

Multidimensional Family Therapy: A Science-Based Treatment System for Adolescent Drug Abuse

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Formulated first in clinical and therapist training settings, multidimensional family therapy (MDFT) connects to the structural-strategic family therapy tradition (Liddle, 1984). The MDFT research program began in 1985 with National Institute on Drug Abuse (NIDA) funding that continues to the present day. MDFT is an empirically supported, family-based intervention for adolescent substance abuse and associated mental health and behavioral problems (Liddle, 2002a; Liddle, Dakof, & Diamond, 1991). The developmental psychology/psychopathology research knowledge base guides assessment, specifies change targets, and informs outcome evaluation. Integrative in several ways, MDFT uses an ecological or contextual conceptual framework to understand development. Research-derived knowledge about risk and protective factors, and proximal causes, correlates, and contributors to adolescent drug and related problems, inform clinical thinking and interventions with every case.

MDFT assesses and intervenes in four domains: (1) the adolescent as an individual *and* a member of a family and peer network; (2) the parent(s), both as individual adults and each in his or her role as mother, father, or caregiver; (3) the family environment and family relationships, as manifested in day-to-day family transactional patterns; and (4) extrafamilial sources of influence such as peers, school, and juvenile justice. Interventions are coordinated across domains. Progress in one area has implications for use in others. Individual meetings with parent(s) and teen set the stage for family sessions, and family meetings may offer content and new outcomes that need to be brought to extrafamily meetings with juvenile justice or school personnel. To maximize transportability, MDFT was developed and tested as a *treatment system* rather than a one-size-fits-all approach. A treatment system offers different versions of a clinical model that vary according to factors such as clinical sample characteristics (older versus younger adolescents, juvenile justice involved versus no involvement in juvenile justice systems) and treatment

parameters (type of clinical setting and treatment dose). Overall our treatment development strategy has been to create a clinically and cost-effective approach for teen substance abuse and delinquency that can be used in a range of clinical settings.

Adolescent Substance Abuse

Considerable scientific progress has been made in our knowledge about the causes and correlates of adolescent alcohol and drug problems (Liddle & Rowe, 2006). We know a great deal about the ingredients, sequence, and interactions that predict initial and increased drug involvement. Adolescent substance abuse can progress along various and intersecting developmental pathways, hence its designation as a multidimensional and multidetermined phenomenon requiring a multiple systems strategy and interventions that target different contexts and domains of functioning (Hawkins, Catalano, & Miller, 1992).

Drug problems are understood through the filters of multiple theoretical lenses. Social-cognitive factors; psychological functioning; personality and temperament; values and beliefs; family factors; peer relationships; environmental influences, such as school and neighborhood/community; and sociocultural factors, such as media influences, all have links to the development and maintenance of teen drug abuse. Responding to longitudinal and cross-sectional findings that have illuminated how drug problems develop, remit, or worsen over time, adolescent drug treatments have changed dramatically over the years. Systems-oriented family-based therapies are the most researched teen drug misuse intervention (Liddle, 2004); and for some, these interventions are referred to as the treatment of choice (Stanton & Shadish, 1997; Williams & Chang, 2000).

Knowledge about risk and protective forces, at multiple system levels and in different domains of individual and family functioning, guides treatment. Intrapersonal factors (e.g., identity, self-competence), interpersonal factors (family and peer relationships), and contextual and environmental factors (school support and community influences) are all included in case conceptualization, treatment planning, and intervention delivery. As a developmental disorder, adolescent drug abuse is a deleterious deviation from healthy, adaptive development (Cicchetti & Rogosch, 2002; Guo, Hill, Hawkins, Catalano, & Abbott, 2002). By working with individual, family, and extrafamilial system levels and targeting interactional change in these systems and at these system intersections, MDFT aims to reorient the adolescent and family toward a more functional developmental trajectory.

Principles of MDFT

1 *Adolescent drug abuse is a multidimensional phenomenon.* MDFT clinical work is guided by an ecological and developmental perspective and corresponding research. Adolescent drug abuse problems are understood intrapersonally, interpersonally, and contextually as well, in terms of the interaction of multiple systems and levels of influence.

2 *Problem situations provide important assessment information and change opportunities.* Current symptoms of the adolescent or other family members, as well as crises pertaining to the adolescent and family, provide critical information as well as valuable change opportunities. Therapists analyze the organizational features and process dimensions of these rich situations, support existing competence and good intentions, and use the stress and distress of these situations to build the case that change is needed.

3 *Change is multidetermined and multifaceted.* Multidimensional problems require multidimensional solutions. Change emerges out of the synergistic effects of interaction among different systems and levels of systems, different people, domains of functioning, time periods, and intrapersonal and interpersonal processes. Assessment and interventions themselves give indications about the timing, routes, or kinds of change that are accessible and potentially efficacious at particular times.

4 *Motivation is malleable.* Motivation to enter treatment or to change may not be present with adolescents or their parents. Treatment receptivity and motivation vary across individual family members and extrafamilial others. Behaviors typically defined as resistance are not immutable, they communicate a great deal about the barriers to successful treatment implementation, and they point to important processes requiring therapeutic focus.

5 *Working relationships are fundamental.* The therapist makes treatment possible through non-judgmental but outcome-focused working relationships with family members and extrafamilial supports, and the facilitation and working through of personally meaningful relationship and life themes. These therapeutic themes emerge from discussions about generic individual and family developmental tasks and the case-specific aspects of the adolescent's and family's development.

6 *Interventions are individualized.* Although they have generic aspects (e.g., promoting competence of adolescent or parent inside and outside of the family), interventions are customized according to each family, family member, and the family's environmental circumstances. Interventions target known etiologic risk behaviors and circumstances related to drug abuse and problem behaviors, and promote protective and development-enhancing personal and interpersonal processes.

7 *Planning and flexibility are two sides of the same therapeutic coin.* Case formulations are practically oriented, prescriptive blueprints that guide the therapist throughout the therapeutic process. Formulations are revised on the basis of new information, in-treatment experiences, and feedback. In collaboration with family members and relevant extrafamilial others, therapists continually evaluate the results of all interventions and alter the intervention plan according to intervention results on a session-by-session and week-by-week basis.

8 *Treatment is phasic.* MDFT relies on research-based knowledge about the laws governing the unfolding of human development. Similarly, finding and focusing relevant therapeutic content and theme development, intervention plans and implementation, and the overall therapy process organize and unfold in stages. Progress in one area (therapeutic relationships with different family members and relevant extrafamilial persons, for instance), lays the foundation for the next steps in the change process – action steps and change strategies with multiple persons inside and outside of the family.

9 *Therapist responsibility is emphasized.* Therapists accept responsibility for promoting participation and enhancing motivation of all involved individuals; creating a workable agenda and clