence), attachment has been an important concept in MDFT (Greenberg et al., 1983). The clinical corollary of attachment is the therapeutic alliance. MDFT places primary importance on the therapeutic alliances between therapist and parent(s) and between therapist and teenager.** These are separate relationships which must be cultivated independently and often differently (see Adolescent Subsystem Module: AEI's and Parent and Other Family Members Module: PRI's).

Initial engagement between the therapist and adolescent, therefore, must focus as much on bonding and cohesion as on authority and limit setting. The therapist accomplishes this, in part, by instituting the developmentally derived expectations of the teenager that may have been abandoned by the parents. The therapist attempts to access areas of adolescent competence and interpersonal skill, which serves in small ways to facilitate the teenager's development, and also builds a foundation for later parent-adolescent communication. The therapeutic alliance of the teenager and therapist is, at its best, therapeutic in and of itself. Moreover, this relationship also serves transitional

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** The concept of the therapeutic alliance in family therapy remains, as yet, underdeveloped. Pinsof & Catherall (1986) provide an example of the kind of work needed in the family systems field that appreciates the tradition and conceptual developments and research on therapeutic alliance in the individual psychotherapy field and builds concepts and research methods for use in family therapy.

functions. It is a bridging context that prepares the teenager for more constructive interchanges with the parents. Thus, the therapeutic relationship is a holon (Minuchin & Fishman, 1981), having both the whole and part functions of any holon.††

Linking as a Mechanism of Change

MDFT conceives of therapeutic change as being multiply determined. Connecting in-session phenomena across sessions reinforces therapeutic continuity. Efforts at generalizing gains made in therapy to the "real" world are enhanced by linking in-session events to tasks for out-of-session change. This is accomplished by linking sessions or parts of sessions across and within sessions and to the out-of-session arena (see Parent and Other Family Members Subsystem Module: Interventions with Other Family Members).

Use of Self by the Therapist

Working with teenagers and their families requires heart, skill and courage. In part, the therapist function as a temporary member of the teen's extended family. That is, the therapist supplements the natural functions of the family by providing a rich relational environment with age-appropriate developmental expectations. The therapist must respectfully expect from the teen and the family the developmental/ interpersonal skills that the family has given up expecting. At times, instead of working either directly or indirectly with the parent-adolescent interaction, the therapist may choose to focus on her relationship or alliance with the adolescent or the parent. This use of self by the therapist is constituted by a willingness to address the therapeutic alliance. These moments illustrate the sincerity and credibility that has been established between therapist and parent or adolescent. The therapist draws on this capital in times of crisis (see Family Interaction Module: Shifting Focus).

Key Concept:

Modeling for the parents, the therapist might adopt the role of an extended family member, specifying, from a position of relational proximity, age appropriate expectations for the teen, and providing ways for him or her to meet these maturity and competence demands.

†† The preparatory aspect of the therapist-adolescent relationship is isomorphic to the therapist-parent(s) relationship. Although different skills and content are involved, the general principles of whole and part functions to the relationship still hold.

Change as Incremental

The focus in this approach is on an *incremental* or successive approximations view of change. This is the emphasis despite the fact that change can be defined as having both continuous and discontinuous elements (Liddle, 1982b). The focus is on working and framing change for family members as a series of small steps. These are defined by Mahrer (1988) as "good moments" of therapy (i.e., processes that are instrumental to change). As Greenberg and Pinsof (1986) have put it, outcome should be broken down into the small o's (small outcomes) that comprise a ground level view of the therapy process. Fixation on the final product, the Big O of a final outcome or a Big Event, can instigate unrealistic expectations and a focus at the wrong level of detail (see Family Interaction Module: Wrapping Up).

Therapist Improvisation: Shifting Domains of Operation

Given that people exist in multiple, interconnected domains, MDFT recognizes that solutions to problems can be generated by work in any one or more of the overlapping domains of human functioning. In a therapy session, this translates into intentional shifting of focus by the therapist, from one individual to another, or from cognitive to behavioral to affective, or present to past. This allows the clinician maximum flexibility for in-session work. When the therapist assesses that a particular approach is not working, she shifts the focus to another dimension, such as from problem solving to affective realm. For example, shifting the temporal focus from present to past is typical in MDFT, especially when past hurts must undergo a healing process in order to bring about a reconciliation between the adolescent and parents. A focus on the past is often necessary in helping adolescents deal with prior experiences of abuse, neglect and loss (see Family Interaction Module: Building a Relationship Bridge).

Finding the Middle Ground

The high level of emotionality that accompanies parent-adolescent conflict is often associated with extreme, opposing stands that pit the parents and adolescent against each other. MDFT seeks to negotiate such extreme stands. For example, in cases in which a crisis is present or the affect regulation ability with parents and teenager is low, separate sessions buy time until each party is helped to adopt a less extreme stance and become able to constructively address and communicate the strong emotions aroused by the parent or adolescent.

Guidelines for Subsystem Sessions

MDFT is careful to avoid reductionistic thinking at the level of the individual or family. We are aware of the importance of extrafamilial influences, and we are equally

able to conceptualize individuals in a systemic manner. The conceptual framework of the approach emphasizes the simultaneous consideration of these influential forces.

Regarding intervention philosophy and implementation, subsystem therapy is the norm. We work with different members and units of the family and wider systems. Theoretically, this may be acceptable to a therapist. Practically speaking, this may also be amenable to a therapist's way of working. However, specifying the guidelines for the practice of a multiple systems focused therapy is complex.

This next section outlines the MDFT guidelines on how to make decisions about session composition as they pertain to individual sessions and on a week-by-week basis.

Guidelines for Seeing a Parent or Adolescent Alone

1. Alliance building

    - First task: understand each subsystem's experience of this family (Remember the *Rashomon effect*. “Rashomon", a 1951 movie Directed by Akira Kurosawa was a cinematic landmark. It is a brilliant study of the nature of truth. Set in the 12th century, a samurai and his wife are traveling through the woods near Kyoto. They are attacked by a bandit, the wife raped and the husband killed. Four different versions of the incident are told by the participants and a woodcutter who was a witness. The film’s presentation and consideration of the relative nature of reality serves as a useful therapeutic allegory in teaching about multiple alliances, and about all interventions in multi-person systems)

    - With parent: "We can, together, come up with some things to do to deal with your son or daughter."

    - With adolescent - as always, try to fulfill the ideal principle: "There can be something in this therapy for you."

2. Elicit and hear the story of the past or of the present

    - Past issues can affect the present.

    - This is what people expect.

    - History is a way to learn about someone.

    - Careful about the pull to orchestrate change too fast.

- Assess perspective of parent regarding parenting philosophy/parental cognition, style, and affect or assess perspective on adolescent on these dimensions vis-a-vis their parent(s).

- Assess parenting commitment (hopelessness and despair).

- Develop a sense of self apart from being a parent or apart from being a son or daughter (do they take care of themselves? of their relationship life?, of work?).

3. Level of functioning---Dysfunction of the parent or adolescent

    - More symptomatology--see them alone more; lower the level of family goals, craft more "individual" goals with parent (these are frequently overwhelmed parents who have a number of problems themselves--drinking, relationship, money problems, job stress).

    - Goals of stabilization are acceptable.

    - Help parent and adolescent get in a position emotionally and content-wise to deal with the other.

4. Theme establishment

    - Developing therapist's generics of therapy and of family life (short term, work hard, show up, prepare for some pain and upset, relapse, teenagers are different than children, parents can still influence and need to influence teenagers, assess and influence assumptions about teenagers, can't try to control everything/choose your battles, themes of demandingness and responsiveness, parental and adolescent abdication, hopelessness, and despair).

5. Beyond joining: Establishing, working, refining, and reworking a theme with one person

    - Multiple system conceptualization and intervention, i.e., parental philosophy, teenager expectations and confusion about the past (e.g., should I forgive?; can I forgive?; what does forgiveness mean to me?), of particular importance with parent(s): rekindle oparental hopes and dreams, commitment and love.

    - Rests upon a multidimensional theory of change perspective (i.e., the "many avenues to change" philosophy--all change in family therapy isn't change via enactment or cognition shifts).

- Work with the self of the parent or adolescent.

6. Preventing failure or saving embarrassment

    - Parent is not ready to talk with teenager, is confused about what to do (e.g., single parent, isolated, no other adult contact or feedback).

    - Always honor the "urgency principle" - continuance in therapy (after engagement of course) is a critical, overriding importance. Breaks in the multiple therapeutic alliances in MDFT are often foreseeable and can be avioded via individual sessions. Sometimes these are ad hoc mini-sessions, done in relation to a whole family session on the same day or evening. The urgency principle says that nothing is more important than keeping the case in treatment; we cannot help if we do not have access to the parent and adolescent.

7. Preparing parent and adolescent for enactment or negotiation or sharing

    - Preparing the parental subsystem (keeping marital issues contained, if possible).

    - Affect is too strong and a cognitive frame needs to be established around an event.

    - Mobilization of hope. The all-important decision to "try again" must be made overt and negotiated with great sensitivity and compassion. Hope does not increase because a therapist says a parent should try again or should be more positive. Hope is a complex of feelings that emanates from a journey or process that is facilitated by the therapist. Paradoxically, hope can be mobilized after an excursion into "parental hell" - that space which is every parent's worst nightmare (i.e., a loss of commitment to parenting or to the welfare of one's child). Clinicians sometimes call this territory "parental abdication." There have been repeated failures, relationships have been devalued, and family members may indeed be in an abdication mode (this actually applies to parents and teenagers). Seeing parent and adolescent alone facilitates dealing with motivational issues as well as basic issues of empathy and compassion (see Dix, 1991; Dix & Grusec, 1985). A primary goal during these individual sessions is to experience the world and the parent or teenager from that person's viewpoint. Of course this is a core tenet of all psychotherapy, from its earliest days. In modern models, however, when there are multiple constituencies, this deep understanding is critical to working with the significant others and facilitates a therapist's connection and work with an individual parent or adolescent. A therapist's knowledge of a parent's experiences and conclusions about their child are important work with that teenager. Work with the adolescent is then done with an appreciation of the

context in which they must struggle to change--the relationship between them and their parent. Conversely, hearing the teenager's story (and helping to rewrite it) is critical to one's work with the teenager's parents. Just as teenagers are taught how to negotiate and communicate more effectively with their parent(s), parents are coached on the basis of this inside knowledge of the other.

1. Overall

    - Early stages to set the foundation, middle to work and rework themes via enactment and tasks that provide continuity across sessions, and later stages to consolidate (e.g., cognitive sealing, affective recollections, behavioral troubleshooting and refinement).

Guidelines for Seeing a Parent and Adolescent Together

1. Early phase: As always, intervention and assessment.

2. After at least a minimal theme has been established and at least minimally accepted (which does not mean it won't be rejected):

    - See parent(s) and adolescent together to establish, work, revise, and rework the themes.

    - Writing is rewriting/Therapy is reworking and revising themes.

    - Examples of themes that have been set with each alone (e.g., negotiation of rights and responsibilities, re-establishing a connection in light of past hurts and disappointments).

3. See parent(s) and adolescent together to establish a joint commitment to do something about the mutually-felt unhappiness or pain (goals of mutual empathy or perspective taking).

4. Give family members the opportunity to create new relational realities, to make new agreements, new plans for how they will be together or apart.

    - Small steps and agreements first. Successive approximations philosophy.

    - Importance of morale.

5. These are experiments of change, they do not necessarily represent change.

- Be careful not to overemphasize in-session events, they are important but not solely determinative.

- Have a multidimensional view of change: Individuals change not only through new experiences of reality via enactment, but through understanding and contemplation. They change as "individuals" and as "subsystem members."

References

Achenbach, T. M. (1986). Developmental perspectives on psychotherapy and behavior change. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change (3rd ed., pp. 117-154). New York: Wiley.

Achenbach, T. M. (1990). What is "developmental" about developmental psychopathology? In J. Rolf, A. S. Masten, D. Cicchetti, K. H., & S. Weintraub (Eds.), Risk and protective factors in the development of psychopathology. New York: Cambridge.

Alexander, J. F., & Barton, C. (1990). Functional Family Therapy. In F. Kaslow (Ed.), Voices in family psychology. Carmel, CA: Sage.

Alexander, J. F., Barton, C., Waldron, H., & Mas, C. H. (1983). Beyond the technology of family therapy: The anatomy of intervention model. In K. D. Craig & R. J. McMahon (Eds.), Advances in clinical behavior therapy (pp. 48-73). New York: Brummel/Mazel.

Alexander, J. F., & Parsons, B. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and relativist. Journal of Abnormal Psychology, 81, 219-225.

Alexander, J. F., Holtzworth-Munroe, A., & Jameson, P. B. (1994). Research on the process and outcome of marriage and family therapy. In A. E. Bergin & S. L. Garfield (Eds.), Handbook of psychotherapy and behavior change (4th ed., pp.). New York: Wiley & Sons.

Allen, R. L. & Hatchett, S. J. (1986). The media and social reality effects: Self and system orientations of Blacks. Communications Research, 13, 97-123.

Allen, J. P., Hauser, S. T., Eickholt, C., Bell, K. L., & O'Connor, T. G. (1994). Autonomy and relatedness in family interactions as predictors of expressions of negative adolescent affect. Journal of Research on Adolescence. Special Issue: Affective Processes in Adolescence. 4(4), 535-552.

American Psychological Association (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. American Psychologist, 48, 45-48.

Atkeson, B. M., Forehand, R. L., & Rickard, K. M. (1982). The effects of divorce on children. In B. B. Lahey & A. E. Kazdin (Eds.), Advances in clinical child psychology (Vol. 9,,pp. 87-131). New york: Plenum.

Atwell, I. & Azibo, D. A. (1991). Diagnosing personality disorder in Africans (Blacks) using the Azibo Nosology: Two case studies. The Journal of Black Psychology, 17, 1-22.

Avis, J. M., & Sprenkle, D. H. (1990). Outcome research on family therapy training: A substantive and methodological review. Journal of Marital & amily Therapy, 16(3), 241-264.

Azar, B. (1994). NIDA-funded research is suited to psychologists. APA Monitor, 25, 28-29.

Azar, B. (1995, September). Scientists' research backs work of family therapists. APA Monitor, 26, 10-11.

Bachman, J. G., Johnston, L. D., & O'Malley, P. M. (1981). Monitoring the Future: Questionnaires from the Nation's High School Seniors. Ann Arbor, MI: Survey Research Center.

Bandura, A. (1978). The self system in reciprocal determinism. American Psychologist, 33, 334-355.

Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. Englewood Cliffs, NJ: Prentice Hall.

Bank, L., Marlowe, J. H., Reid, J. B., Patterson, G. R., & Weinrott, M. R. (1991). A copmparative evaluation of parent-training interventions for families of chronic delinquents. Journal of Abnormal Child Psychology, 19(1), 15-33.

Barton, C., Alexander, J. F., Waldron, H., Turner, C. W., & Warburton, J. (1985). Generalizing treatment effects of functional family therapy: Three replications. American Journal of Family Therapy, 13(3), 16-26.

Baumrind, D. (1985). A developmental perspective on adolescent drug abuse. Advances in Alcohol & Substance Abuse, 4(3/4), 41-67.

Baumrind, D. (1991). The influence of parenting style on adolescent competence and substance abuse. Journal of Early Adolescence, 11, 56-95.

Baumrind, D., & Moselle, K. A. (1985). A developmental perspective on adolescent drug abuse. Advances in Alcohol and Substance Abuse: Alcohol and Substance Abuse in Adolescence, 4(3/4), 41-67.

Bearison, D. J., & Zimiles, H. (1986). Thought and emotion: Developmentalperspective, Hillsdale, NJ: Lawrence Erlbaum Associates.

Becker, W. C. (1964). Consequences of different kinds of parental discipline. In M. L. Hoffman & L. W. Hoffman (Eds.), Review of child development research (Vol. 1, pp. 169-208). New York: Russell Sage Foundation.

Belsky, J., Steinberg, L., & Draper, P. (1991). Childhood experience, interpersonal development, and reproductive strategy: An evolutionary theory of socialization. Child Development, 62, 647-670.

Belsky, J. & Vondra, J. (1985). Characteristics, consequences, and determinants of parenting. In L. L'Abate (Ed.), Handbook of family psychology and therapy (pp. 523-536). Homewood, IL: The Dorsey Press.

Benson, P. L. & Donahue, M. J. (1989). Ten-Year Trends in At-Risk Behaviors: A National Study of Black Adolescents. Journal of Adolescent Research, 4, 125-139.

Biafora, F. A., Warheit, G. J., Zimmerman, R. S., Gil, A. G., Apospori, E., Taylor, D., & Vega, W. A. (1993). Racial mistrust and deviant behaviors among ethnically diverse Black adolescent boys. Journal of Applied Social Psychology, 23, 891-910.

Billingsley, A., & Caldwell, C. H. (1991). The Church, the Family, and the School in the African American Community. Journal of Negro Education, 60.

Blechman, E. A. (1990). A new look at emotions and the family: A model of effective family communication. In E. A. Blechman (Ed.), Emotions and the Family; for better or worse. Hillsdale, NJ: Lawrence Erlbaum Associates.

Block, J., Block, J. H., & Keyes, S. (1988). Longitudinal foretelling drug usage in adolescence: Early childhood personality and environmental precursers. Child Development, 59, 336-355.

Blos, P. (1962). On adolescence. New York: Free Press.

Blos, P. (1979). The adolescent passage. New York: International Universities Press.

Bowlby, J. (1988). A secure base. New York: Basic Books.

Bowman, P. J. & Howard, C. (1985). Race-related socialization, motivation and academic achievement: A study of Black youths in the three-generation families. Journal of the American Academy of Child Psychiatry, 24, 134-141.

Borduin, C., Mann, B., Cone, L., Henggeler, S., Fucci, B., Blaske, D., & Williams, R. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. Journal of Consulting and Clinical Psychology, 63, 569-578.

Boyd-Franklin, N. (1989). Black Families in Therapy: A Multisystems Approach. New York: The Guilford Press.

Boyd-Franklin, N. (1992). Culturally sensitive treatment of the inner-city African American adolescent: A multi systems model. In W. Snyder & T. Ooms (Ed.), Empowering Families, Helping Adolescents: Family Centered Treatment of Adolescents with Alcohol, Drug Abuse, and Mental Health Problems. (pp71-76). Rockville, MD: Department of Health and Human Services.

Boykin, A. W. & Ellison, L. M. (1995). The multiple ecology of Black youth socialization: An afrographic analysis. In Taylor, R.L. (Eds), African American Youth: Their Social Economic Status in the U.S. Westport, CT: Prager Publishers.

Bronfenbrenner, U. (1979). The ecology of human development: Experiments by nature and design. Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. (1983). The context of development and the development of context. In R. M. Lerner (Ed.), Developmental psychology: Historical and philosophical perspectives (pp. 147-184). Hillsdale, NJ: Lawrence Erlbaum.

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. Developmental Psychology, 22(6), 723-742.

Brook, D. W., Brook, J. S., Lettieri, D. J., & Stimmel, B. (1985). Adolescent alcohol and substance use and abuse: A cause of concern or for complacency. Alcohol and Substance Abuse in Adolescence, 4,

Brook, J. S., Brook, D. W., Gordon, A. S., & Whitman, M. (1984). Identification with perternal attributes and its relationship to the son's personality and drug use. Developmental Psychology, 20, 1111-1119.

Brook, J. S., Whiteman, M., Nomura, A. S., Gordon, A. S., & Cohen, P. (1988). Personality, family and ecological influences on adolescent drug use: A developmental analysis. In R. H. Coombs (Ed.), The family contect of adolescent drug use (pp. 123-162). New York: Haworth Press.

Brook, J. S., Brook, D. W., Gordon, A. S., Whiteman, & Cohen, P. (1990). The psychosocial etiology of adolescent drug use: A family interactional approach. Genetic, Social, and General Psychology Monographs, 116.

Brook, J. S., Nomura, C., & Cohen, P. (1989). A network on influences on adolescent drug involvement: Neighborhood, school, peer, and family. Genetic, Social and General Psychology Monographs, 115, 125-145.

Brown, M. (1985). I'll pitch, you catch: Substituting peer vision for live supervision of family therapy. Family Therapy, 12, 279-284.

Brown, B. (1990). Peer groups. In S. Feldman & G. Elliott (Eds.), At the threshold: The developing adolescent. Cambridge, MA: Harvard University Press.

Brown, D. R., Ndubuishi, S. C., & Gary, L. E. (1990). Religiosity and psychological distress among Blacks. Journal of Religion & Health, 29, 55-68.

Bry, G. H. (1983). Family-based approaches to reducing adolescent substance use: Theories, techniques and findings. In T. J. Glynn, C. G. Leukefeld, & J. P. Ludford (Eds.), Preventing adolescent drug abuse: Intervention strategies. (NIDA Research Monograph 47). Rockville, MD: DHHS.

Bukstein, O. G., Brent, D. A., & Kaminer, Y. (1989). Comorbidity of substance abuse and other psychiatric disorders in adolescents. American Journal of Psychiatry, 146, 1131-1141.

Bugental, D. B., & Shennum, W. A. (1984). "Difficult" children as elicitors and targets of adult communication patterns: An attributional-behavioral transactional analysis. Monographs of the Society for Research in Child Development, 49(1), Serial No. 205.

Burke, R. J., & Weir, T.(1978). Sex differences in adolescent life stress, social support, and well-being. The Journal of Psychology, 98, 277-288. Burke, & Weir 1978

Campbell, E., Adams, G. R., & Dobson, W. R. (1984). Family correlates of identity formation in late adolescents: A study of the predictive utility of connectedness and individuality in family relations. Journal of Youth and Adolescence, 13, 509-525.

Campos, J. J., Campos, R. G. & Barrett, K. C. (1989). Emergent themes in the study of emotional development and emotion regulation. Developmental Psychology, 25, 394-402.

Carnegie Council on Adolescent Development. (1989). Turning points: Preparing American youth for the 21st century. The report of the task force on education of young adolescents. New York: Carnegie Corporation.

Carter, R. T. (1991). Racial attitudes and psychological functioning. Journal of Multicultural Counseling and Development, 19, 105-114.

Carter, B., & McGoldrick, M. (Eds.) (1989). The changing family life cycle (2nd ed.). Boston, MA: Allyn & Bacon.

Casey, R. J., & Berman, J. S. (1985). The outcome of psychotherapy with children. Psychological Bulletin, 98, 388-400.

Caspi, A., & Moffitt, T. E. (1996). The continuity of maladaptive behavior: From description to understanding in the study of antisocial behavior. In D. Ciccheti & D.

Cohen (Eds.), Developmental Psychopathology: Vol. 2 Risk, disorder, and adaptation (pp. 472-511). New York: John Wiley & Sons, Inc.

Cauce, A. M. (1987). School and peer competence in early adolescence: A test of domain-specific self-perceived competence. Developmental Psychology, 23, 287-291.

Children's Defense Fund. (1992). The state of America's children: 1992. Washington, DC Author.

Church, E. (1994). The role of autonomy in adolescent psychotherapy. Psychotherapy, 31, 101-108.

Cicchetti, D. (1984). The emergence of developmental psychopathology. Child Development, 55, 1-7.

Coie, J. D., & Jacobs, M. R. (1993). The role of social context in the prevention of conduct disorder. Development and Psychopathology, 5, 263-275.

Colarusso, C. A. & Nemiroff, R. A. (1987). Clinical implications of adult developmental theory. American Journal of Psychiatry, 144, 1263-1270.

Collins, W. A. (1990). Parent-child relationships in the transition to adolescence: Continuity and change in interaction, affect, and cognition. In R. Montemayor, G. Adams, & T. Gullotta (Eds.), Advances in adolescent development, Vol. 2. The transition from childhood to adolescence: A transitional period? (pp. 85-106). Beverly hills: Sage.

Collins, W.A. (1992). Parents' cognitions and developmental changes in relationships during adolescence. In I. E. Sigel, A. V. McGillicuddy-DeLisi, & J. J. Goodnow (Eds.) Parental belief systems: The psychological consequences for children (2nd Ed.) (pp. 175-197). Hillsdale, NJ: Lawrence Erlbaum Associates.

Collins, W.A. & Gunnar, M. R. (1990). Social and personality development. Annual Review Psychology, 41, 387-416.

Conger, R. D., Conger, K. J., Elder, G. H., Lorenz, F. O., Simons, R. L., & Whitbeck, L. B. (1992). A family process model of economic hardship and adjustment of early adolescent boys. Child Development, 63, 526-541.

Congressional Record-Senate. (1990). Using family therapy to treat adolescent drug abuse (H. Joanning, R. Lewis, & H. Liddle). May 1, 1990, S5506-S5507.

Coombs, R. (1988). The family context of adolescent drug abuse. New York: Haworth.

Coombs, R. H., Landsverk, J. (1988). Parenting styles and substance use during childhood and adolescence. Journal of Marriage and the Family, 50, 473-482.

Coombs, R. H. & Paulson, M. J. (1988). Contrasting family patterns of adolescent drug users and nonusers. In R.H. Coombs (Ed.), The family context of adolescent drug use, 59-72. New York: Haworth Press.

Cooper, C. R., Grotevant, H. D., & Condon, S. M. (1983). Individuality and connectedness in the family as a context for adolescent identity formation and role-taking skill. In H. D. Grotevant & C. R. Cooper (Eds.), New directions for child development: Adolescent development in the family (pp. 43-59). San Francisco, CA: Jossey-Bass.

Costello, E. J., Burns, B. J., Angold, A., & Leaf, P. J. (1993). How can epidemiology improve mental health services for children and adolescents? Journal of the Americal Academy of Child Adolescent Psychiatry, 32(6), 1106-1114.

Cross, S. & Markus, H. (1991). Possible selves across the life span. Human Development, 34, 230-255.

Crowley, P., & Riggs, P. D. (1995). Adolescent substance abuse disorder with conduct disorder and comorbid conditions. In E. Rahdert & D. Czechowicz (Eds.), Adolescent drug abuse: Clinical assessments and therapeutic interventions (pp. 49-111). (NIDA Research Monograph 156, NIH Publication No. 95-3908). Rockville, MD: NIDA.

Csikszentmihalyi, M., & Larson, R. (1984). Being adolescent: Conflict and growth in the teenage years. New York: Basic Books, Inc.

CSAT (Center for Substance Abuse Treatment) (1988). Adolescent substance abuse: Assessment and treatment (Treatment Improvement Protocol Series [TIPS]. Rockville, MD: Author.

Dadds, M. R., & McHugh, T. A. (1992). Social support and treatment outcome in behavioral family therapy for child conduct problems. Journal of Consulting and Clinical Psychology, 60(2), 252-259.

Dadds, M. R., Schwartz, S., & Sanders, M. R. (1987). Marital discord and treatment outcome in behavioral treatment of child conduct disorders. Journal of Consulting and Clinical Psychology, 55, 396-403.

Davidge, A. M., & Forman, S. G. (1988). Psychological treatment of adolescent substance abusers: A review. Children and Youth Services Review, 10, 45-55.

DeAngelis, T. (1994, March). Mass now requires multi cultural training. APA Monitor, p41.

DeLeon, G., & Jainchill, N. (1986). Circumstance, motivation, readiness and suitability as correlates of treatment tenure. Journal of Psychoactive Drugs, 18, 203-208.

Dembo, R., Farrow, D., Des Jarlais, D. C., Burgos, W., & Schmeidler, J. (1981). Examining a causal model of early drug involvement among inner-city junior high school youths. Human Relations, 34(3), 169-193.

Department of Health & Human Services (1994). Youth Health Service, Inc: Guidelines for Replication. Rockville, MD: Department of Health and Human Services.

Diamond, G. S., & Liddle, H. A. (1996a). Resolving a therapeutic impasse between parents and adolescents in multidimensional family therapy. Journal of Consulting and Clinical Psychology, 64(3), 481-488.

Diamond, G. S., & Liddle, H. A. (1996b). Why parents and adolescents drop out of family therapy. Presentation to the Pennsylvania Community Providers Association, 1996 Annual Conference, Champion, PA. Diamond, G.

Dishion, T. J., & Andrews, D. W. (1995). Preventing escalation in problem behaviors with high-risk young adolescents: Immediate and 1-year outcomes. Journal of Consulting and Clinical Psychology, 63(4), 538-548.

Dishion, T. J., & Loeber, R. (1985). Adolescent marijuana and alcohol use: The role of parents and peers revisited. American Journal of Drug and Alcohol Abuse, 11(1/2), 11-25.

Dishion, T. J., Patterson, G. R., & Reid, J. R. (1988). Parent and peer facts associated with drug sampling in early adolescence: Implications for treatment. In E. R. Rahdert & J. Garbowski (Eds.), Adolescent drug abuse: Analyses of treatment research

(pp. 69-93). NIDA Research Monograph 77, DHHS Pub. No. (ADM) 88-1523. Rockville, MD: National Institute on Drug Abuse.

Dishion, T. J., Reid, J. B., & Patterson, G. R. (1988). Empirical guidelines for a family intervention for adolescent drug use. Journal of Chemical Dependency Treatment, 1, 189-224.

Dix, T. (1991). The affective organization of parenting: Adaptive and maladaptive processes. Psychological Bulletin, 110(1), 3-25.

Dix, T. H. & Grusec, J. E. (1985). Parent attribution processes in the socialization of children. In I. Sigel, (Ed.), Parental belief systems: The psychological consequences for children (pp. 201-233). Hillsdale, NJ: Lawrence Erlbaum.

Doane, J. A., Hill, W. L., & Diamond, D. (l991). A developmental view of therapeutic bonding in the family: Treatment of the disconnected family. Family Process, 30, 155-176.

Dodge, K. A. (1989). Coordinating responses to aversive stimuli: Introduction to a special section on the development of emotional regulation. Developmental Psychology, 25, 339-342.

Dodge, K. A., & Garber, J. (Eds.) (l989). The development of affect regulation and dysregulation. New York, NY: Cambridge University Press.

Dornbusch, S. M. (1989). The sociology of adolescence. Annual Review of Sociology, 15, 233-259.

Dornbusch, S. M., Carlsmith, J. M., Bushwall, S. J., Ritter, P. L., Leiderman, H., Hastorf, A. H. & Gross, R. T. (1985). Single parents, extended households, and the control of adolescents. Child Development, 56, 326-341.

Dryfoos, J. G. (1990). Adolescents at risk: Prevalence and prevention. New York: Oxford University Press.

Elliot, D. S., Huizinga, D., & Ageton, S. S. (1985). Explaining delinquency and drug use. Beverly Hills, CA: Sage.

England, M. J., & Cole, R. F. (1992). Building systems of care for youth with serious mental illness. Hospital and Community Psychiatry, 43(6), 630-633.

Erikson, E. H. (1968). Identity: Youth and crisis. New York: Norton.

Falco, J. (1988). Preventing abuse of drugs, alcohol, and tobacco by adolescents. Working paper for Carnegie Council on Adolescent Development. Washington, DC.

Falicov, C. (1988). Learning to think culturally. In H. A. Liddle, D. C. Breunlin & R. C. Schwartz (Eds.), Handbook of family therapy training and supervision (pp. 335-357). New York, NY: Guilford Press.

Farrington, D. P. (1995). The development of offending and antisocial behavior from childhood: Key findings from the Cambridge study in delinquent development. Journal of Child Psychology and Psychiatry, 36, 1-36.

Feldman, S. S., & Elliot, G. R. (1990). At the threshold - The developing adolescent (pp. 388-413). Cambridge, MA: Harvard University Press.

Fischer, K. W., Shaver, P. R., & Carnochan, P. (1989). A skill approach to emotional development: From basic- to subordinate- category emotions. In W. Damon

(Ed.), Child development today and tomorrow (pp. 107-136). San Francisco, CA: Jossey-Bass.

Fletcher, A. C., Darling, N., Steinberg, L. D., & Dornbusch, S. M. (1995). The company they keep: Relation of adolescents' adjustment and behavior to their friends perceptions of authoritative parenting in the social network. Developmental Psychology,31(2), 300-310. Ford, M. E. (1982). Social competition and social competence in adolescence. Developmental Psychology, 18(3), 323-340.

Ford, D. Y., Harris, J. J., and Schuerger, J. M. (1993). Racial identity development among gifted black students: Counseling issues and concerns. Journal of Counseling and Development, 71, 409-417.

Fordham, S. (1988). Racelessness as a factor in Black student's school success: Pragmatic strategy or Pyrrhic victory? Harvard Educational Review, 58, 54-84.

Fordham, S. & Ogbu, J.U. (1986). Black students' school success: Coping with the burden of "acting white." The Urban Review, 18, 176-206.

Forehand, R. L. & McMahon, R. J. (1981). Helping the noncompliant child. New York: The Guilford Press.

Forgatch, M. S. (1989). Patterns and outcome in family problem solving: The disrupting effect of negative emotion. Journal of Marriage and the Family, 51, 115-124.

Forsyth, D. R. & Strong, S. R. (1986). The scientific study of counseling and psychotherapy: A unificationist view. American Psychologist, 41, 113-119.

Freud, A. (1958). Adolescence. Psychoanalytic Study of the Child, 13, 255-278.

Friedman, A.S. (1989). Family therapy vs. parent groups: Effect on adolescent drug abusers. The American Journal of Family Therapy, 17, 335-347. Friedman 1989

Friedman, A. S., Utada, A., & Morrissey, M. R. (1987). Families of adolescent drug abusers are "rigid": Are these families either "disengaged" or "enmeshed" or both? Family Process, 26, 131-148.

Fuligni, A. J., & Eccles, J. S. (1993). Perceived parent-child relationships and early adolescents' orientation toward peers. Developmental Psychology, 29(4), 622-632.

Furman, W. (1980). Promoting social development: Developing implications for treatment. In B. Lahey & A. Kazdin (Eds.), Advances in clinical child psychology (Vol. 3, pp. 1-40). New York: Plenum.

Garfield, S. L. & Bergin, A. E. (1986). Handbook of Psychotherapy and Behavior Change. New York, NY: John Wiley & Sons.

Greene, B. (1990). Sturdy bridges: The role of African American mothers in the socialization of African American children. Special Issue: Motherhood: A feminist perspective. Women and Therapy, 10, 205-225.

Gibbs, J. T. (1982). Psycholosocial factors related to substance abuse among delinquent females: Implications for prevention and treatment. American Journal for Orthopsychiatry, 52(2), 261-271.

Gibbs, J. T. (1991). Black adolescents at-risk: Approaches to prevention. In R. M. Lerner, A. C. Petersen, J. Brooks Gunn (Eds.), Encyclopedia of Adolescence. New York: Garland Publishing.

Grier, W. & Cobbs, P. (1968). Black Rage. New York: Basic Books.

Glynn, T. J., & Haenlein, M. (1988). Family theory and research on adolescent drug use: A review. In R. H. Coombs (Ed.), The family context of adolescent drug use (pp. 39-56). New York: The Haworth Press.

Goodnow, J. J. (1988). Parents' ideas, actions and feelings: Models and methods from developmental and social psychology. Child Development, 59, 286-320.

Gottman, J. M. (1983). How children become friends. Monographs of the Society for Research in Child Development, 48(3).

Gottman, J. M., & Levenson, R. W. (1984). Why marriages fail: Affective and physiological patterns inmarital interaction. In J. C. Masters & K. Yarkin-Levin (Eds.), Boundary areas in social and developmental psychology, (pp.67-106). Orlando, FL: Academic Press.

Gottman, J. M., & Levenson, R. W. (1986). Assessing the role of emotion in marriage. Behavioral Assessment, 8, 31-48.

Gould, M. S., Shaffer, D., & Kaplan, D. (1985). The characteristics of dropouts from a child psychiatric clinic. Journal of the American Academy of Child Psychiatry, 24, 316-328.

Greenberg, M. T., Siegel, J. M., & Leitch, C. J. (1983). The nature and importance of attachment relationships to parents and peers during adolescence. Journal of Youth and Adolescence, 12(5), 373-386.

Greenberg, L. S. & Pinsof, W. M. (1986). Process research: Current trends and future perspectives. In L. S. Greenberg & W. M. Pinsof (Eds.), The Psychotherapeutic Process: A Research Handbook (pp. 3-20). New York: Guilford Press.

Greenberg, L. S., & Safran, J. D. (1987). Emotion in psychotherapy: Affect, cognition, and the process of change. New York: Guilford.

Greenberger, E. (1984). Children, families, and work. In N. D. Reppucci, L. A. Weithorn, E. P. Mulvey, & J. Monahan (Eds.), Children, mental health, and the law (pp. 103-122). Beverly Hills: Sage.

Greif, E. B., & Ulman, K. J. (1982). The psychological impact of menarche on early adolescent females: A review of the literature. Child Development, 53, 1413-1430.

Griffin, W. A. (1993). Transitions from negative affect during marital interaction: Husband and wife differences. Journal of Family Psychology, 6(3), 230-244.

Grossman, K. E., & August-Frenzel, P. (1991). Emotional Development. In R. M. Lerner, A. C. Petersen, & J. Brooks-Gunn (Eds.), Encyclopedia of adolescence (pp. 301-306). New York: Garland Publishing Inc.

Grotevant, H. D., & Cooper, C. R. (Eds.). (1983). Adolescent development in the family. San Francisco: Jossey-Bass.

Grych, J. H. & Fincham, F. D. (1990). Marital conflict and children's adjustment: A cognitive contextual framework. Psychological Bulletin, 108, 267-290.

Haley, J. (1963). Strategies of psychotherapy. New York: Grune & Stratton.

Haley, J. (1973). Uncommon therapy. New York: Norton.

Haley, J. (1976). Problem solving therapy. San Francisco: Jossey-Bass.

Hammond, W. R. & Yung, B. (1993). Psychology's role in the public health response to assaultive violence among young African American men. American Psychologist, 48, 142-154.

Hardy, K. V. (1996). Breathing Room. The Family Therapy Networker, 20, 53-59.

Hauser, S.T., Powers, S. I., & Noam, G. G. (1991). Adolescents and their families: Paths of ego development.. New York: The Free Press.

Hauser, S. T., Powers, S. I., Noam, G. G., Jacobson, A. M., Weiss, B., & Follansbee, D. J. (1984). Familial contexts of adolescent ego development. Child Development, 55, 195-213.

Haviland, J. M., & Kramer, D. A. (1991). Affect-cognition relationships in adolecent diaries: The case of Anne Frank. Human Development, 34, 143-159.

Haviland, J., & Lewica, M. (1987). The induced affect response: 10 week old infants' responses to three emotion expressions. Developmental Psychology, 23, 97-104.

Hawkins, J. D., Arthur, M. W., & Catalano, R. F. (1995). Preventing substance abuse. In M. Tonry & D. P. Farrington (Eds.), Building a safer society: Strategic approaches to crime prevention. Crime and Justice: A revew of the research (Vol. 19, pp. 343-427). Chicago, IL: University of Chicago Press.

Hawkins, J. D., Catalano, R. F., & Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. Psychological Bulletin, 112, 64-105.

Hazelrigg, M. D., Cooper, H. M., & Borduin, C. M. (1987). Evaluating the effectiveness of family therapies: An integrative review and analysis. Psychological Bulletin, 101(3), 428-442.

Henggeler, S. W. (1994). A consensus: Conclusions on the APA Task Force Report on innovative models of mental health services for children, adolescents, and their families. Journal of Clinical Child Pdychology, 23, 3-6.

Henggeler, S. W., & Borduin, C. M. (1990). The treatment of parent-child difficulties. In S. Henggeler & C. M. Borduin (Eds.), Family therapy and beyond: A multisystemic approach to treating the behavior problems of children and adolescents (pp 62-93). Pacific Grove, CA: Brooks Cole Publishing Co.

Henggeler, S. W., Borduin, C. M., Melton, G. B., Mann, B. J., Smith, L. A., Hall, J. A., Cone, L., & Fucci, B. R. (1991). Effects of multisystemic therapy on drug use and abuse in serious juvenile offenders: A progress report from two outcome studies. Family Dynamics Addiction Quarterly, 1, 40-51.

Henggeler, S., Melton, G., & Smith, L. (1992). Family preservation using Multisystemic Therapy: An effective alternative to incarcerating serious juvenile offenders. Journal of Consulting and Clinical Psychology, 60, 953-961.

Henggeler, S. W., Rodick, D., Borduin, C. M., Hanson, C. L., Watson, S. M., Urey, J. R. (1986). Multisystemic treatment of juvenile offenders: Effects on adolescent behavior and family interaction. Developmental Psychology, 22(1), 132-141.

Henggeler, S. W., & Santos, A. B. (Eds.). (1995). Innovative services for difficult to treat populations. Washington, DC: American Psychiatric Association Press.

Henggeler, S. W., Schoenwald, S. K., Prickrel, S. G., Rowland, M. D. & Santos, A. B. (1994). The contribution of treatment outcome research to the reform of children's mental health services: Multisystemic therapy as an example. Journal of Mental Health Administration, 21, 221-239.

Hill, J. (1980). The family. In M. Johnson (Ed.), Toward adolescence: The middle school years. Seventy-ninth yearbook of the National Society for the Study of Education (pp. 32-55). Chicago, IL: University of Chicago Press.

Hill, J. P. (1987). Research on adolescents and their families: Past and prospect. In C. E. Irwin (Ed.), Adolescent social behavior and health. New directions for child development, 37, San Francisco: Jossey-Bass.

Hill, J. P., & Holmbeck, G. N. (1986). Attachment and autonomy during adolescence. Annals of Child Development, 3, 145-189.

Hinshaw, S. P. (1992). Externalizing behavior problems and academic underachievement in childhood and adolescence: Causal relationships and underlying mechanisms. Psychological Bulletin, 111(1), 127-155.

Hinshaw, S., Lahey, B., & Hart, E. (1993). Issues of taxonomy and comorbidity in the development of conduct disorder. Development and Psychopatholgy, 5, 31-49.

Hirschi, T. (1969). Causes of delinquency. Berkeley, CA: University of California Press.

Hoffman, L. (1981). Foundations of family therapy. New York: Basic Books.

Holmbeck, G. N. & Updegrove, A. L. (1995). Clinical-developmental interface: Implications of developmental research for adolescent psychotherapy. Psychotherapy, 32, 16-33.

Hooley, J. M. (1985). Expressed emotion. Clinical Psychology Review, 5, 119-139.

Ianni, F. A. (1983). Home, school, and community in adolescent education. Clearinghouse on Urban Education.

Ingersoll, G. M., & Orr, D. P. (1989). Behavioral and emotional risk in early adolescents. Journal of Early Adolescence, 9, 396-408.

Institute of Medicine Report (1989). Research on Children and Adolescents with Mental, Behavioral & Developmental Disorders. Washington, DC: U. S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration.

Institute of Medicine [IOM]. (1994). Reducing risks for mental disorders: Frontiers for preventive intervention research. Washington, DC: National Academy Press.

Jackson, J. S., McCullough, W. R., Gurin, G. (1988). Family socialization environment and identity development in Black Americans. In H. P. McAdoo (Eds.), Black Families (2nd ed., pp. 242-256). Newberry Park, CA: Sage.

Jessor, R. (1993). Successful adolescent development among youth in high-risk settings. American Psychologist, 48, 117-126.

Jessor, S. L. & Jessor, R. (1975). Transition from virginity to nonvirginity among youth: A social-psychological study over time. Developmental Psychology, 11, 473-484.

Jessor, R. & Jessor, S. L. (1977). The social - psychological framework. In Jessor, R., Jessor, S.L. Problem behavior & psychosocial development: A longitudinal study of youth (pp. 17-42). New York: Academic Press.

Jessor, R., Van Den Bos, J., Vanderryn, J., Costa, F. M., & Turbin, M. S. (1995). Protective factors in adolescent problem behavior: Moderator effects and developmental change. Developmental Psychology, 31(6), 923-933.

Johnson, L. D. (1992, October). We want rappers. The Source, 18.

Johnston, L. D., O'Malley, P., & Bachman, J. (1995). National survey results on drug use from the monitoring the future study 1975-1994. Volume I: Secondary school students (pp. 327, 189 respectively). (NIH Pub. No. 96-4027). Rockville, MD: National Institute on Drug Abuse.

Juarez, R. (1985). Core issues in psychotherapy with the Hispanic child. Psychotherapy, 22, 441-448.

Jurich, A. (1990, July/August). The jujitsu approach: Confronting the belligerent adolescent. Family Therapy Networker, 43-45, 47, 64

Kagan, J. (1989). Unstable ideas: Temperament, cognition, and self. Cambridge, MA: Harvard University Press.

Kalichman, S. C., Kelly, J. A., Hunter, T. L., Murphy, D. A., & Tyler, R. (1993). Culturally tailored HIV-AIDS risk-reduction messages targeted to African American urban women: Impact on risk sensitization and risk reduction. Journal of Consulting and Clinical Psychology, 61, 291-295.

Kandel, D. B. (1975). Stages in adolescent involvement in drug use. Science, 190, 912-914.

Kandel, D. & Andrews, K. (1987). Process of adolescent socialization by parents and peers. International Journal of the Addictions, 22, 319-342.

Kandel, D. B., Kessler, R. C., & Margulies, R. Z. (1987). Antecedents of adolescent initiation into stages of drug use: A developmental analysis. Journal of Youth and Adolescence, 7, 13-40.

Kaslow, F. (Ed.) (1986). Supervision and training: Models, dilemmas, and challenges. New York: Haworth.

Kaufman, E. (1985). Family systems and family therapy of substance abuse: An overview of two decades of research and clinical experience. The International Journal of the Addictions, 20, 897-916.

Kazdin, A. E. (1989). Developmental Psychopathology: Current Research, Issues, and Directions. American Psychologist, 44, 180-187.

Kazdin, A. E. (1982). Symptom substitution, generalization, and response covariation: Implications for psychotherapy outcome. Psychological Bulletin, 91, 349-365.

Kazdin, A. E. (1987). Treatment of antisocial behavior in children: Current status and future directions. Psychological Bulletin, 102, 187-203.

Kazdin, A. E. (1989). Developmental psychopathology: Current research, issues and directions. American Psychologist, 44, 180-187.

Kazdin, A. E. (1991). Effectiveness of psychotherapy with children and adolescents. Journal of Consulting and Clinical Psychology, 59, 758-798.

Kazdin, A. E. (1993). Adolescent mental health: Prevention and treatment programs. American Psychologist, 48, 127-141.

Kazdin, A. E. (1994). Methodology, design, and evaluation in psychotherapy research. In A. Bergin & S. Garfield (Eds.), Handbook of psychotherapy and behavior change (4th ed., pp. 19-71). New York: Wiley.

Kazdin, A. E. (1995). Conduct Disorders in childhood and adolescence (2nd ed.). Thousand Oaks, CA: Sage.

Kazdin, A. E., Bass, D., Ayers, W. A., & Rodgers, A. (1990). Empirical and clinical focus of child and adolescent psychotherapy research. Journal of Consulting and Clinical Psychology, 58, 729-740.

Kazdin, A. E., Bass, D., Siegel, T., & Thomas, C. (1989). Cognitive-behavioral therapy and relationship therapy in the treatment of children referred for antisocial behavior. Journal of Consulting and Clinical Psychology, 57, 522-535.

Kazdin, A. E., & Kagan, J. (1994). Models of dysfunction in developmental psychopathology. Clinical Psychology: Science and Practice, 1(1), 35-52.

Kazdin, A. E., Stolar, M. J., & Marciano, P. L. (1995). Risk factors for dropping out of treatment among white and Black families. Journal of Family Psychology, 9, 402-417.

Kellam, S. G., Brown, C. H., Rubin, B. R., & Ensminger, M. E. (1983). Paths Leading to teenage psychiatric symptoms and substance use: Developmental epidemiological studies in Woodlawn. In S. B. Guze, F. J. Earls, & J. E. Barrett (Eds.), Childhood psychopathology and development (pp. 17-51). New York: Raven Press.

Kellam, S. G., & Rebok, G. W. (1992). Building developmental and etiological theory through epidemiologically based preventive intervention trials. In J. McCord & R. E. Tremblay (Eds.), Preventing antisocial behavior: Interventions from birth through adolescence (pp.162-195). New York: Guilford Press.

Kelley, H. H. (1984). Affect in interpersonal relations. In Controversial issues in emotion theory.

Kendall, P. C., Lerner, R. M., & Craighead, W. E. (1984). Human Development and Intervention in Childhood Psyghopathology. Child Development, 55, 71-82.

Kett, J. (1977). Rites of passage: Adolescnets in America 1790-present. New York: Basic Books.

Keyes, S. & Block, J. (1984). Prevalence and patterns of substance use among early adolescents. Journal of Youth and Adolescence, 13(1), 1-14.

Klein, N. C., Alexander, J. F., & Parsons, B. V. (1976). Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation. Journal of Consulting & Clinical Psychology, 45(3),469-474.

Kleinman, P. (1992). Retention of cocaine abusers in outpatient psychotherapy. American Journal of Drug & Alcohol Abuse, 18, 29-43.

Kobak, R. R. & Sceery, A. (1988). Attachment in late adolescence: Working models, affect regulation, and representations of self and others. Child Development, 59, 135-146.

Koestler, A. (1979). Janus: A Summing Up. New York: Vintage Books.

Landrine, H. & Klonoff, E. A. (1994). The African American acculturation scale: Development, Reliability, and Validity. Journal of Black Psychology, 20, 104-127.

Larson, K. A. (1989). Task-related and interpersonal problem-solving training for increasing school success in high-risk young adolescents. RASE-Remedial and Special Education, 10, 32-42.

Larson, R., & Richards, M. H. (1991). Daily companionship in late childhood and early adolescence: Changing developmental contexts. Child Development, 62, 284-300.

Lebow, J. L. (1987). Developing a personal integration in family therapy: Principles for model construction and practice. Journal of Marital and Family Therapy, 13(1), 1-14.

Lebow, J. L., & Gurman, A. S. (1995). Research assessing couple and family therapy. Annual Review of Psychology, 46, 27-57.

Levin, J. S., & Taylor, R. J. (1993). Gender & age differences in religiosity among Black Americans. The Gerontologist, 33, 16-23.

Leff, J. & Vaughn, C. (1985). Expressed emotion in families. New York: Guilford Press.

Lerner, R. M. (1991). Changing organism-context relations as the basic process of development: A developmental contextual perspective. Developmental Psychology, 27(1), 27-32.

Lerner, R.M., Entwisle, D., Hauser, S.T. (1994). The crisis among contemporary American Adolescents: A call for the integration of research, policies, and programs. Journal of Research on Adolescence, 4, 1-4.

Lerner, R.M., Petersen, A.C. & Brooks-Gunn, J. (Eds.). (1991). Encyclopedia of Adolescence (Vols. 1-2). New York: Garland Publishing Inc.

Levine, B. L. (1985). Adolescent substance abuse: Toward an integration of family systems and individual adaptation theories. The American Journal of Family therapy, 13(2), 3-16.

Lewis, R. A., Piercy, F. P., Sprenkle, D. H., & Trepper, T. S. (1990). Family-based interventions for helping drug-abusing adolescents. Journal of Adolescent Research, 5(1), 82-95.

Liddle, H. A. (1982). On the problems of eclecticism: A call for epistemoligc clarification and human scale theories. Family Process, 21, 243-250.

Liddle, H. A. (1983). Guest editor's introduction: Special issue on family therapy training. Journal of Strategic and Systemic Therapies, 2(3), 1-2.

Liddle, H. A. (1984). Toward a dialectical-contextual-coevolutionary translation of structural-strategic family therapy. Journal of Strategic and Systemic Therapies, 4, 66-79.

Liddle, H. A. (1985). Five factors of failure in structural-strategic family therapy: A contextual construction: In S. Coleman (Ed.), Failures in family therapy. New York: Guilford.

Liddle, H. A. (1987a). Editor's introduction I: Family psychology: The journal, the field. Journal of Family Psychology, 1(1), 5-22.

Liddle, H. A. (1987b). Editor's introduction II: Family psychology: Tasks of an emerging (and emerged) discipline. Journal of Family Psychology, 1(2), 149-167.

Liddle, H. (1988). Integrating developmental thinking and the family life cycle: Implications for training family therapists. In C. Falicov (Ed.) Family Transitions: Continuity and Change over the Life Cycle. New York: Guiford Press.

Liddle, H. A. (1991a). The adolescents and families project: Multidimensional family therapy in action. In ADAMHA monograph from the first national conference on the treatment of adolescent drug, alcohol and mental health problems. Washington, DC: United States Public Health Service, Government Printing Office.

Liddle, H. A. (1991b). Engaging the adolescent in family systems therapy. In T. Nelson (Ed.), Interventions in family therapy. New York: Haworth.

Liddle, H. A. (1991c). Empirical values and the culture of family therapy. Journal of Marital and Family Therapy, 17(4), 327-348.

Liddle, H. A. (1992). A multidimensional model for the adolescent who is abusing drugs and alcohol. In W. Snyder & T. Ooms (Eds.), Empowering Families, helping adolescents: Family-centered treatment of adolescents with alcohol, drug abuse, and other mental health problems. U.S. Department of Health and Human Services, Office for Treatment Improvement, ADAMHA, Washington, DC: United States Public Health Service, U.S. Government Printing Office.

Liddle, H. A. (1993). Engaging adolescents in family therapy: Some early phase skills. In T. Nelson and T. Trepper (Eds.), 101 Interventions in Family Therapy. New York: Haworth.

Liddle, H. A. (1994). The anatomy of emotions in family therapy with adolescents. Journal of Adolescent Research. Special Issue: Affective Expression and Emotions During Adolescence. 9(1), 120-157.

Liddle, H. A. (1995). Conceptual and clinical dimensions of a multidimensional, multisystems engagement strategy in family-based adolescent treatment. Psychotherapy, 32, 39-58.

Liddle, H.A., Becker, D., & Diamond, G. M. (1997). Family therapy supervision. In C.E. Watskins (Ed.), Handbook of psychotherapy supervision (pp. 400-418). New York: John Wiley & Sons, Inc. p. 33.

Liddle, H. A. & Dakof, G. A. (in press). Status report a clinical research program on family-based adolescent drug abuse treatment. In H. A. Liddle, D. Santisteban, R. Levant, & J. Bray (Eds.). Family psychology intervention science. Washington, D.C.: American Psychological Associations Publications.

Liddle, H. A. & Dakof, G. A. (1993). Family-based intervention for adolescent drug abuse: Effects of a randomized clinical trial. Presented at the 1993 Society for Psychotherapy Research Conference, Pittsburgh, PA.

Liddle, H. A., & Dakof, G. A. (1995). Efficacy of family therapy for drug abuse: Promising but not definitive. Journal of Marital and Family Therapy, 21, 511-543.

Liddle, H. A., & Dakof, G. A. (1995). Family-based treatments for adolescent drug abuse: State of the science. In E. Rahdert & D. Czechowicz (Eds.), Adolescent drug abuse: Clinical assessment and therapeutic interventions (pp. 218-254). NIDA Research Monograph 156, NIH Pub. No. 95-3908. Rockville, MD: National Institute on Drug Abuse Publications.

Liddle, H. A., Dakof, G. A., & Diamond, G. (1991). Adolescent substance abuse: Multidimensional family therapy in action. In E. Kaufman & P. Kaufman (Eds.), Family Therapy of Drug and Alcohol Abuse (pp. 120-171). Boston: Allyn and Bacon.

Liddle, H. A., Dakof, G. A., Parker, K., & Diamond, G. S. (1991). The adolescent and families project. Paper presented at the 1991 American Psychological Association Convention, San Francisco, CA.

Liddle, H. A., Dakof, G. A., Parker, K., Diamond, G., Garcia, R., Barrett, K., & Hurwitz, S. (1992). Effectiveness of family therapy versus multi-family therapy and group therapy: Results of the Adolescents and Families Project -- a randomized clinical trial. Paper presented at the annual meeting of the American Psychological Association, Washington, DC, August.

Liddle, H. A. & Diamond, G. (1991). Adolescent substance abusers in family therapy: The critical initial phase of treatment. Family Dynamics of Addiction Quarterly, 1(1), 55-68.

Liddle, H. A., Diamond, G., Dakof, G., Arroyo, J., Guillory, P., Holt, M., & Watson, M. (1991). Adolescent substance abuse: Multidimensional Family Therapy in action. In E. Kaufman & P. Kaufman (Eds.), Family therapy approaches with drug and alcohol problems (2nd ed.). Boston: Allyn and Bacon.

Liddle, H. A., Schmidt, S., & Ettinger, D. (in press). Adolescent development research: Guidelines for clinicians. Journal of Marital and Family Therapy.

Loeber, R. (1982). The stability of antisocial and delinquent child behavior. Child Development, 53, 1431-1446.

Loeber, R. (1985). Patterns and development of antisocial child behavior. Annals of Child Development, 2, 77-116.

Loeber, R. (1988). Behavioral precursors and accelerators of delinquency. In W. Buihiuisen & S. A. Mednick (Eds.), Explaining crime, (pp. 51-67). Leiden, The Netherlands: Brill.

Loeber, R. (1990). Development and risk factors of juvenile antisocial behavior and delinquency. Clinical Psychology Review, 10, 1-41.

Loeber, R. (1991). Antisocial Behavior: More enduring than changeable? Journal of the American Academy of Child and Adolescent Psychiatry, 30(3), 393-397.

Loeber, R., & Hay, D. F. (1994). Developmental approaches to aggression and conduct problems. In M. Rutter & D. F. Hay (Eds.), Development through life: a handbook for clinicians (pp. 488-516). Oxford: Blackwell Scientific.

Loeber, R., & Dishion, T. J. (1983). Early predictors of male delinquency: A review. Psychological Bulletin, 94, 68-99.

Loeber, R., & Stouthamer-Loeber, M. (1986). Family factors as correlates and predictors of juvenile conduct problems and delinquency. In M. Tonry & N. Morris (Eds.), Crime and Justice: An Annual Review of Research: Vol. 7 (pp. 29-149). Chicago, IL: University of Chicago Press.

Long, N. & Forehand, R. L. (1987). The effects of parental divorce and parental conflict on children: An overview. Journal of Developmental and Behavioral Pediatrics, 8, 292-296.

Luborsky, L., & Crits-Christoph, P. (1990). Understanding transference: The CCRT method. New York: Basic Books.

Lyons-Ruth, K. (1995). Broadening our conceptual frameworks: Can we reintroduce relational strategies and implicit representational systems to the study of psychopathology? Developmental Psychology, 31(3), 432-436.

Maccoby, E. E. & Martin, J. A. (1983). Socialization in the context of the family: Parent-child interaction. In E. M. Hetherington (Ed.,) Handbook of child psychology, Vol. 4, Socialization, personality, and social development (pp. 1-102). New York: Wiley.

Madanes, C. (1981). Strategic family therapy. San Francisco: Jossey-Bass.

Mahoney, M. J. (1984). Integrating cognition, affect, and action: A comment. Cognitive Therapy and Research, 8, 585-589.

Mahrer, A. R. (1988). Research and clinical applications of "good moments" in psychotherapy. Journal of Integrative and Eclectic Psychotherapy, 7, 81-93.

Mahrer, A. R. (1988). Research and clinical applications of "good moments" in psychotherapy. Journal of Integrative and Eclectic Psychotherapy, 7, 81-93.

Mann, B. J., & Borduin, C. M. (1991). A critical review of psychotherapy outcome studies with adolescents: 1978-1988. Adolescence, 26, 505-541.

Mann, B. J., Borduin, C. M., Henggeler, S. W. & Blaske, D. M. (1990). An investigation of systematic conceptualizations of parent-child coalitions and symptom change. Journal of Consulting and Clinical Psychology, 58, 336-344.

Markus, H. & Nurius, P. (1986). Possible selves. American Psychologist, 41, 954-969.

Melton, G. B., & Hargrove, D. S. (1995). Planning mental health services for children and youth. New York: Guilford Press.

Melton, G. B., & Pagliocca, P. (1992). Treatment in the juvenile justice system: Directions for policy and practice. In J. Cocozza (Ed.), Responding to the mental health nedds of youth in the juvenile justice system (pp. 107-139). Seattle, WA: National Coalition for the Mentally Ill in the Criminal Justice System.

Miller, G. E., & Prinz, R. J. (1990). Enhancement of social learning family interventions for childhood conduct disorder. Psychological Bulletin, 108, 291-307.

Millstein, S.G., & Litt, R. (1990). Risk factors for AIDS among adolescents. New Directions for Child Development, 50, 3-15.

Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.

Minuchin. S., & Fishman, H. C. (1981). Family Therapy Techniques. Cambridge, MA: Harvard University Press.

Moffitt, T. E. (1993). Adolescence-limited and life-course-persistent antisocial behavior: A developmental taxonomy. Psychological Review, 100(4), 674-701.

Montemayor, R. (1983). Parents and adolescents in conflict: All families some of the time and some families most of the time. Journal of Early Adolescence, 3, 83-103.

Montemayor, R. (1986). Family variation in parent-adolescent storm and stress. Journal of Adolescent Research, 1, 15-31. Morrow-Bradley, C., & Elliott, R. (1986). Utilization of psychotherapy research by practicing psychotherapists. American Psychologist, 41, 188-197.

Mounts, N. S., & Steinberg, L. (1995). An ecological analysis of peer influence on adolescent grade point average and drug use. Developmental Psychology, 31(6), 915-922.

Nadelman, E. A. (1989). Drug prohibition in the United States: Costs, consequences, and alternatives. Science, 245, 939-947.

National Institute on Drug Abuse (1991). National Household Survey on Drug Abuse: Main Findings 1990. Rockville, MD: U. S. Dept. of Health and Human Services.

National Institute on Drug Abuse (in press). Family dynamics and interventions research dissemination and applications, and clinical report. Rockville, MD: National Institute on Drug Abuse.

Needle, R., Su, S., Doherty, W., Lavee, Y., & Brown, P. (1988). Familial, interpersonal, and intrapersonal correlates of drug use: A longitudinal comparison of adolescents in treatment, drug-using adolescents not in treatment, and non-drug-using adolescents. The International Journal of the Addictions, 23(12), 1211-1240.

Newberry, R. C. (1992, June). Are some of the hip-hop generation unreachable? The Houston Post, A-13.

Newberry, A. M., Alexander, J. F., & Turner, C. W. (1991). Gender as a process variable in family therapy. Journal of Family Psychology, 5, 158-175.

Newcomb, M. D., (1992). Understanding the multidimensional nature of drug use and abuse: The role of consumption, risk factors, and protective factors. In M. Glantz & R. Pickens Vulnerability to Drug Abuse. Washington, DC: APA.

Newcomb, M. (1995). Identifying high-risk yourth: Prevalence and patterns of adolescent drug abuse. In E. Rahdert & D. Czechowicz (Eds.), Adolescent drug abuse: Clinical assessments and therapeutic interventions (pp. 7-38). NIDA Research Monograph 156, NIH Pub. No. 95-3908. Rockville, MD: National Institute on Drug Abuse.

Newcomb, M. D., & Bentler, P. M. (1988). Impact of adolescent drug use and social support on problems of young adults: A longitudinal study. Journal of Abnormal Psychology, 97, 64-75.

Newcomb, M. D. & Bentler, P. M. (1989). Substance use and abuse among children and teenagers. American Psychologists, 44, 242-248.

Newcomb, M. D., & Felix-Ortiz, M. (1992). Multiple protective and risk factors for drug use and abuse: Cross-sectional and prospective findings. Journal of Personality and Social Psychology, 63(2), 280-296.

Newcomb, M. D., & Harlow, L. L. (1986). Life events and substance use among adolescents: Mediating effects of perceived loss of control and meaninglessness in life. Journal of Personality and Social Psychology, 51(3), 564-577.

Newcomb, M. D., Maddahian, E., & Bentler, P.M. (1986). Risk factors for drug use among adolescents: Concurrent and logitudinal analyses. American Journal of Public Health, 76, 525-531.

Nichols, M. P. & Schwartz, R. C. (1998). Family therapy: Concepts and methods (4th ed.). Needham Heights: Allyn and Bacon.

Nightingale, E. O., & Wolverton, L. (1993). Adolescent roleness in modern society. Teachers College Record, 94(3), 472-486.

Nobles, W. (1980). African philosophy: Foundations for Black psychology. In R. Jones (Ed.), Black psychology (2nd ed.) (pp. 23-26). New York: Harper & Row.

Nobles, W. (1986). African Psychology: Toward its Reclamation, Re-ascension, and Revitalization. Oakland, CA: Institute for the Advanced Study of Black Family Life and Culture, Inc.

Nolen-Hoeksema, S. & Girgus, J. S. (1994). The emergence of gender differences in depression during adolescence. Psychological Bulletin, 115(3), 424-443.

Noller, P., & Callan, V. J. (1986). Adolescent and parent perceptions of family cohesion and adaptability. Journal of Adolescence, 9, 97-106.

O'Donnell, J., Hawkins, J. D., & Abbott, R. D. (1995). Predicting serious delinquency and substance use among aggressive boys. Journal of Consulting and Clinical Psychology, 63(4), 529-537.

Oetting, E. R., & Beauvais, F. (1986). Peer cluster theory: Drugs and the adolescent. Journal of Counseling and Development, 65, 17-22.

Offer, D., Howard, K. I., Schonert, K. A., & Ostrov, E. (1991). To whom do adolescents turn for help? Differences between disturbed and nondisturbed adolescents. Journal of American Academy of Child and Adolescent Psychiatry, 30, 623-630.

Offer, D., Ostrov, E., & Howard, K. L. (1981). The mental health professional's concept of the normal adolescent. Archives of General Psychiatry, 38, 149152.

Ogbu, J. (1978). Minority Education and Caste: The American System in Cross Cultural Perspective. New York, NY: Academic Press.

Paikoff, R. L.& Brooks-Gunn, J. (1991). Do parent-child relationships change during puberty? Psychological Bulletin, 110, 47-66.

Pandina, R. J., Johnson, V., Labouvie, E. W. (1992). Affectivity: A central mechanism in the development of drug dependence. In M. Glantz & R. Pickens (Eds.), Vulnerability to Drug Abuse. Washington, DC: APA.

Pandina, R. J., & Schuele, J. A. (1983). Psychosocial correlates of alcohol and drug use of adolescent students and adolescents in treatment. Journal of Studies on Alcohol, 44, 950-973.

Papini, D. R., & Roggman, L. A. (1992). Adolescent perceived attachment to parents in relation to competence, depression, and anxiety: A longitudinal study. Journal of Early Adolescence, 12(4), 420-440.

Papini, D. R., Roggman, L. A., & Anderson, J. (1991). Early adolescent perceptions of attachment to mother and father: A test of the emotional distancing and buffering hypotheses. Journal of Early Adolescence, 11, 258-275.

Parham, T. A. & Helms, J. E. (1985). Relation of racial identity attitudes to self-actualization and affective states of Black students. Journal of Counseling Psychology, 32, 431-440.

Paster, V. S. (1985). Adapting psychotherapy for the depressed, unacculturated, acting out, black male adolescent. Psychotherapy, 22, 408-417.

Patterson, G. R. (1982). A social learning approach. Vol. 3: Coercive family process. Eugene, OR: Castalia Publishing Company.

Patterson, G. R. (1986). Performance models for antisocial boys. American Psychologist, 46, 99-106.

Patterson, G. R., & Chamberlain, P. (1994). A functional analysis of resistance during parent training therapy. Clinical Psychology: Science and Practice, 1, 53-70.

Patterson, G. R., DeBarsyhe, B. D., & Ramsey, E. (1989). A developmental perspective on antisocial behavior. American Psychologist, 44(2), 329-335.

Patterson, G. R., & Dishion, T. J. (1985). Contributions of families and peers to delinquency. Criminology, 23, 63-79.

Patterson, G. R., Dishion, T. J., & Bank, L. (In press). Family interaction: A process model of deviancy training. In L. Eron (Ed.), special edition of Aggressive Behavior.

Patterson, G.R., Reid, J.B. & Dishion, T.J. (1991). Antisocial boys: A social interactional approach. Eugene, OR: Castalia.

Patterson, G. R., Reid, J. B., & Dishion, T. J. (1992). A social learning approach to family intervention: IV. Antisocial boys. Eugene, OR: Castalia.

Patterson, G. R. & Stoolmiller, M. (1991). Replications of a dual failure model for boys' depressed mood. Journal of Consulting and Clinical Psychology, 59(4), 491-498.

Patterson, G. R., & Stouthamer-Loeber, M. (1984). The correlation of family management practices and delinquency. Child Development, 55, 1299-1307.

Patterson, G. R. & Yoerger, K. (1993). Developmental models for delinquent behavior. In S. Hodgins (Ed.), Mental Disorder and Crime (pp. 140-169). Newbury Park, CA: Sage Publications.

Peele, S. (1986). The "cure" for adolescent drug abuse: Worse than the problem? Journal of Counseling and Development, 65, 23-24.

Petersen, A. C. (1988). Adolescent development. In M. R. Rosenzweig & L. W. Porter (Eds.), Annual Review of Psychology (Vol. 39; pp. 583-608). Palo Alto, CA: Annual Reviews.

Petersen, A. C. & Hamburg, B. A. (1986). Adolescence: A developmental approach to problems and psychopathology. Behavior Therapy, 17, 480-499.

Petraitis, J., Flay, B. R., & Miller, T. Q. (1995). Reviewing theories of adolescent substance use: Organizing pieces in the puzzle. Psychological Bulletin, 117(1), 67-86.

Phillips, F. B. (1990). NTU psychotherapy: An Afrocentric approach. The Journal of Black Psychology, 17, 55-74.

Phinney, J. S. & Chavira, V. (1995). Parental Ethnic Socialization and Adolescent coping with problems related to ethnicity. Journal of Research on Adolescence, 5, 31-53.

Pinderhughes, E. (1982). Afro-American families and the victim system. In M. McGoldrick, J. K. Pearce, & J. Giordano (Eds.), Ethnicity and Family Therapy (pp.108-122). New York: Guilford Press.

Pinsof, W. (1989). A conceptual framework and methodological criteria for family therapy process research. Journal of Consulting and Clinical Psychology, 57, 53-59.

Project PRIDE. (1995). 1995 PRIDE Survey Press Release. Released at the Community Anti-Drug Coalitions (CADCA) Leadership Forum, Washington, DC.

Radke-Yarrow, M., & Zahn-Waxler, C. (1990). Research on children of affectively ill parents: Some considerations for theory and research on normal development. Development and Psychopathology, 2, 349-366.

Rahdert, E. & Czechowicz, D. (1995). Advances in adolescent drug abuse treatment. In E. Rahdert & D. Czechowicz (Eds.), Adolescent drug abuse: Clinical assessements and therapeutic interventions. NIDA Research Monograph 156, NIH Pub. No. 95-3908. Rockville, MD: National Institute on Drug Abuse.

Reid, J.B. (1993). Prevention of conduct disorder before and after school entry: Relating interventions to developmental findings. Development and Psychopatholoy, 5, 243-262.

Reilly, D. M. (1975). Family factors in the etiology and treatment of youthful drug abuse. Family Therapy, 2, 149-171.

Reilly, D. M. (1979). Drug-abusing families: Intrafamilial dynamics and brief triphasic treatment. In E. Kaufman & P. N. Kaufmann (Eds.), Family therapy of drug and alcohol abuse. New York: Gardner Press.

Rhodes, J. E., & Jason, L. A. (1990). A social stress model of substance abuse. Journal of Consulting and Clinical Psychology, 58, 395-401.

Ridley, C. R., Mendoza, D. W., Kanitz, B. E., Angermeier, L., and Zenk, R. (1994). Cultural sensitivity in multi cultural counseling: A perceptual schema model. Journal of Counseling Psychology, 41, 125-136.

Robbins, M. S., Alexander, J. F., Newell, R. M. & Turner, C. W. (1996). The immediate effect of reframing on client attitude in family therapy. Journal of Family Psychology, 10, 28-34.

Robin, A. L., & Foster, S. L. (1989). Negotiating parent adolescent conf7ict: A behavioral-family systems approach. New York: Guilford.

Rosten, L. (1975). Religions of America: Ferment and Faith in an Age of Crisis. New York, NY: Simon & Schuster.

Rowe, D. (1994). Limits of Family Influence. New York: Guilford Press.

Rutter, M. (1980). Changing youth in a changing society: Patterns of adolescent development and disorder. Cambridge, MA: Harvard University Press.

Rutter, M. (1985). Family and school influences on cognitive development. Journal of Child Psychology and Psychiatry, 26, 683-704.

Rutter, M. (1987). Psychosocial resilence and protective mechanisms. American Journal of Orthopsychiatry, 57, 316-331.

Ryan, R. M. & Lynch, J. H. (1989). Emotional autonomy versus detachment: Revisiting the vicissitudes of adolescence and young adulthood. Child Development, 60, 340-356.

Saarni, C. & Crowley, M. (1990). The development of emotion regulation: Effects on emotional state and expression. In E. A. Blechman (Ed.), Emotions and the Family: For Better or Worse. Hillsdale, NJ: Lawrence Erlbaum Associates.

SAMHSA (1995). Substance Abuse and Mental Health Services Administration. National Household Survey on Drug Abuse: Population Estimates, 1994. DHHS Pub. No. (SMA)95_3063. Washington, DC: Support of Documents, U.S. Government Printing Office.

Safran, J. D., & Greenberg, L. S. (1991). Affective change processes: A synthesis and critical analysis. In J. D. Safran, & L. S. Greenberg, L. S. (Eds.), Emotion, Psychotherapy, and Change (pp. 339-362). New York: Guilford Press.

Sameroff, A. J. & Feil, L. A. (1985) Parental concepts of development. In I. Sigel, (Ed.) Parental belief systems: The psychological consequences for Children (pp. 83-105). Hillsdale, NJ: Lawrence Erlbaum.

Santisteban, D.A., Szapocznik, J., Perez-Vidal, A. & LaPerriere, A. (1996). Engaging behavior problem/drug abusing youth and their families into treatment: A replication and further exploration of the factors that contribute to differential effectiveness. Journal of Family Psychology, 10(1), 35-44.

Santostefano, S. (1986). Cognitive controls, metaphors, and contexts: An approach to cognition and emotion. In D. J. Bearison & H. Zimiles (Eds.), Thought and emotion: Developmental perspectives (pp.175-210). Hillsdale, NJ: Lawrence Erlbaum Associates.

Schaap, C. (1984). A comparison of the interaction of distressed and nondistressed married couples in a laboratory situation: Literature survey, methodological issues, and an empirical investigation. In K. Hahlweg & N. S. Jacobson (Eds.), Marital Interaction: Analysis and Modification (pp. 133-158). New York: Guilford Press.

Schlegel, R.P. & Barry, H. (1991). Adolescence: An anthropological inquiry. New York: Free Press.

Schmidt, S. & Liddle, H. A. (1992). Parental influence in families of adolescent drug abusers. National Institute on Drug Abuse Grant (Number 1F31 DA05545-01).

Schmidt, S. E., Liddle, H. A., & Dakof, G. A. (1996). The relationship of change in parenting with change in adolescent symptomatology in Multidimensional Family Therapy. Journal of Family Psychology, 10(1), 12-27.

Seelig, W. R., Goldman-Hall, B. J., & Jerrell, J. M. (1992). In-home treatment of families with seriously disturbed adolescents in crisis. Family Process, 31, 135-149.

Segal, B. (1986). Intervention and prevention of drug taking behavior: A need for divergent approaches. The International Journal of the Addictions, 21, 165-173.

Sessa, F. M. & Steinberg, L. (1991). Family structure and the development of autonomy during adolescence. Journal of Early Adolescence, 11(1), 38-55.

Shalala, D. (1995, February). White Paper: Effectiveness of substance abuse treatment. Washington, DC: United States Department of Health and Human Services.

Shantz, C. V. (1983). Social cognition. In J. H. Flavell & E. M. Markman (Eds.), Handbook of Child Psychology, Vol. 3: Cognitive development (pp. 495-555). New York: Wiley.

Shaver, P., Schwartz, J., Kirson, D., & O'Conner, C. (1987). Emotion knowledge: Further exploration of a prototype approach. Journal of Personality and Social Psychology, 52(6), 1061-1086.

Shedler, J., & Block, J. (1990). Adolescent drug use and psychological health: A longitudinal inquiry. American Psychologist, 45(5), 612-630.

Shirk, S. R. (Ed.) (1988*).* Cognitive development and child psychotherapy. New York: Plenum.

Silverberg, S. B. & Steinberg, L. (1987). Adolescent autonomy, parent-adolescent conflict, and parental well-being. Journal of Youth and Adolescence, 16(3), 293-311.

Simons, R. L., Conger, R. D., & Whitbeck, L . B. (1988). Parent and peer factors in learning substance abuse: A causal model. Journal of Drug Issues, 18, 293-315.

Simons, R. L. & Robertson, J. F. (1989). The impact of parenting factos, deviant peers, and coping style upon adolescent drug use. Family Relations, 38, 273-281.

Simons, R. L., Whitbeck, L. B., Conger, R. D., & Melby, J. N. (1991). The effect of social skills, values, peers, and depression on adolescent substance use. Journal of Early Adolescence, 11(4), 466-481.

Smetana, J. (1988). Concepts of self and social convention: Adolescents' and parents' reasoning about hypothetical and actual family conflicts. In M. Gunnar & & W. A. Collins (Eds.), Minnesota symposia on child psychology: Development during the transition to adolescence (Vol. 21, pp. 79-122). Hillsdale, NJ: Lawrence Erlbaum.

Smetana, J. G., Yau, J., Hanson, S. (1991). Conflict resolution in families with adolescents. Journal of Research on Adolescence, 1(2), 189-206.

Spencer, M. B. & Markstrom-Adams, C. (1990). Identity processes among racial and ethnic minority children in America. Child Development, 61, 290-310.

Sroufe, L. A. (1983). Infant-caregiver attachment and patterns of adaptation in preschool: The roots of maladaptation and competence. In M. Perlmutter (Ed.), Minnesota symposia in child psychology (Vol. 6). Hillsdale, NJ: Erlbaum.

Sroufe, L. A., & Rutter, M. (1984). The domain of developmental psychopathology. Child Development, 55, 17-29.

Sroufe, L. A., Schork, E., Motti, F., Lawroski, N., & LaFreniere, P. (1984). The role of affect in social competence. In C. E. Izard, J. Kagan, & R. B. Zajonc (Eds.), Emotions, cognition, and behavior (pp. 289-319). Cambridge, MA: Cambridge University Press.

Stanton, M. D. (1981). An integrated structural/strategic approach to family therapy. Journal of Marital and Family Therapy, 7, 427-439.

Stanton, M. D. (1984). Fusion, compression, diversion, and the workings of paradox: A theory of therapeutic/systemic change. Family Process, 23, 135-168.

Stanton, M. D. (1990). The family and drug abuse: Concepts and rationale. In A. S. Friedman & S. Granick (Eds.), Treatment Modalities (pp. 398-430). Washington, DC: Lexington Books.

Stanton, M.D. & Shadish, W. R. (1997). Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. Psychological Bulletin, 122 (2), 170-191.

Stanton, M. D., Todd, T. C. (1982). The family therapy drug abuse and addiction. New York: Guilford Press.

Steinberg, L. (1987). Familial Factors in Delinquency: A Developmental Perspective. Journal of Adolescent Research, 2, 255-268.

Steinberg, L. (1990). Autonomy, conflict, and harmony in the family relationship. In S. S. Feldman & G. R. Elliott (Eds.), At the threshold - The developing adolescent (pp. 255-276). Cambridge, MA: Harvard University Press.

Steinberg, L. D. (1991). Adolescent transitions and alcohol and other drug use prevention. In E. N. Goplerud (Ed.), Preventing adolescent drug use: From theory to practice. OSAP Prevention Monograph-8. Rockville, MD: DHHS.

Steinberg, L., Darling, N. E., & Fletcher, A. C. (1995). Authoritative parenting and adolescent adjustment: An ecological journey. In P. Moen, G. Elder, & K. Luscher (Eds.), Linking lives and contexts: Perspectives on the ecology of human development. Washington, DC: American Psychological Association.

Steinberg, L., Elmen, J. D., & Mounts, N. S. (1989). Authoritative parenting, psychosocial maturity, and academic success among adolescents. Child Development, 60, 1424-1436.

Steinberg, L., Fletcher, A., & Darling, N. (1994). Parental monitoring and peer influences on adolescent substances abuse. Pediatrics, 93, 1-5.

Steinberg, L., & Lamborn, S. D., Dornbusch, S. M., & Darling, N. (1992). Impact of parenting practices on adolescent achievement: Authoritative parenting, school involvement, and encouragement to succeed. Child Development, 63, 1266-1281.

Stevenson, H. C. & Renard, G. (1993). Trusting ole' wise owls: Therapeutic use of cultural strengths in African American Families. Educational Psychology: Research and Practice, 24, 433-442.

Strupp, H. H., & Binder, J. L. (1984). Psychotherapy in a new key: A guide to time-limited dynamic therapy. New York: Basic Books.

Sue, S. (1988). Psychotherapeutic services for ethnic minorities: Two decades of research findings. American Psychologist, 43, 301-308.

Sue, S., McKinney, H., Allen, D. B., & Hall, J. (1974). Delivery of community mental health services to Black & White clients. Journal of Consulting and Clinical Psychology, 42, 794-801.

Sue, D. W. & Sue, D. (1990). Counseling the Culturally Different: Theory and Practice. New York, NY: John Wiley & Sons.

Szapocznik, J., Kurtines, W. M., Foote, F. H., Perez-Vidal, A., & Hervis, O. (1983). Conjoint versus one-person family therapy: Some evidence for the effectiveness of conducting family therapy through one person. Journal of Consulting and Clinical Psychology, 51, 889-899.

Szapocznik, J., Kurtines, W., Santisteban, D. A., & Rio, A. T. (1990). Interplay of advances between theory, research, and applications in treatment interventions aimed at behavior problem children and adolescents. Journal of Consulting and Clinical Psychology, 58, 696-703.

Szapocznik, J., Perez-Vidal, A., Brickman, A., Foote, F., Santisteban, D., Hervis, O., & Kurtines, W. (1988). Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach. Journal of Consulting and Clinical Psychology, 56, 552-557.

Taylor-Gibbs, J. (1994). Anger in young black males: Victims or Victimizers. In R. G. Majors & J. U. Gordon (Eds.), The American Black Male: His Present Status and His Future. Chicago, IL: Nelson Hall Publishers, Inc.

Terrell, F. & Barrett, R. K. (1979). Interpersonal trust among college students as a function of race, sex, and socioeconomic class. Perceptual and Motor Skills, 48, 1194.

Terrell, F. & Terrell, S. L. (1984). Race of counselor, client sex, cultural mistrust level, and premature termination from counseling among Black clients. Journal of Counseling Psychology, 31, 371-375.

Terrell, F., Terrell, S. L., & Golin, S. (1979). Language performance of Black and White children in Black and White situations. Language and Speech, 20, 377-383.

Tharp, R. G. (1991). Cultural diversity and treatment of children. Journal of Consulting and Clinical Psychology, 59, 799-812.

Thompson, C. E., Worthington, R., & Atkinson, D. R. (1994). Counselor content orientation, counselor race and Black women's cultural mistrust, and self-disclosures. Journal of Counseling Psychology, 41, 155-161.

Thornton, M. C., Chatter, L. M., Taylor, R. J. & Allen, W. R. (1990). Sociodemographic and environmental correlates of racial socialization by Black parents. Child Development, 61, 401-409.

Tobler, N. S. (1986). Meta-analysis of 143 adolescent drug prevention programs: Quantitative outcome results of program participants compared to a control or comparison group. The Journal of Drug Issues, 16, 537-567.

Todd, T. C. (1986). Structural-strategic marital therapy. In N. S. Jacobson & A. S. Gurman (Eds.), Clinical handbook of marital therapy (pp. 71-105). New York: Guilford Press.

Todd, T. C. & Selekman, M. (Eds.). (1991). Principles of family therapy for adolescent substance abuse. Boston, MA: Allyn & Bacon.

Tolan, P. H., Guerra, & Kendall, P. C. (1995). A developmental-ecological perspective on antisocial behavior in children and adolescents: Toward a unified risk and intervention framework. Journal of Consulting and Clinical Psychology, 63(4), 579-584.

Tolan, P. H. & Loeber, R. (1993). Antisocial behavior. In P. H. Tolan & B. J. Cohler (Eds.), Handbook of Clinical Research and Practice with Adolescents (pp. 307-332). New York, NY: John Wiley & Sons, Inc.

Tramontana, M. G. (1980). Critical review of research on psychotherapy outcome with adolescents: 1967-1987. Psychological Bulletin, 88, 429-450.

U.S. Bureau of the Census (1990). Statistical Abstracts of 1990 (10th edition). Washington, DC: U.S. Bureau of the Census.

U. S. Congress, Office of Technology Assessment. (1986). Children's mental health; Problems and services. Washington, DC: U. S. Government Printing Office.

U.S. Congress, Office of Technology Assessment. (1991). Adolescent health: Vol. 1. Summary and policy options (Publication No. OTA-H-468). Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services (1985). Series No.-- Washington, DC: U.S. Department of Health and Human Services.

U. S. Department of Justice. (1990). Uniform Crime Reports, Federal Bureau of Investigation. Washington, DC: U. S. Department of Justice.

Vail, A. (1978). Factors influencing lower class Black patients remaining in therapy. Journal of Consulting and Clinical Psychology, 46, 341.

Viale-Val, G., Rosenthal, R. H., Curtiss, G., & Marohn, R. (1984). Dropout from adolescent psychotherapy: A preliminary study. Journal of the American Academy of Child Psychiatry, 23(5), 562-568.

Volk, R. J., Edwards, D. W., Lewis, R. A., Sprenkle, D. H. (1989). Family systems of adolescent substance abusers. Family Relations, 38, 266-272.

Vuchinich, S. (1987). Starting and stopping spontaneous family conflicts. Journal of Marriage and the Family, 49, 591-601.

Vuchinich, S., Bank, L., & Patterson, G. R. (1992). Parenting, peers, and the stability of antisocial behavior in preadolescent males. Developmental Psychology, 28, 510-521.

Wachtel, P. L. (1977). Psychoanalysis and behavior therapy: Toward an integration. New York: Basic Books.

Watkins, C.E. & Terrell, F. (1988). Mistrust level and it's effects on counselor expectations in Black client-White counselor relationships: An analogue study. Journal of Counseling Psychology, 35, 194-197.

Watkins, C. E., Terrell, F., Miller, F. S., & Terrell, S. L. (1989). Cultural Mistrust and its effects on expectational variables in Black client-White counselor relationships. Journal of Counseling Psychology, 36, 447-450.

Weinberg, N., Rahdert, E., Colliver, J. D., Glantz, M.D. (1998). Adolescent substance abuse: A review of the past 10 years. Journal of the American Academy of Child and Adolescent Psychiatry. 37(3), 252-261.

Weist, M. D., Ollendick, T. H., & Finney, J. W. (1991). Toward the Empirical Validation of Treatment Targets in Children. Clinical Psychology Review, 11, 515-538.

Weisz, J. R., Weiss, B., Alicke, M. D., & Klotz, M. L. (1987). Effectiveness of psychotherapy with children and adolescents: A meta-analysis for clinicians. Journal of Consulting and Clinical Psychology, 55, 542-549.

Weithorn, L. (1988). Mental hospitalization of troublesome youth. Stanford Law Review, 40, 773--837.

Whitbeck, L. S., Conger, R. D., Kao, M-Y. (1993). The influence of parental support, depressed affect, and peers on the sexual behaviors of adolescent girls. Journal of Family Issues, 14(2), 261-278.

Wills, T. A. (1990). Social support and the family. In E. Brenman (Ed.), Emotions and the family: for better of for worse (pp. 75-98). Hillsdale, NJ: Erlbaum.

Wills, T. A. & Vaughn, R. (1989). Social support and smoking in early adolescence. Journal of Behavioral Medicine, 12, 321-339.

Wills, T. A., Vaccaro, D. & McNamara, G. (1992). The role of life events, family support, and competence in adolescent substance use: A test of vulnerability and protective factors. American Journal of Community Psychology, 20(3), 349-373.

Youniss, J., DeSantis, J. P., & Henderson, S. H. (1992). Parents' approaches to adolescents in alcohol, friendship, and school situations. In I. E. Sigel, A. V. McGillicuddy-DeLisi, J. J. Goodnow (Eds.), Parental Belief Systems: the Psychological Consequences for Children (2nd ed., pp. 199-216). Hillsdale, NJ: Lawrence Erlbaum Associates.

Youniss, J. & Smollar, J. (1985). Adolescent Relations with Mothers, Fathers, and Friends (pp.1-14). Chicago, IL: University of Chicago Press.

Zajonc, R. B. (1984). On the primacy of affect. American Psychologist, 35, 117-123.

VIII. Appendices

Appendix A. Research Document

Center for Treatment Research on Adolescent Drug Abuse
Summary of Research Program

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Overview

The Center for Treatment Research on Adolescent Drug Abuse (CTRADA) began in 1991 as the first NIDA-funded clinical research center focusing on adolescent drug abuse treatment. The mission of CTRADA is to:

- Create a scientific climate of discovery and rigor that will facilitate the expansion of knowledge in adolescent drug abuse (ADA) treatment through basic and applied studies,
- improve family oriented treatments for drug abusing adolescents,
- test the efficacy and effectiveness of family oriented as well as existing treatments for drug abusing adolescents
- develop a greater understanding of treatment factors, and patient and family characteristics that increase or decrease the likelihood of treatment success,
- create the opportunity for synergism among treatment studies and researchers targeting a broad range of ADA populations: dually diagnosed, ethnically diverse, gender specific.
- disseminate information on successful treatment models to the local and national drug abuse community,
- serve as a national resource to the National Institute on Drug Abuse (NIDA) for matters related to the treatment of ADA, and
- promote translation of findings from basic to applied research to practice and policy.

CTRADA is funded by grants from the National Institute on Drug Abuse (NIDA) and the Center for Substance Abuse Treatment (CSAT). Although CTRADA's program of research is spearheaded by the development, testing, and refinement of family-based interventions for adolescent drug abuse, investigators at CTRADA also conduct basic research studies on adolescent drug abuse with implications for interventions with these youth.

MDFT Overview

The MDFT approach was developed as a stand alone, outpatient therapy to treat adolescent substance abuse and associated behavioral problems of clinically referred teenagers. MDFT has been evaluated in a number of federally funded research projects: (a) four completed randomized clinical trials [three treatment trials (one of which was a multisite trial) and one prevention trial)] and (b) several treatment development and process studies which have illuminated core change mechanisms of the therapeutic process (Liddle & Hogue, 2001).

Three new controlled clinical studies are in process. One randomized trial compares the clinical effectiveness of MDFT vs. Residential Treatment for dually diagnosed adolescent substance abusers. In conjunction with this study, we are conducting an economic evaluation, comparing the relative benefit-cost of MDFT vs. residential treatment. A second in process controlled trial is a comparative study of the effectiveness of peer group therapy and MDFT for young adolescent substance abusers. The third ongoing study is a controlled technology transfer study examining the process and outcomes of transporting MDFT into a hospital-based day treatment adolescent drug abuse program.

Since 1991, this work has occurred within a NIDA-funded research center, the Center for Treatment Research on Adolescent Drug Abuse. This center was the first NIH/NIDA funded research center on adolescent substance abuse. The focal theme of this research center is the development and testing of family based treatments for adolescent alochol and drug abuse and associated problems. MDFT studies have been conducted at different locations in the U.S., including Philadelphia, various cities in the San Francisco Bay area, central Illinois, and Miami. The study populations were ethnically diverse, and their problem severity varied as well (i.e., from high-risk early adolescents to multi-problem, juvenile justice-involved, dually diagnosed female and male adolescent substance abusers).

The MDFT treatment approach has been recognized as one of a new generation of comprehensive, multicomponent, theoretically-derived and empirically-supported adolescent drug abuse treatments (Center for Substance Abuse Treatment, 1999; Lebow & Gurman, 1995; National Institute on Drug Abuse, 1999; Nichols & Schwartz, 1998; Selekman & Todd, 1991; Stanton & Shadish, 1997; Waldron, 1997; Weinberg, Rahdert, Colliver, & Glantz, 1998; Williams & Chang, 2000; Winters, Latimer, & Stinchfield, 1999). MDFT is included in NIDA's Principles of Drug Addiction Treatment book as one of three empirically supported drug treatments for adolescent drug abuse (http://www.nida.nih.gov; http://www.nida.nih.gov/BTDP/Effective/Liddle.html**);** in APA's Division 50 The Addictions Newsletter issue on empirically supported drug therapies (Liddle & Rowe, Spring 2000); and in the OJJDP monograph series on evidence based treatments for delinquency (Liddle, in press). MDFT is also included in the CSAP (http://www.strengtheningfamilies.org/html/programs_1999/10_MDFT.html**)** and Office of Juvenile Justice and Delinquency Prevention Strengthening Families--Exemplary Programs Initiative. MDFT is also being tested within CSAT's initiative on Adolescent Treatment Models, formerly known as the funding initiative on Exemplary Adolescent Treatment Programs. The

therapy approach and its research program have been recognized with national and other awards from the American Psychological Association (1991), American Family Therapy Academy (1995), American Association for Marriage and Family Therapy (1996), and the Florida Association for Marriage and Family Therapy (2000).

I. Randomized Clinical Trials:

1. Liddle, H.A., Dakof, G.A., Parker, K., Diamond, G.S., Barrett, K., & Tejeda, M (2001), Multidimensional family therapy for adolescent drug abuse: Results of a controlled clinical trial. American Journal of Drug and Alcohol Abuse, 27(4), 651-687.

One hundred and eighty-two clinically referred marijuana and alcohol abusing adolescents were randomized to one of three treatments: multidimensional family therapy, adolescent group therapy and multifamily educational intervention. Each treatment represented a different theory base and treatment format. All treatments were manualized and delivered on a once-a-week outpatient basis. The therapists were experienced community clinicians trained to model-specific competence prior to the study, and then supervised throughout the clinical trial. The amount of treatment of all three treatment conditions was controlled so that each treatment consisted of 14-16 weekly office-based therapy sessions. A theory-based multimodal assessment strategy measured symptom changes and prosocial functioning at intake, termination, and 6 and 12 months following termination.

Participants were drug using adolescents (M age = 16) who at the time of intake had, on average, a 2.5 year history of drug use. Eighty percent were male; 51% were white non-Hispanic, 18% African American, 15% Hispanic, and 16% other ethnicities. Forty-eight percent came from single parent households, 31% two-parent, and 21% step-parent; and median yearly family income was $25,000. Youth were primarily polydrug users, coupling near daily use of marijuana and alcohol with weekly use of cocaine, hallucinogens, or amphetamines, and 61% were on juvenile probation. Results revealed strong time effects at termination for drug use (F (1,92) = 53.15, p = .0001, eta^2 = .36) and acting-out behaviors (F (1,92) =12.55, p = .001, eta^2 = .12). Importantly, there was a significant time by treatment interaction for drug use, (F (2,92) = 6.61, p = .002, eta^2 = .12). Youth who received MDFT had notably lower drug use than comparison youth. At the 12-month follow-up, improvements in drug taking and acting out behaviors were maintained. Changes from intake to termination through the 12 month follow-up period indicate that the time x treatment interaction was significant for adolescent drug use (F (6, 276) = 2.68, p = .02, eta^2 = .05). For Grade Point Average, a significant time x treatment interaction was found from intake to 12 months after intake (F (2,64) = 3.17, p = .05, eta^2 = .09).

The general pattern of results indicate an overall improvement among youth in all 3 treatments, with the greatest and most consistent improvement among those who received MDFT, suggesting that MDFT is an effective approach to ameliorating adolescent substance abuse and associated behavior problems. MDFT displayed greater reductions in the teen's drug use than the other two conditions. Forty-five percent of adolescents in MDFT (versus 32% in

AGT and 26% in MFEI) demonstrated clinically significant change in drug use, such that their drug use profiles at follow-up fell below intake eligibility criteria. At 1 month post termination, drug use fell by 54% (comparison of pre-treatment to termination levels of use), and at 12 months post treatment, drug use was approximately 48% less than the pre-treatment level. In addition, only MDFT participants reported significant improvement in family competence and GPA. The family functioning dimension was a behavioral rating of videotapes of family interactions before and after treatment. The percentage of adolescents in MDFT achieving a GPA above 2.0 (passing) rose from 25% at intake to 68% at follow-up; the parallel rates for AGT were 43% at intake and 60% at follow-up, and for MFEI, 33% at intake and 41% at follow-up. Finally, MDFT outperformed AGT but not MFEI in preventing treatment attrition: 33 of 45 MDFT participants completed treatment (73%), 34 of 52 in MFEI (65%), and 29 of 55 in AGT (52%).

2. *Liddle, H. A., Dakof, G. A., Turner, C., & Tejeda, M. (in press). Advances in adolescent drug abuse treatment: Findings from the multidimensional family therapy research program. (NIDA Research Monograph on the 2001 CPDD Conference, Paper at Adolescent Drug Abuse Treatment Symposium). Scottsdale, Arizona: NIDA.*

The efficacy of Multidimensional Family Therapy was examined in comparison to individual adolescent treatment - Cognitive Behavior Therapy (CBT). This study is particularly noteworthy because of the comparison it provides - it is the first adolescent drug abuse study comparing family therapy to a state-of-the-art psychotherapy. Additionally, this study has many design and analysis features expected in the highest quality contemporary intervention science (e.g., DSM diagnosis on all subjects, manualized interventions representing commonly applied treatments (family and individual treatment) extensive manual adherence analyses, state of the art measures, multiple measures of adolescent outcome, state of the science statistical methods, true intent-to-treat design). Two-hundred twenty-four adolescents referred to a community clinic for substance abuse treatment were randomly assigned to one of the two treatments. The final sample was primarily male (81%), African American (72%), and low income (38% report total yearly family incomes of less than $10,000; 23% between 10,000-20,000) with 41% of families on public assistance. Seventy-five percent were referred from the juvenile justice system with 55% on juvenile probation at the time of intake. Self-reported adolescent drug use, and adolescent-reported and parent-reported externalizing and internalizing symptomatology, were assessed at intake and again at 6 and 12 months following treatment termination.

The analyses employed Hierarchical Linear Models (HLM: Bryk & Raudenbush, 1987) and progressed through two different stages. The first stage involved the comparison of treatment effectiveness *within* each of the treatment conditions to determine if within-treatment time effects were present as well as to determine the shape and slope of the change being observed. The second phase of analyses involves comparing changes across the two treatments. Specifically, we investigated whether the treatments differed in the effectiveness of improving the target symptoms of substance abuse, externalizing symptoms and internalizing symptoms, and if the treatments exhibited differential rates of change in accomplishing their improvement

of substance abuse, externalizing and internalizing symptoms. We employed hierarchical linear modeling because of the well-known limitations of repeated measures analysis of variance in analyzing panel data (cf. Ware, 1985). Beyond these limitations, however, HLM has particular promise in psychotherapy research because it captures the nature of the therapeutic change process and provides a statistical mechanism for determining the shape of therapeutic change not only though the therapeutic process but after the suspension of therapy (Newman and Tejeda, 1996, 1999; Speer and Greenbaum, 1995). Our use of HLM in this study, then, is intended to enhance understanding not only about the effectiveness of each treatment, but to also capture in the analyses questions related to treatment durability and the nature of the improvement in the outcomes.

Multidimensional Family Therapy was successful in reducing marijuana use (linear slope effect $t = -3.94$, $p < .001$), drug involvement (linear slope effect $t = -5.82$, $p < .001$), as well as externalizing (parent report $t = -6.09$, $p < .001$; youth report $t = -4.05$ $p < .001$) and internalizing symptoms (parent report $t = -3.72$, $p < .001$; youth report $t = -2.46$, $p = .014$). Thus, the significant linear rate of change was present for each of the outcomes, indicating that the shape of the change is linear and negative in the direction of improvement. Cognitive Behavioral Therapy was likewise effective for drug involvement (linear slope effect $t = -3.19$ $p < .002$), and parent report of externalizing (t - -2.81, $p = .005$), and internalizing symptoms ($t = -3.27$, $p = .001$). However, the shape of the change was not linear over time for certain outcome variables. For example, the linear effect was not significant for marijuana use, adolescent report of externalizing symptoms and adolescent report of internalizing symptoms. For the Cognitive Behavioral Therapy treatment group, there is a general leveling off in marijuana use after the 6-month follow-up.

Examination of the Level 2 analysis, comparing treatment conditions, revealed that there were no significant differences between conditions in the rate of change over time with respect to marijuana use, parent report of the youth's externalizing symptoms, and youth report of internalizing symptoms. A significant difference between treatment conditions for the linear slope was observed for the Personal Involvement with Chemicals scale of the PEI ($t = 2.29$, $p = .022$). There is support, then, that adolescents receiving Multidimensional Family Therapy in comparison to youth who received cognitive behavioral therapy continue to improve after termination as measured by the PEI, Personal Involvement with Chemical subscale. For externalizing symptoms, there was a significant difference between treatment conditions on parent's report of their child's externalizing symptoms ($t = 2.07$ $p = .038$) with adolescents receiving Multidimensional Family Therapy continuing to improve after termination, and adolescents in the Cognitive Behavioral Therapy condition showing a leveling off of symptom reduction. Finally, with respect to internalizing symptoms, there was a significant between treatment difference with respect to adolescent report of their symptoms with youth in Multidimensional Family Therapy condition reporting continued improvement after treatment; while adolescents in the Cognitive Behavioral Therapy condition appearing relatively stable after suspension of treatment ($t = 2.29$, $p = .022$). Lastly, we examined whether any demographic variables (adolescent age at intake, gender, race, criminal justice involvement, family structure, family income, mother's education) added to Level 2 would act as an important covariate to

treatment condition. None of these variables improved the explanatory power of the basic hierarchical models already discussed.

Considering the results as a whole leads us to conclude that in this comparison of two state-of-the-art treatments for adolescent substance abuse, as expected, both treatments emerged as at least somewhat efficacious. Both treatments reduced symptomatology from intake to termination across all three domains of functioning: drug use, externalizing symptomatology, and internalizing symptomatology. However, while both are efficacious from intake to termination they show different long-term trajectories. The rate of improvement of symptoms between the two treatments is different such that only MDFT was able to maintain the symptomatic gain after termination of treatment. Multidimensional family therapy shows a significantly different slope from cognitive behavioral therapy suggesting that youth who received MDFT continued to evidence treatment improvement after termination. The advantage to MDFT, then, concerns its ability, in comparison to cognitive behavioral therapy, to retain the effects of treatment beyond the treatment phase.

It is important to recognize that these results were achieved with two theoretically different but standard psychotherapies. The two models tested here are traditional psychotherapeutic interventions provided in standard service delivery formats. The treatments were both clinic based therapies providing once a week face-to-face therapy with no booster sessions. The fact that improvement in symptomatolgy was found in such modest treatments delivered to such a challenging patient population, given its risk exposure and level of initial dysfunction, is an important indicator of the promise of CBT (in terms of immediate therapy effects) and especially MDFT (in terms of immediate and continued effects at one year post termination) in the treatment of adolescent drug abuse. Although the data show efficacy, we would be foolish to say they were stunning. Clearly, there is room for improvement. The success of comprehensive, multiple systems focused therapies, with their intensity of service delivery, case management components, and home-based service delivery contexts (Henggeler et al., 1995; Scannapieco, 1994; Santos et al, 1995), leads us to speculate that improved outcome would be achieved by integrating the psychotherapeutic models tested here into a more multisystemic service delivery context which includes case management, face-to-face therapy sessions of more than once per week, delivered in the home if necessary. One of our current controlled studies is testing our most intensive and extensive version of MDFT developed to date.

3. Dennis, M.L., Titus, J.C., Diamond, G., Donaldson, J., Godley, S.H., Tims, F., Webb, C., Kaminer, Y., Babor, T., French, M., Godley, M.D., Hamilton, N., Liddle, H., & Scott, C. (in press). The Cannabis Youth Treatment (CYT) experiment: A multi-site study of five approaches to outpatient treatment for adolescents. Addiction; Diamond, G., Godley, S.H., Liddle, H.A., Sampl, S., Webb, C., Tims, F., & Meyers, R. (in press). Five outpatient treatment models for adolescent marijuana use: A description of the Cannabis Youth Treatment Interventions. Addiction.

A third completed randomized study tested MDFT in a multisite field effectiveness trial – the CSAT Cannabis Youth Treatment (CYT) study (Dennis et al., 2000). Consistent with

previous findings, MDFT had a positive impact on drug use and other problem behaviors, and it also showed the capacity to promote positive gains in individual and family protective factors at termination and at three and six month follow up periods. In the CYT study, which tested a 12-15 session version of MDFT over a three month treatment delivery period, MDFT reduced days of marijuana use by 29% from baseline to three months. At a three month follow up assessment, 42% of teens were abstinent and nearly two-thirds (65%) of adolescents receiving MDFT reported a decrease in substance abuse disorder symptoms within the prior month. At the six month assessment point, the teens evidenced a 43% reduction in drug use, and at the twelve month follow up the adolescents evidenced a 41% reduction in drug use.

Cost effectiveness of MDFT. The CYT study was the first project in which cost issues of MDFT were addressed. Cost estimate analyses indicate that MDFT compares quite favorably to current cost parameters of standard outpatient adolescent treatment. The National Treatment Improvement Study (NTIES) (Center for Substance Abuse Treatment, 1998; Gerstein & Johnson, 1999) is one of the few studies to provide formal cost estimates of adolescent outpatient drug treatment. The NTIES study surveyed a nationally representative sample of adolescent treatment program directors who estimated the costs of outpatient adolescent drug treatment. The CYT study (Dennis et al., in press) used NTIES data as a benchmark against which to compare the five adolescent marijuana treatments in the CYT study. The economic cost of each treatment in the CYT was determined using the Drug Abuse Treatment Cost Analysis Program (DATCAP) (French et al., in press). The average weekly cost of MDFT was less than both the median estimate and the mean cost estimate[i] from the program directors. The median weekly cost of outpatient adolescent drug treatment in the NTIES study was $267, and the weekly mean (average) treatment cost was $365. The average weekly cost of providing MDFT per adolescent was $164. Given these treatment cost findings, Dennis et al. (in press) conclude that MDFT - a stand alone comprehensive family based adolescent drug treatment - is affordable and programmatically sustainable at current funding levels.

In sum, three major controlled clinical trials with clinically referred treatment samples have all found MDFT to be efficacious for adolescent drug abuse and related problems. The approach also demonstrated the capacity to promote protective factors that are instrumental to the continuation of changes in drug problems. As Brown (1990) has noted in her discussion of recovery patterns of drug using teens, treatments must not only show that they can reduce drug taking per se, but their efficacy evidence should also include changes in the social ecology in which they live everyday. The evidence that MDFT can change dysfunctional family interaction patterns (Diamond & Liddle, 1996), parenting practices (Schmidt et al., 1996), and impact school performance (Liddle et al., 2001) suggest that the MDFT approach addresses theory- and research-based, contextually-oriented effectiveness criteria.

4. Hogue, A., Liddle, A. & Leckrone, J. (2002). Family-based prevention counseling for high-risk young adolescents: Immediate outcomes. Journal of Community Psychology, 30, 1-22.

A prevention intervention version of MDFT, MDFP (Multidimensional Family Prevention) has been tested in a controlled prevention trial that evaluated immediate post-

intervention outcomes for a group of at-risk, inner-city young adolescents and their families (Hogue & Liddle, 1999; Liddle & Hogue, 2000; Hogue & Liddle, in press). Adolescents were recruited from a community youth program in which every member completed a risk factor screening measure that assessed individual risk in four areas: adolescent drug use history and attitudes, and history of delinquent behavior; peer drug use history and attitudes; family drug use history and attitudes, and history of police involvement; and adolescent school attendance, performance, and behavior. Youth were then randomly assigned to an MDFP ($n = 61$) or control ($n = 63$) condition. The study sample was comprised of early adolescents (mean age 12.5 years), predominantly girls (56%), almost entirely African American (97%), and mostly low income (57% of families reported annual income less than $15,000, and 53% received public assistance).

Intervention effects were examined for nine targeted outcomes within four domains of functioning: self-competence, family functioning, school involvement, and peer associations. These domains are considered to be proximal mediators--that is, indices of risk and protection--of the ultimate behavioral symptoms to be prevented: substance use and antisocial behavior. The immediate efficacy of MDFP was investigated by testing the within-subjects interaction (Group X Time) term of repeated measures ANOVA. Testing the interaction term indicates whether there is a significant difference between groups in aggregated change over time on the target variable. Intervention cases showed greater gains than controls on four of the nine outcomes, one outcome apiece within each of the four domains: increased self-concept ($F(1,112) = 6.44$, $p < .05$), a trend toward increased family cohesion ($F(1,122) = 3.21$, $p < .10$), increased bonding to school ($F(1,122) = 5.60$, $p < .05$), and decreased antisocial behavior by peers ($F(1,122) = 7.29$, $p < .01$). Effect size estimates for these improvements were in the small-to-moderate range ($\eta^2 = .03$-$.06$).

These results offer preliminary evidence for the short-term efficacy of family-based prevention counseling for at-risk young adolescents. In comparison to controls, adolescents and their families who received MDFP showed gains in four key indicators of adolescent well-being. Results also suggest that MDFP enjoyed some success in reversing negative developmental trends. While controls experienced decreases in family cohesion and school bonding and an increase in peer delinquency, MDFP subjects reported strengthened family and school bonds and reduced peer delinquency. Overall, these gains were small to moderate in magnitude, and they were evident regardless of the adolescent's sex, age, or initial severity of behavioral symptoms. This initial study demonstrates that an individually tailored, family-based prevention model can be successfully implemented with at-risk minority youth. Furthermore, family prevention counseling can foster change in multiple behavioral domains that represent developmentally important mediational influences on the ultimate formation of problem behaviors.

ONGOING CLINICAL TRIALS

1. Alternative to Residential Treatment Study: A Comparative Controlled Trial of Multidimensional Family Therapy vs. Residential Drug Treatment for Co-Morbid Adolescent Substance Abusers

The fundamental objective of this on-going study currently in its fifth year of funding is to compare the therapeutic effectiveness of an intensive in-home family-based treatment, Multidimensional Family Therapy, with a multifaceted Residential Treatment, Adolescent Residential Treatment, and to delineate the mechanisms of change for each treatment. The study targets juvenile justice involved, dually-diagnosed adolescent drug abusers referred for residential treatment. The primary aims are to: (1) experimentally compare the effectiveness of family-based treatment with adolescent residential treatment in ameliorating drug use and symptoms of co-morbidity among dually diagnosed adolescents, and (2) identify the mechanisms by which each treatment achieves its effects. The study is a 2 treatment conditions (Multidimensional Family Therapy, Adolescent Residential Treatment) by 6 time periods (intake; 2, 4, 12, and 18 months post-intake, and termination/discharge) randomized design. Six hypotheses are specified: (1) The progression of adolescent symptomatology over time (drug use and co-morbidity) in the two treatments will reflect differences in the rate of change between the two treatments at 2 months post-intake with youth participating in residential treatment evidencing more improvement than youth receiving family-based treatment. A reversal will begin to occur between 12 and 18 months post-intake with youth participating in family-based treatment evidencing more improvement than those who received residential treatment. (2) For the MDFT condition, therapeutic alliance between therapist-adolescent and therapist-parent, measured during the first 2 months of treatment, will predict increased parent commitment to and involvement with their adolescent at month 2. (3) Parent commitment to and involvement with their adolescent measured at 2 months post-intake will predict improvement in (a) parenting behaviors and (b) adolescent social skills/life skills at 4 months post-intake. (4) Improvement in parenting behaviors and adolescent social skills at 4 months post-intake will predict reduction in adolescent symptomatology at termination, and 12-18 months post-intake. (5) For the residential treatment condition, therapeutic alliances between adolescent-primary therapist and adolescent-peer counselor measured during the first 2 months of treatment will predict increased (a) social skills/life skills and (b) adoption of philosophy and behaviors of 12-step model at month 4. (6) Improvement in (a) social skills and (b) adoption of philosophy and behaviors of 12-step model at 4 months post-intake will predict reduction of adolescent symptomatology and improvement in adolescent functioning at termination, and 12-18 months post-intake.

Preliminary analyses of approximately 95 youth treated to date indicate that the sample is quite severe in all areas of functioning. The average age of the sample is 15. 74% are male and 26% female. The ethnic breakdown of the total sample is 14% African American, 74% Hispanic, and 8% Caucasian. Only 19% of youth reside in a 2-parent household. 44% of parents/guardians were unemployed at intake, with only 6% of parents having graduated college. The average yearly income of the sample is $22,000 and 36% of families in the study were on public assistance at intake. Adolescents in the study have a long history of school failure, legal problems, and previous treatment. All youth are diagnosed with a comorbid psychiatric disorder (as a criteria for inclusion in the study), with approximately 75% having conduct disorder and 25% diagnosed with depression. Almost three-fourths of the youth (74%) have failed in previous substance abuse treatment before participating in this study. Sixty-five percent of adolescents report having to repeat at least one grade in school. Forty-nine percent of adolescents reported having legal charges pending and 53% reported being on probation at the

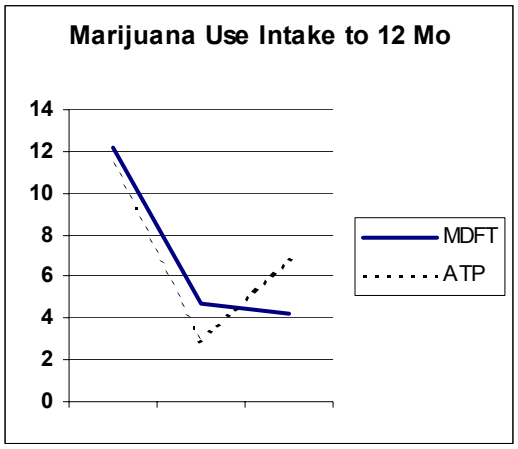
time of intake to treatment. The family background of the adolescents in our study also indicates serious difficulties. Three-fourths of the sample (75%) currently have or have had a family member other than the adolescent with alcohol problems, 52% have had a family member with a drug problem, and 54% have had a family member with legal problems. Twenty percent report having a family member who has had mental health problems.

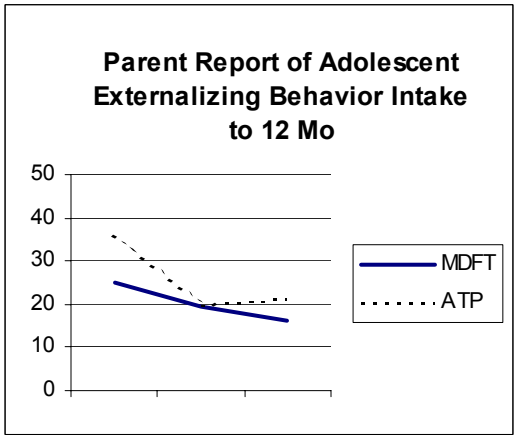
Despite the extensive problems of these teens and families, MDFT can successfully engage and retain these difficult youth and their families in treatment. Adolescents spend an average of 243 days in MDFT, compared to only 112 days in residential treatment. These preliminary results are promising in terms of the ability of MDFT, an outpatient alternative to residential treatment, to engage and retain serious drug abusing youth ant their families in therapy.

Preliminary Outcome Analyses. Data from our current study were analyzed using repeated measures analysis of variance (RMANOVA) to determine not only if differences exist between the two conditions of MDFT and RT on marijuana use and externalizing symptoms. Our original hypotheses were that, from intake to discharge, participants assigned to the RT condition would show greater improvement on marijuana use and externalizing symptoms than those participants assigned to the MDFT condition because of the residential components of the treatment. We further hypothesized that while participants assigned to the MDFT condition would show continued reduction of marijuana use and externalizing symptoms after discharge from treatment, the RT participants would show deterioration on marijuana use and externalizing symptoms after discharge from their in-patient treatment environment. From intake to discharge, participants in the RT condition experienced a 77% reduction in marijuana use while the MDFT participants reported a 66% reduction of marijuana use resulting in a significant time effect over both conditions ($F(1,68)= 28.49$, $p<.001$). No time by condition effect was observed. Additionally, from intake to discharge, RT participants reported a 45% reduction in externalizing symptoms and MDFT participants reported a 22% reduction in externalizing symptoms resulting in a significant time effect over both conditions ($F(1,60)=25.29$, $p<.001$). Further, the time by condition effect was statistically significant, with parents of adolescents in the residential condition reporting less externalizing symptoms at the end of treatment ($F(1,60)=4.81$, $p=.032$). However, it should be mentioned that these adolescents had been in a controlled environment until the end of their treatment. Thus, contrary to the hypothesis that RT would be superior to MDFT in reducing marijuana use from intake to discharge, the preliminary findings suggest that MDFT, an outpatient alternative to residential care, and Residential Treatment, were equivocal in effect on marijuana at termination.

Although sample sizes decrease because the current study has not yet concluded, we did conduct analyses using data from a subsequent assessment point. Looking further out to 12 months after intake, we continue to find equivocal findings between MDFT and RT on marijuana use [i.e., time effects ($F(2,50)=11.72$, $p<.001$) are statistically significant but the time by condition interaction effect is nonsignificant]. However, RT participants report increasing their marijuana use after their discharge from Residential Treatment; whereas MDFT participants continue to show a slight reduction in their marijuana use, after treatment ends. These effects persist to our 12 month follow up. For externalizing symptoms, we begin to find preliminary support for our long-term hypotheses. Parents of adolescents receiving MDFT report a gradual

decrease in externalizing symptoms up to 12 months following intake. Parents of adolescents receiving residential treatment report a gradual increase in adolescent externalizing behavior from discharge to 12 months following intake [both time ($F(2,43)=20.19$, $p<.001$) and the time by condition interaction ($F(2,43)=3.30$, $p=.047$) are statistically significant].





2. Family Therapy for Early Adolescent Substance Abuse: Multidimensional Family Therapy Compared to Adolescent Group Therapy

Early adolescence (ages 12 to 15) is a particularly vulnerable developmental period for the initiation of drug use and other problem behaviors. We know that early onset of drug use is one of the strongest predictors of serious adolescent drug abuse and problems in adulthood. However, few intervention studies have addressed questions about this unique adolescent age group. With these questions in mind, we are conducting a collaborative research project with a community treatment facility, The Village, Inc., funded by the Center for Substance Abuse Treatment (CSAT) as part of their Adolescent Treatment Models' initiative. The study is a clinical trial comparing Multidimensional Family Therapy (MDFT) with a manualized peer group treatment. Adolescents who are referred for outpatient drug treatment and eligible for the study are randomized to one of these two treatments, both of which are provided by clinicians at The Village. This represents the first test of MDFT with: 1) an exclusively early adolescent drug-using population, and 2) in a rigorous "real world" clinical setting. This study has several aims: 1) To compare the effectiveness of MDFT vs. a manualized peer- and psychoeducationally-focused group treatment, with a sample of drug using early adolescents; 2) To investigate the therapeutic mechanisms in each treatment; and 3) To explore gender-related issues in adolescent treatment for substance abuse.

Preliminary analyses of the demographic characteristics of approximately 80 youth treated to date indicate that the average age of the sample is 13.72. 71% are male and 29% female. The ethnic breakdown of the total sample is 39% African American, 46% Hispanic, and 4% Caucasian and 11% from other ethnicities. Fifty percent of the sample have incomes less than $22,000.

Preliminary Outcome Analyses.

Intake to Discharge Findings. Data were analyzed using latent growth curve modeling techniques with the software Mplus (Muthen & Muthen, 1998-2002) and assessments at intake, 6 weeks following intake and discharge. Treatment effects favoring MDFT were found for marijuana use (t=2.14, p<.05), peer delinquency (t=2.53, p<.05), youth reported externalizing symptoms (t=2.42, p<.05), and youth reported family cohesion (t=2.71, p<.01). In addition, a nonsignificant trend favoring MDFT was found for self-reported delinquent behavior (t=1.95, p<.10). In most cases, MDFT achieved it's impact within the first 6 weeks of treatment.

Intake to 6 Month Follow-Up Findings. Data from this study were also analyzed using repeated measures analysis of variance (RMANOVA) to determine not only if differences exist between the two conditions of MDFT and group treatment on number of problems associated with substance abuse, frequency of substance use, and overall mental distress.

From intake to 6 months following intake, participants in the MDFT condition experienced a 76% reduction in drug-related problems while the group participants reported a 45% increase in drug-related problems. The time by condition interaction effect was statistically significant (F(1,48)= 7.98, p=.007). Although a similar trend was observed in drug-related problems, with MDFT participants demonstrating a 47% reduction in drug-related problems and group participants demonstrating a 78% increase, the time by condition interaction effect was nonsignificant (F(1,48)= 1.53, p=.222). It should be restated that although these findings demonstrate an increase in substance use frequency and substance-related problems for the group condition, rates of drug use are still quite low at the 6 month follow-up (M=.12, sd=.13). These preliminary findings support our hypothesis, suggesting that MDFT is more effective than group treatment in decreasing adolescent substance use and related problems. In terms of mental distress, MDFT participants demonstrated an 80% decrease in mental distress while group participants reported a 20% decrease, resulting in a statistically significant time (F(1,48)= 6.96, p=.011). Power was insufficient to result in a significant time by condition interaction effect (F(1,48)= 1.17, p=.285).

II. Adherence / fidelity studies and related work

Hogue, A., Liddle, H. A., Rowe, C. L., Turner, R. M., Dakof, G. D., & LaPann, K. (1998). Treatment adherence and differentiation in individual versus family therapy. Journal of Counseling Psychology, 45(1), 104-114; and Hogue A., Liddle, H.A., & Rowe, C. (1996). Treatment adherence process research in family therapy: A rationale and some practical guidelines. Psychotherapy: Theory, Research, Practice, & Training, 33(2), 332-345.

Developing procedures for establishing and monitoring therapist adherence to and competence in family-based treatment models has been important component of all of our efficacy studies and our training and dissemination work. Early on, CTRADA investigators developed an observational rating system for evaluating fidelity to manualized treatment protocols, with an obvious emphasis on MDFT. The Therapist Behavior Rating Scale (TBRS; (Hogue, Rowe, Liddle, & Turner, 1994) is an observational, macroanalytic evaluation tool that serves the dual purpose of establishing treatment integrity thresholds and providing process-level

data on therapist interventions (Hogue, Liddle, & Rowe, 1996). To date, four treatment adherence process studies have been conducted with various versions of the TBRS (Hogue et al, 1998; Hogue, Johnson-Leckrone, & Liddle, 1999; Diamond et al, submitted; Hogue, Samuolis, Dauber, & Liddle, 2000). Those studies have demonstrated that the TBRS has adequate reliability and validity, that MDFT can be successfully taught to Master's level therapists as prescribed by the manual, and that the TBRS can be used to identify the therapeutic interventions that predict treatment gains for teens in MDFT.

The first study (Hogue et al, 1998) examined treatment fidelity to MDFT and CBT in the randomized clinical trial described previously. Principal components analysis conducted on the 26 TBRS-1 items across 90 therapy sessions yielded five factors, two modality-specific and three shared intervention scales. Each factor scale was examined for its reliability and utility in differentiating between treatment conditions. Interrater reliability and internal consistency were was very good for the MDFT scale ($ICC_{(2,6)}$ = .86, Cronbach's alpha = .77), CBT scale (.91, .74), and Affect/Systems-Focused scale (.76, .78). Reliability coefficients were lower but still acceptable for the Behavior/Skills-Focused scale ($ICC_{(2,6)}$ = .58, Cronbach's alpha = .68) and Cognition-Focused scale (.60, .68). Three analytic procedures were used to evaluate treatment adherence. First, variance composition analysis was conducted. It was hypothesized that Modality would be a strong determinant of variance in the modality-specific scales and a weak determinant in scales that represent common interventions. Results showed that modality predicted the predominance of variance in both the CBT scale (.39) and the MDFT scale (.48). For the three shared intervention scales, scale variance was distributed across multiple effects, with modality accounting for less variance in these scales than in the modality scales. Second, multigroup profile analysis was used to examine whether the two treatment conditions exhibited parallel profiles of scale scores across all five scales combined. Using Wilks' lambda criterion as the test of significance, the hypothesis of parallel profiles was rejected, $F(4, 85) = 30.56$, $p < .001$. Thus, the two treatments displayed significantly different patterns of peaks and valleys in mean scores across the five scales (see Figure 2). Also as predicted, the modality effect explained a significant amount of unique variance (eta^2 = .59) in the weighted combination of the five scales. Third, mean comparisons between the MDFT and CBT conditions were carried out on each scale, using a Bonferroni-adjusted criterion value of .01 (.05/5). As expected, MDFT therapists scored significantly higher on the MDFT scale ($t(56) = 10.22$, $p < .001$), whereas CBT therapists were higher on the CBT scale ($t(49) = 6.77$, $p < .001$). Differences between conditions were also found for two other scales. The MDFT condition used more Affect/Systems-Focused interventions ($t(88) = 6.77$, $p < .001$), whereas the CBT condition showed more Behavior/Skills-Focused interventions ($t(88) = 2.51$, $p < .01$).

These results confirmed that a high degree of treatment fidelity was achieved in the study using standard MDFT training protocols. Therapists in each condition used model-unique (prescribed) techniques and avoided (proscribed) techniques characteristic of the other condition. Analyses also indicated that in accordance with MDFT manualized guidelines, MDFT therapists worked to a larger extent in the affective domain, used systemically- and developmentally-focused interventions involving multiple family members, and concentrated on establishing a collaborative therapy relationship. In contrast, but as prescribed, CBT therapists operated at a predominantly behavioral level, worked on generating and promoting alternative behaviors and

perspectives in their clients, and focused attention on drug use sequelae in the target adolescent.

In sum, procedures and measures for establishing and evaluating MDFT integrity have been developed and shown useful and psychometrically adequate. Through a series of studies, we have developed and refined a set of adherence and competence scales, and shown that they can differentiate MDFT from other treatments. We also have obtained evidence that therapists without extensive knowledge or experience in family-based treatments can be trained to deliver MDFT in accord with manual-specified guidelines. Thus, the experience, framework and instrumentation exist for evaluating this important aspect of training in the proposed study.

Supervision and training models. Building and testing a treatment requires considerable attention to clinician training and supervision. Over the years we have attended to this area of work and we have developed ideas about the content and process of training, the construction of a training program including training materials and edited training videotapes, effective supervision methods, and a conceptual framework about how therapists acquire new skills and perform manualized treatments competently (Liddle, 1985; Liddle, Becker, & Diamond, 1997). MDFT therapists have at least a master's degree and two years of post-masters experience. Training in MDFT includes approximately 100 hours of model-related literature review, didactic seminars, review of videotapes with an MDFT supervisor and previously trained therapists, and completion of 2-3 pilot cases. These sessions are supervised live or by videotape. Following training, MDFT therapists routinely receive 1-2 hours of face-to-face supervision per week that includes a review of developments and case conceptualization for every case, videotape review of sessions, and live supervision of current cases. Case logs are used to track which family members and which ecological systems (e.g., school, recreational, religious, legal) are being included in treatment planning and implementation, the time spent in each area of work week by week, and the therapist's and supervisor's written evaluation of week by week outcomes.

III. Treatment Development and Therapy Process Studies

We have conducted a program of process research on the MDFT approach. This work has attempted to illuminate some key but murky or difficult aspects of therapy with drug using teenagers. We have addressed core challenges such as how to engage adolescents and parents in treatment, and how to address some fundamental aspects of dysfunction that present with significant regularity across many cases. The process studies have focused both on the description and clarification of the core client processes of dysfunction and healing or improvement as well as on the therapist behaviors that intersect with these client processes. These studies provide a first wave of insights, systematically derived, about mechanisms of change within the model. The process studies have employed both hypothesis-driven (focus on confirming clinical theory) and discovery-oriented (focus on refining or extending existing theory and exploring unspecified phenomena) methodological approaches (Shoham-Salomon, 1990). The studies to date have addressed four questions that are fundamental to understanding how MDFT pursues clinical change: 1. Does MDFT materialize change in family interactions as the model specifies? 2. Does MDFT improve those parenting behaviors that are linked to adolescent drug use and behavior problems, and are these changes in parenting related to

reductions in drug and behavior problems? 3. Can MDFT therapists establish productive working alliances with multiproblem, ethnic minority, inner-city youths? 4. Can MDFT therapists engender culturally meaningful interventions that enhance treatment engagement of African American adolescents?

Resolving parent-adolescent impasses.

Diamond, G.S. & Liddle, H.A. (1996). Resolving a therapeutic impasse between parents and adolescents in multidimensional family therapy. Journal of Consulting and Clinical Psychology, 64, 481 – 488.

G. S. Diamond and Liddle (1996) used task analysis to identify the combination of clinical interventions and family interactions necessary to resolve in-session impasses. These are clinical situations characterized by negative exchanges, emotional disengagement, and poor problem-solving between parents and adolescents. The sample in this process study was substance abusing, juvenile justice referred teenagers and their families. Therapist behaviors that contributed to defusing these negative interactions included: (a) actively blocking, diverting, or addressing and working through negative affect; (b) implanting, evoking, and amplifying thoughts and feelings that promote constructive dialogue; and (c) creating emotional treaties among family members by alternately working in session with parents alone and adolescents alone--a kind of shuttle diplomacy. In cases with successful resolution of the impasse, the therapist transformed the nature and tone of the conversation in the session. The therapist shifted the parent's blaming and hopelessness to attention to their feelings of regret and loss and perhaps sadness about what was occurring with their child. At the same time, the therapist elicited the adolescent's thoughts and feelings about relationship roadblocks with the parent and others. These in-session shifts of attention and emotion made possible new conversations between parent and adolescent. In so doing, the parents developed empathy for the difficult experiences of their teenager and offered support, even admiration, for their teen's coping. These interventions and processes facilitated personal disclosure by the adolescent and created give and take exchanges. Severity of family conflict and pessimism predicted successful resolution of the impasse, with the most conflicted and pessimistic families less likely to move to a new conversational level.

This study yielded clinical insights in four areas. First, we found a theory-based way to reliably define and identify family transactional processes that are known determinants of poor developmental outcomes in children and teenagers. Second, we broke down in behavioral terms the components of the impasse, defining the unfolding sequential contributions of both parent and adolescent. Third, we specified the relation of different therapist actions to the impasse. Fourth, we demonstrated that therapists can change an in-session therapeutic impasse and thus impact one of the putative mechanisms of developmental dysfunction related to drug abuse.

Changing parenting practices.

Schmidt, S. E., Liddle, H.A. & Dakof, G. A. (1996). Changes in parenting practices and

adolescent drug abuse during multidimensional family therapy. Journal of Family Psychology, 10, 12-27.

Schmidt, Liddle, and Dakof (1996) investigated the nature and extent of change in parenting behaviors, as well as the link between parental subsystem change and reduction in adolescent symptomatology. In a sample of parents whose teenagers were juvenile justice referred and showed significant drug and mental health problems, parents showed significant decreases in negative parenting behaviors (e.g., negative affect, verbal aggression) and increases in positive parenting (e.g., monitoring and limit-setting, positive affect and commitment) over the course of therapy. Moreover, these changes in parenting behaviors were associated with reductions in adolescent drug use and problem behaviors. Four different patterns of parent-adolescent tandem change were identified: 59% of families showed improvement in both parenting practices and adolescent symptomatology, 21% evidenced improved parenting but no change in adolescent problems, 10% showed improved adolescent symptoms in the absence of improved parenting, and 10% showed no improvement in either parenting or adolescent functioning. These results support an elemental tenet of family-based treatments: change in a fundamental aspect of the family system (parenting practices) is related to change at the critical level of interest – reduction of adolescent symptoms, including drug abuse. Furthermore, these data suggest that parenting risk and protective factors for drug use are accessible to intervention within a therapeutic environment. Subsequent work has clarified the theory and empirical basis of interventions in the parenting realm (Liddle et al., 1998).

Building therapist-adolescent alliances.

Diamond, G. M., Diamond, G. S., & Liddle, H. A. (2000). The therapist-parent alliance in family-based therapy for adolescents. Journal of Clinical Psychology, 56(8), 1037-1050.

Diamond, G. M., Liddle, H. A., Hogue, A., & Dakof, G. A. (2000). Alliance building interventions with adolescents in family therapy: A process study. Psychotherapy, 36, 355-368.

We examined the impact of adolescent engagement interventions on improving initially poor therapist-adolescent alliances (G. M. Diamond, Liddle, Hogue, & Dakof, 2000). The sample was juvenile justice involved, substance abusing inner city teens, most of whom had a dual diagnosis of substance abuse and a mental health disorder (Rowe, Liddle, & Dakof, in press). Cases with weak therapist-adolescent alliances in the first treatment session were observed over the course of the first three sessions. Significant gains in working alliance were evident when therapists emphasized the following alliance-building interventions: attending to the adolescent's experience, formulating personally meaningful goals, and presenting one's self as the adolescent's ally. Lack of improvement or deterioration in alliance was associated with the therapist continually socializing the adolescent to the nature of therapy. Moreover, in improved alliance cases therapists increased their use of alliance-building interventions from session two to session three (therapist perseverance), whereas therapists in unimproved cases decreased their use (therapist resignation). These results indicate that although it is an important early-stage

therapist method, when therapists over-focus on orienting adolescents to therapy, and thus wait too long to discuss how the therapy can be personally meaningful for the teenager, a productive working relationship is not formed. Details about how to engage teenagers in family-based therapy are described elsewhere (Liddle & Diamond, 1991; Liddle, et al., 1992).

Crafting culturally specific interventions.

Jackson-Gilfort, A., Liddle, H. A., Tejeda, M.J., & Dakof, G. A. (2001). Facilitating engagement of African-American male adolescents in family therapy: A cultural theme process study. Journal of Black Psychology, 27(3), 321-340.

Jackson-Gilfort, Liddle, Tejeda and Dakof (2001) investigated whether therapeutic discussion of culturally specific themes enhanced treatment engagement of African American male youths with an inner city Philadelphia sample of juvenile justice involved, substance abusing teenagers. Exploration of particular themes - anger and rage, alienation, and the journey from boyhood to manhood (i.e., what it means to become an African American man) - were associated with both increased participation and decreased negativity by adolescents in the very next treatment session. These results suggest that use of certain culturally meaningful themes are directly linked to adolescent investment in the treatment process. Jackson-Gilfort et al., 2001 describe how these themes pertaining to African American development were derived and give illustrations of their clinical use.

Examining core processes of change in family therapy.

Alexander, J. F., Robbins, M., Turner, C., Liddle, H. A., & Szapocznik, J. Change processes in family therapy with drug using youth. (NIDA Grant No. P50 DA011328; H. Liddle, PI)

The major goals of this study are to develop and extend the empirical base for understanding the common ingredients (or core processes) of family therapy that predict dropout in family therapy with drug abusing youth. In doing so, this study pursues three specific aims: AIM 1 examines the extent to which there exist core factors across three established family-based treatments for adolescent drug abuse; AIM 2 examines the extent to which these core factors explain different trajectories that characterize families that drop out early (Early Dropout), those that drop out later (Late Dropout), and those that complete the intervention (Completer); AIM 3 examines mechanisms of action by analyzing microsequential relationships between specific indicators of core therapist and core family constructs.

IV. Economic Evaluation of Adolescent Drug Treatments

Liddle, H. A. (P.I.). & French, M. T. (Co-P.I.). Economic Evaluation of Adolescent Drug Services. NIDA Grant no. 1R01 DA13298.

Economic evaluation of adolescent drug abuse treatment is a critical and largely unexplored area of research. This study addresses a largely unexplored issue in the adolescent drug abuse field today - the relative costs and benefits of intensive outpatient family therapy vs. Residential Treatment. Although research with adult substance abusers suggests that intensive outpatient approaches may be more cost-beneficial than Residential Treatment, no controlled study of this nature with adolescent drug abusers has been conducted. This study involves an extension of the alternative to residential treatment study (see ongoing studies above). In addition to the outcome measures discussed above, adolescents and their parents provide service utilization data at each assessment point over the course of 18 months to determine the extent of services utilized by the youth and their family members during and following treatment. Dr. Gayle Dakof of CTRADA and Dr. Michael Miller of The Village completed a standardized assessment to estimate the costs of treatment service delivery (the Drug Abuse Treatment Cost Analysis Program [DATCAP]). Clinical records from health, MH/SA, and juvenile justice agencies will be reviewed to confirm the use of these services and to estimate the costs of service utilization. The benefit-cost analysis will examine the costs of each intervention and the societal benefits in relation to health, mental health/substance abuse (MH/SA), criminal activity, juvenile justice (JJ), and school outcomes. Preliminary results from the DATCAP indicate that there is nearly a 3:1 difference (favoring MDFT) in the costs of delivering the two treatments in this trial. The residential treatment condition has a weekly cost per client of $1,138 while weekly cost per client of MDFT is $384 (French et al, submitted).

Dissemination Studies Adapting and Transporting MDFT into Practice Settings

1. Liddle, H./ Rowe, C. (P.I.). Transporting Family Therapy to Adolescent Day Treatment. NIDA Grant No. 1R01 DA 13089

Liddle H. A., Rowe, C. L., Quille, T. J., Dakof, G. A., Mills, D. S., Sakran, E., & Biaggi, H. (2002). Transporting a research-based adolescent drug treatment into practice. Journal of Substance Abuse Treatment, 22(4), 231-243.

We have long believed that the utility of MDFT and any associated training program would ultimately hinge on its transportability to non-research settings and its adoption by diverse groups of community providers. Thus, another of our major research foci has been on adapting and streamlining the MDFT model and training methods for use with front line staff in community agencies and clinics.

This study represents our latest and most systematic attempt to refine, adapt, and train agency providers to implement the MDFT model in an existing community-based drug treatment program for adolescent drug abusers ("Transporting Family Therapy to a Day Treatment Program for Adolescent Drug Abusers," H. Liddle, PI, NIDA Grant # RO1 DA13089-04), and to evaluate the feasibility and durability of the training. Like the proposed study, this ongoing study has 3 main phases. During a 12-month Baseline/ Pre-Exposure phase (Phase I), we observed and assessed multiple aspects of the day treatment program, including patient outcomes and potential

challenges to training the providers and implementing the approach. Phase IIa (Training/ Exposure) involved 6 months of intensive training of day treatment program staff and administrators by MDFT clinicians. We are currently completing the 12-month Continued Implementation phase (Phase IIb), which involves less intensive but still regular supervision, ongoing coordination with program administrators, and evaluation of the delivery of the treatment and patient outcomes. In the final 12-month Durability/ Practice phase (Phase III), the technology transfer intervention will be complete. Regular supervision by the MDFT team will be withdrawn, but we will continue to assess the impact of our training intervention on provider practices and adherence to MDFT parameters and techniques, as well as on program and environmental factors, and client outcomes.

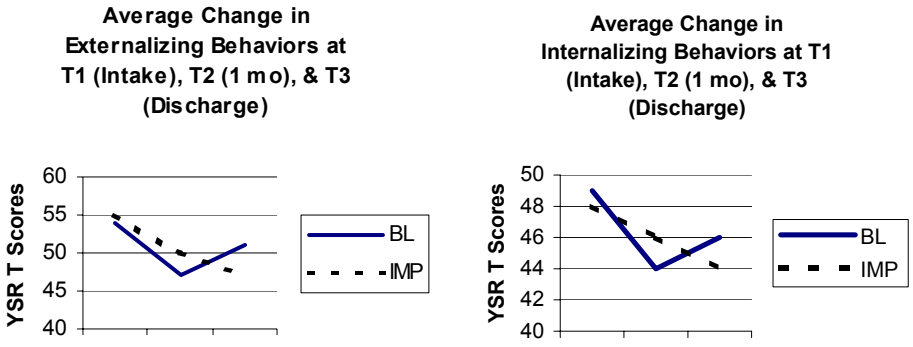
Although the MDFT team has had extensive experience in developing and evaluating methods for training and supervising family therapists (e.g., Liddle et al, 1988, 1997), this study is noteworthy in that we are attempting to train a multidisciplinary clinical team with a broader range of training needs and experience, more of a drug counseling orientation, and less of a family therapy background than has been the norm in our other studies. This required us to adapt many of the techniques used successfully and refined over the years in our previous clinical trials. For example, training had to begin with group didactic sessions in which basic information about adolescent development, families, drug addiction, the recovery process, and other core MDFT topics were presented. Providers from different disciplines, e.g. social workers, mental health technicians (MHT's), and teachers had to be trained separately to address their specific roles on the unit, and MDFT materials had to be re-formatted to better fit their diverse training and experience levels. Training time thus varied accordingly.

Preliminary data from this technology transfer effort are very encouraging. We first examined whether the intervention effectively changed therapist practices in accordance with MDFT guidelines. Paired sample t-tests of therapeutic contact log data indicated that therapists did indeed have more treatment sessions and more contacts with families and other important contacts in the adolescent's life (as prescribed by the MDFT model) during Implementation (following MDFT training) than in the Baseline (pre-training) phase. Therapists demonstrated (on a per case basis) a 140% increase in the number of individual sessions held (from 1.0 at Baseline to 2.4 at Implementation per week), a 267% increase in family therapy sessions (from .3 at Baseline to 1.1 at Implementation per week), a 63% increase in out-of-session phone contacts with parents (from 7.6 at Baseline to 12.4 at Implementation per week), and a 750% increase in contacts with juvenile justice personnel (from .8 at Baseline to 6.8 at Implementation per week) (all significant at $p<.001$). Additionally, the ADTP therapists demonstrated a 1,600% increase in contacts with school personnel (from .04 to .68 per week) from Baseline to Implementation ($p=.01$). These changes in practice patterns not only reflect our success in motivating community based therapists to adhere more closely to the parameters prescribed by the MDFT model but also are promising given research findings that suggest that greater dosage during drug treatment is associated with better outcomes for both teens (Latimer et al, 2000) and adults (Simpson, 1997; Condelli & Hubbard, 1994).

A related goal of the study was to assess the impact of our MDFT technology transfer intervention on the organizational climate of the ADTP, as measured by adolescent reports about a range of program factors using the COPES (Moos, 1996). This instrument was administered at

discharge from therapy to 20 adolescents during the Baseline phase of the study and to another 13 during Implementation, and the results compared using independent sample t-tests. These preliminary analyses indicated that the ADTP was judged by adolescent clients to be more organized and orderly (p=.04) and the program expectations to be clearer (p=.01) during the Implementation than the Baseline phase.

Finally, we were interested in determining if such changes in practice patterns and organizational climate translated into improved client outcomes. Preliminary results suggest that they do. Repeated measures analyses of variance (RMANOVA) indicated that in the Baseline phase sample, adolescents reported a 25% reduction in marijuana use from intake to their 1-month assessment, whereas adolescents in the Implementation phase reported a 50% reduction in marijuana use over that 1-month period (p=.13, η^2=.04). In terms of other problem behavior outcomes, we found that adolescents entering the ADTP during the Baseline phase reported a 13% decrease in externalizing symptoms from intake to the 1-month assessment but an 8% increase (worsening) from the 1-month to the discharge assessment. By contrast, adolescents entering the ADTP during the Implementation phase reported an 11% decrease in externalizing symptoms from intake to the 1-month assessment and an additional 6% decrease from the 1-month to the discharge assessment. Although this preliminary sample is not yet large enough to show statistical significance, there appeared to be a clinically meaningful underlying quadratic trend in these data (η^2=.06). Parent reports of their adolescent's externalizing behaviors produced an identical effect size for the same underlying quadratic trend. There also was a quadratic trend underlying the adolescent reports of internalizing symptoms approaching statistical significance (p=.08, η^2=.11). Again, greater reductions in internalizing symptoms were evident in the Implementation than the Baseline phase. These findings are represented graphically in the figures below.



We also have initial evidence to suggest that the positive changes in therapists' practice patterns that were demonstrated during the Implementation phase were linked to the more dramatic improvement in client outcomes during this same phase as compared to Baseline. For instance, the correlation between the change in number of individual and family sessions from Baseline to Implementation and the change in adolescent-reported internalizing and externalizing symptoms from intake to discharge was clinically meaningful (r > .30). Additionally, the correlation between the change in number of out of session phone contacts with parents and the

change in parent-reported adolescent externalizing symptoms was also clinically meaningful (r = .50). Finally, an association was also found between changes in therapists' practice patterns and reductions in adolescents' self-reported marijuana use (r > .25). Thus, there appears to be an association between therapists' utilization of the MDFT model and the demonstrated improvements in adolescent outcomes over the course of this dissemination study.

In sum, although preliminary, we are very encouraged by these results of our first systematic technology transfer attempt. These findings indicate that MDFT can be successfully adapted and transported into community drug treatment settings, and that this dissemination effort had a positive impact on therapist practice patterns, the organizational climate of the treatment program, and client outcomes. Further, there may be links between therapists' use of MDFT in day-to-day practice and the better client outcomes that were achieved following training in this model. The next logical steps in this program of research are (1) to modify the model further to create a brief, more community-friendly and hence more transportable version of MDFT ("Brief Family-Based Therapy for Adolescent Drug Abusers," R01 DA015995, H. Liddle, PI), and (2) to modify the training intervention itself to more effectively and efficiently improve the practices of community-based drug counselors working with adolescents, as is proposed in the current study. In these new endeavors, we will be developing more rigorous methods to evaluate community therapist adherence and competence in delivering MDFT following training in the model, and we propose to apply more sophisticated analytic techniques to link our training system with client outcomes.

2. *Liddle, H. A. (P.I.), Quille, T., Dakof, G., & Rowe, C. Brief Family-Based Therapy for Adolescent Drug Abuse. NIDA Grant No. 1 R01 DA015995.*

This newly funded study responded to a NIDA initiative inviting applications for studies of how researchers could modify and test "community-friendly" versions of empirically supported treatments for use in practice settings. The study is a 3-year treatment development study in which we will develop and evaluate through an iterative process a brief, prescriptive, 8-session, family-based therapy for adolescent drug abusers that is specifically intended to be community-friendly. This treatment will be a brief therapy adaptation of MDFT. As part of the proposed project, a therapy manual for this brief version of the treatment (MDFT-B) and associated training materials, suitable for use with community-based drug counselors will be produced. Therapist adherence and competence measures also will be developed. This will be followed by a randomized, controlled pilot study of 70 adolescent drug abusers and their families, in which we will test the acceptability and efficacy of MDFT-B versus Community Treatment As Usual (CTAU), and examine predictors of outcome in both. The study could produce one of the first brief, family-based therapies for adolescent drug abusers and yield findings that would have significant implications for technology transfer efforts.

Long-Term Outcomes of Adolescents in Drug Treatment

Dakof, G. (P.I.), Liddle, H. A., Rowe, C., & French, M.. Long-Term Outcomes of Adolescents in Drug Treatment. NIDA Grant No. 1 R01 DA15412.

This project expands the scope of an ongoing randomized study in which MDFT is being tested against residential treatment for severe, dually diagnosed adolescent drug abusers by extending the follow-up period of the study into young adulthood. The study entails the first controlled long-term study of two state-of-the-science, commonly-practiced treatment modalities for adolescent drug abuse--intensive family-based treatment and residential treatment. Youth and their parents/guardians will be assessed at 2, 3, and 4- year follow-up periods on a range of drug use, family and psychosocial functioning, as well as economic evaluation measures. The study has three aims: (a) to compare the long term effectiveness of residential treatment with outpatient, family-based treatment; (b) to examine the relationships among predictors and outcome variables during the four-year post intake period; and (c) to contrast the total and net long-term monetary benefits of the residential treatment and the outpatient family based treatment.

Psychiatric Comorbidity and Adolescent Drug Treatment

Rowe, C. (P.I.). Comorbidity and Adolescent Drug Abuse Treatment. NIDA Grant No. 1 R03 DA13657-01

Another area of work within the CTRADA program of research has been the investigation of psychiatric comorbidity and its impact on drug treatment outcomes. An initial study explored differences at intake to treatment between adolescent substance abusers in different comorbid groups (Rowe, Liddle, & Dakof, 2001). Three clinically distinct groups emerged when teens were classified based on established cut-off scores on adolescent and parent reports of youth externalizing and internalizing symptoms: Externalizers (high externalizing symptoms; normal range internalizing symptoms), Exclusive Substance Abusers (normal range internalizing and externalizing symptoms), and Mixed Substance Abusers (high externalizing and internalizing symptoms). Exclusive Substance Abusers showed a general pattern of more positive family relationships, less family conflict, less parental psychopathology, and less substance use than either of the other groups. Adolescents in the Mixed group had parents with significantly greater psychopathology than either of the other groups. This study revealed that clinically referred adolescent substance abusers with comorbid externalizing problems and those with high levels of both externalizing and internalizing problems are likely to be challenging to treat and may be at high risk for treatment failure. A follow up study explored the differential predictors of drug use among these comorbid groups upon intake to treatment and found that contrary to the "self medication" hypothesis, internalizing symptoms did not predict drug use for any of the group (in fact, internalizing symptoms were *negatively* correlated with drug use). Rather, across groups, externalizing symptoms were the strongest predictor of drug use. Further, peer drug use was a stronger predictor of teen drug use for Externalizers than Mixed youth, and

family dysfunction was a more salient factor in the drug use of Mixed teens than Externalizers (Rowe, Henderson, Dakof, & Liddle, 2002).

These investigators have also explored the impact of comorbidity on treatment outcomes in two studies. A study examining the long-term trajectories of different comorbid groups revealed that Exclusive Substance Abusers, who had a diagnosable substance use disorder but no comorbid psychiatric disorders based on the DISC, had the most positive treatment outcomes in both MDFT and CBT in terms of their drug use from intake to 12 months post-treatment (Rowe, Liddle, Dakof, & Tejeda, 2001). A second study investigated the predictive validity of a typology designed to provide a more multidimensional and clinically meaningful classification scheme than simply grouping adolescent substance abusers on psychiatric comorbidity. The cluster analysis, which was based on 10 variables including risk and protective factors, associated psychopathology and other problems, and substance use severity, revealed three groups similar to the groups described above: Exclusive Substance Abusers had the lowest level of overall risk, substance use, and comorbid symptoms; Mixed Substance had the greatest family risk and comorbid psychopathology; and Deviant Substance Abusers were distinguished by serious substance abuse and peer substance use. When examined over the course of treatment in MDFT and CBT and up to 12 months post-discharge, Deviant Substance Abusers had the poorest behavioral outcomes (Rowe, Liddle, & Caruso, under review). These studies are aimed at identifying future treatment development directions in MDFT to more effectively intervene with teens with a range of presenting problems.

Predictors of Engagement in Treatment

Dakof, G.A. Tejeda, M., & Liddle, H.A. (2001). Predictors of engagement in adolescent drug abuse treatment. Journal of the American Academy of Child and Adolescent Psychiatry, 40, 274 –281.

The objective of this study was to identify key demographic, parent, and adolescent pre-treatment factors that influence engagement into outpatient drug abuse treatment. Youths aged 12 – 17 years (N= 224, 81% male, 72% African American) referred for drug treatment and their parents participated in this study. Marijuana was the primary substance of abuse. Data were gathered prior to treatment on demographic variables as well as on both parent and youth perspectives on youth, parent, and family functioning. A discriminant function analysis revealed that engagement in treatment is related to, in order of weighting, more positive parental expectations for their adolescent's educational achievement (SDF = 0.68), higher parental reports of youth externalizing symptoms (SDF = 0.59), and higher levels of family conflict perceived by the youth (SDF = 0.36). Family income, gender, minority group status, juvenile justice status, family structure, mother's age and psychopathology, and treatment characteristics did not distinguish treatment engaged from unengaged adolescents. The results suggest that both parent and youth perceptions are pivotal to whether or not adolescents are engaged into psychotherapy. These findings support the MDFT emphasis on working with both the youth and his or her parents, and directly influence MDFT treatment development issues concerning engagement and retention.

Gender Differences in Adolescent Drug Abuse

Dakof, G. A. (2000). Understanding gender differences in adolescent drug abuse: Issues of comorbidity and family functioning. Journal of Psychoactive Drugs, 32, 25-32.

This study investigated gender differences in patterns of comorbidity and family functioning in 95 adolescents (mean age 15.2 yrs) referred for substance abuse treatment. Data were obtained from parents and adolescents during treatment evaluations. The findings indicate that male and female adolescent substance users differed in several clinically meaningful ways. Drug-using females used drugs and engaged in externalizing behaviors as extensively as males, but were distinguished by their higher levels of internalizing symptoms and family dysfunction. Families of substance-abusing girls had more conflict and less cohesion than families of substance-using males.

Summary

This document summarizes the MDFT effectiveness and mechanisms studies completed and in process. As a developmentally- and ecologically oriented treatment, MDFT takes into account the interlocking environmental and individual systems in which clinically referred teenagers reside. The clinical outcomes achieved in the four completed controlled trials (one of which was a multi-site study not conducted by the developer of MDFT, and another was a prevention trial, which also was not conducted by the developer) include success in functional areas that have been found to be causative in creating dysfunction, including family factors, drug use, peer deviance factors, and externalizing and internalizing variables in core areas that create and perpetuate dysfunction. We also have data to suggest that this treatment can facilitate positive, prosocial development and increase in protective factors as well. This includes positive changes in parenting practices, school functioning, and overall family functioning. We have tracked outcomes to one year post treatment and have found that the effectiveness of the treatment on decreasing negative symptoms and increasing positive factors can be retained without any post treatment booster sessions. The cost of this treatment relative to contemporary estimates of similar outpatient treatment is favorable toward MDFT. The clinical trials have not included any treatment as usual or weak control conditions, they have all tested MDFT against other manualized, commonly used interventions. The approach is manualized (Liddle, 2001), training materials have been developed, and we have demonstrated that the treatment can be taught to clinic therapists.

References

Alexander, J. F., Robbins, M., Turner, C., Liddle, H. A., & Szapocznik, J. Change processes in family therapy with drug using youth. (NIDA Grant No. P50 DA011328).

Brown, B. B. (1990). Peer groups and peer culture. In S. S. Feldman, & G. R. Elliott (Eds.), At the threshold: The developing adolescent (pp. 171-196). Cambridge, MA: Harvard University Press.

Bryk, A. S., & Raudenbush, S. W. (1987). Application of hierarchical linear models in assessing change. Psychological Bulletin, 101, 147 - 158.

Center for Substance Abuse Treatment (1998). Guidelines for adolescent drug abuse treatment (Treatment improvement series). Rockville, MD: Author.

Center for Substance Abuse Treatment (1999). Screening and Assessing Adolescents for Substance Use Disorders: Treatment Improvement Protocol (TIP) Series 31. (DHHS Publication No. SMA 99-3282). Washington, DC: US. Department of Health and Human Services. Available: http://health.org/govpubs/BKD306/index.htm

Dakof, G. (P.I.), Liddle, H. A., & French, M.. Long-Term Outcomes of Adolescents in Drug Treatment. NIDA Grant No. 1 R01 DA15412.

Dakof, G.A. Tejeda, M., & Liddle, H.A. (2001). Predictors of engagement in adolescent drug abuse treatment. Journal of the American Academy of Child and Adolescent Psychiatry, 40, 274 –281.

Dennis, M. L., Babor, T. F., Diamond, G., Donaldson, J., Godley, S. H., Titus, J. C., Tims, F., Webb, C., Herrell, J., Buchan, B. J., Burleson, J. A., Fraser, J., French, M., Godley, M. D., Hamilton, N., Kadden, R., Kaminer, Y., Liddle, H., Roebuck, M. C., Sampl, S., Scott, C. K., Tejeda, M., & White, W. L. (2000). The Cannabis Youth Treatment (CYT) experiment: Preliminary findings. A report to H. Westley Clark, Director Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.

Dennis, M. L., Titus, J., Diamond, G., Babor, T., Donaldson, J., Godley, S. H., Tims, F., Webb, C., Liddle, H. A., & Scott, C. (in press). The Cannabis Youth Treatment (CYT) Experiment: A multi-site study of five approaches to outpatient treatment for adolescents. Addiction.

Diamond, G. M., Diamond, G. S., & Liddle, H. A. (2000). The therapist-parent alliance in family-based therapy for adolescents. Journal of Clinical Psychology, 56(8), 1037-1050.

Diamond, G. M., Liddle, H. A., Hogue, A., & Dakof, G. A. (2000). Alliance building interventions with adolescents in family therapy: A process study. Psychotherapy, 36, 355-368.

Diamond, G. S., & Liddle, H. A. (1996). Resolving a therapeutic impasse between parents and adolescents in Multidimensional Family Therapy. Journal of Consulting and Clinical Psychology, 64(3), 481-488.

French, M., Roebuck, C., Dennis, M., Babor, T., Diamond, G., Godley, S., & Tims, F. (in press). The economic cost of outpatient marijuana treatment for adolescents: Findings from the multi-site experiment. Addiction.

Gerstein, D.R., & Johnson, R.A. (1999). Adolescent and young adults in the national treatment improvement evaluation study. (National Evaluation Data Services Report). Rockville, MD: Center for Substance Abuse Treatment.

Henggeler, S. W., Schoenwald, S. K., & Pickrel, S. G. (1995). Multisystemic therapy: Bridging the gap between university- and community-based treatment. Journal of Consulting and Clinical Psychology, 63(5), 709-717.

Hogue, A., & Liddle, H. (1999). Family-based preventive intervention: An approach to preventing substance abuse and antisocial behavior. American Journal of Orthopsychiatry, 69, 275-293.

Hogue, A. & Liddle, H. A. (in press). Mechanisms of change in Multidimensional Family Therapy. In T. Patterson (Ed.), Handbook of Psychotherapy (Volume on Cognitive and Behavioral Therapies). New York: John Wiley & Sons.

Hogue, A., Liddle, H., & Becker, D. (in press). Multidimensional family prevention for at-risk adolescents. In T. Patterson (Ed.), Comprehensive handbook of psychotherapy. NY: Wiley.

Hogue, A., Liddle, A. & Leckrone, J. (in press). Immediate effects of a family based prevention intervention for at risk youth, inner city youth. American Journal of Community Psychology.

Hogue A., Liddle, H.A., & Rowe, C. (1996). Treatment adherence process research in family therapy: A rationale and some practical guidelines. Psychotherapy: Theory, Research, Practice, & Training, 33(2), 332-345.

Hogue, A., Liddle, H. A., Rowe, C. L., Turner, R. M., Dakof, G. D., & LaPann, K. (1998). Treatment adherence and differentiation in individual versus family therapy. Journal of Counseling Psychology, 45(1), 104-114.

Jackson-Gilfort, A., Liddle, H. A., Tejeda, M. J., & Dakof, G. A. (2001). Facilitating engagement of African-American male adolescents in family therapy: A cultural theme process study. Journal of Black Psychology, 27(3), 321-340.

Lebow, J. L., & Gurman, A. S. (1995). Research assessing couple and family therapy. Annual Review of Psychology, 46, 27-57.

Liddle, H.A. (1985). Redefining the mission of family therapy training: Can our differentness make a difference? Journal of Psychotherapy and the Family. 1(4), 109-124.

Liddle, H.A. (in press). Multidimensional Family Therapy vs. Cognitive Behavior Therapy for adolescent substance abusers. In forthcoming NIDA Monograph presenting the Proceedings of the CPDD meeting, Scottsdale, AZ, 2001.

Liddle, H. A., Becker, D., & Diamond, G. M. (1997). Family therapy supervision. In C. Watkins (Ed.), Psychotherapy supervision (pp. 400-418). New York: Wiley Publishers.

Liddle, H. A., Dakof, G. A., Parker, K., Diamond, G. S., Barrett, K., & Tejeda, M. (in press). Multidimensional family therapy for adolescent drug abuse: Results of a randomized clinical trial. American Journal of Alcohol and Drug Abuse.

Liddle, H.A., Dakof, G.A., Turner, R.M., & Tejeda, M., (submitted). Treating adolescent substance abuse: A comparison of individual and family therapy interventions. Journal of Consulting and Clinical Psychology.

Liddle, H.A. & Diamond, G. (1991). Adolescent substance abusers in family therapy: The critical initial phase of treatment. Family Dynamics of Addictions Quarterly, 1, 55-68.

Liddle, H.A., Diamond, G., Dakof, G.A., Arroyo, J., Guillory, P., Holt, M. & Watson, M. (1992). The adolescent module in multidimensional family therapy. In G. Lawson & A. Lawson (Eds.), Family therapy with adolescent drug abusers. (pp. 165-186). Rockville, MD: Aspen.

Liddle, H. A. (P.I.). & French, M. T. (Co-P.I.). Economic Evaluation of Adolescent Drug Services. NIDA Grant no. 1R01 DA13298.

Liddle, H. A., & Hogue, A. (2000). A developmental, family-based, ecological preventive intervention for antisocial behavior in high-risk adolescents. Journal of Marital and Family Therapy, 26(3), 265-280.

Liddle, H. A., & Hogue, A. (2001). Multidimensional Family Therapy: Pursuing empirical support through planful treatment development. In E. Wagner & H. Waldron (Eds.), Adolescent substance abuse. NY: Elsivier (pp. 227-259).

Liddle, H. A. (P.I.), Quille, T., & Dakof, G. Brief Family-Based Therapy for Adolescent Drug Abuse. NIDA Grant No. 1 R01 DA015995.

Liddle, H.A., & Rowe, C. (2000, Spring). Multidimensional family therapy for adolescent drug abuse. Addictions Newsletter, 7(2), 10-23.

Liddle, H. A., Rowe, C. L., Dakof, G., & Lyke, J. (1998). Translating parenting research into clinical interventions for families of adolescent. Clinical Child Psychology and Psychiatry, 3, 419 - 443.

Liddle H. A., Rowe, C. L., Quille, T. J., Dakof, G. A., Mills, D. S., Sakran, E., & Biaggi, H. (2002). Transporting a research-based adolescent drug treatment into practice. Journal of Substance Abuse Treatment, 22(4), 231-243.

National Institute on Drug Abuse. Effective Drug Abuse Treatment [on-line]. Available: www.nida.nih.gov/BTDP/Effective/Liddle.html

National Institute on Drug Abuse (NIDA) (1999). Principles of drug addiction treatment: A research-based guide. Rockville, MD: Author.

Newman, F. L., & Tejeda, M. J. (1996). The need for research designed to support decisions in the delivery of mental health services. American Psychologist, 51, 1040-1049.

Newman, F. L. & Tejeda, M. J. (1999).Criteria for Selecting Statistical Procedures For Progress & Outcome Assessment. In Maruish, M. (Ed.) Use of Psychological Testing for Treatment Planning & Outcome Assessment (2nd Edition). (pp. 225-266). Lawrence, Erlbaum & Associates: Mahwah, NJ.

Nichols, M. P., & Schwartz, R. C. (1998). Family therapy: Concepts and methods (4th ed.). Needham Heights, MA: Allyn & Bacon.

Office of Juvenile Justice & Delinquency Prevention. (1999). Multidimensional Family Therapy. In 1999 Strengthening America's Families Project. [on-line]. Available: http://www.strengtheningfamilies.org/html/programs_1999/10_MDFT.html

Rowe, C. (P.I.). Transporting Family Therapy to Adolescent Day Treatment. NIDA Grant No. 1R01 DA 3089.

Rowe, C. L., Liddle, H. A., & Dakof, G. A. (2001). Classifying adolescent substance abusers by level of externalizing and internalizing symptoms. Journal of Child and Adolescent Substance Abuse, 11(2), 41-65.

Rowe, C. L., Liddle, H. A., Dakof, G. A., & Tejeda, M. (2001, June). Treatment outcomes of adolescent substance abusers with comorbid psychiatric disorders. Paper presented at the College on Problems of Drug Dependence 63rd Annual Scientific Meeting. Scottsdale, AZ.

Rowe, C. L., Henderson, C., Dakof, G. A., & Liddle, H. A. (2002, June). Differential predictors of drug use among comorbid youth. Poster presented at the Annual Conference of the College on Problems of Drug Dependence. Quebec City, Quebec, Canada.

Rowe, C. L., Liddle, H. A., Caruso, J., & Dakof, G. A. (under review). Clinical variations of adolescent substance abuse: An empirically based typology. Journal of Child and Adolescent Substance Abuse.

Scannapieco, M. (1994). Home based services program: effectiveness with at risk families. Children and Youth Services Review, Vol. 16, Nos. 5/6, pp. 363-377.

Schmidt, S., Liddle, H. A., & Dakof, G. (1996). Changes in parenting practices and adolescent drug abuse during multidimensional family therapy. Journal of Family Psychology, 10, 12-27.

Selekman, M. D., & Todd, T. C. (1991). Major issues from family therapy research and theory: Implications for the future. In T. Todd & M. Selekman (Eds.), Family Therapy with adolescent Substance Abusers (pp. 311 - 325). Boston: Allyn & Bacon.

Shoham-Salomon, V. (1990). Interrelating research processes of process research. Journal of Consulting & Clinical Psychology, 58 (3), 295-303.

Speer, D.C., & Greenbaum, P.E. (1995). Five methods for computing significant individual client change and improvement rates: Support for an individual growth curve approach. Journal of Consulting and Clinical Psychology, 63(6), 1044-1048.

Stanton, M. D., & Shadish W. R. (1997). Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. Psychological Bulletin, 122, 170-191.

Waldron, H. B. (1997). Adolescent substance abuse and family therapy outcome: A review of randomized trials. In T. H. Ollendick & R. J. Printz (Eds.), Advances in clinical child psychology (Vol. 19, pp. 199-234). New York: Plenum Press.

Ware, J.H. (1985). Linear models for the analysis of longitudinal studies. American Statistician, 39, 95-101.

Weinberg, N. Z., Rahdert, E., Colliver, J. D., & Glantz, M. D. (1998). Adolescent substance abuse: A review of the past 10 years. Journal of the American Academy of Child and Adolescent Psychiatry, 37(3), 252-261.

Williams, R. J., Chang, S. Y.and Addiction Centre Adolescent Research Group (2000). A comprehensive and comparative review of adolescent substance abuse treatment outcome. Clinical Psychology: Science and Practice, 7, 138-166.

Winters, K. C., Latimer, W. L., & Stinchfield, R. D. (1999). Adolescent treatment for alcohol and other drug abuse. In T. Tarter, R. T. Ammerman, & P. J. Ott (Eds.), Sourcebook on substance abuse: Etiology, methodology, and intervention (pp. 350-361). New York: Allyn and Bacon.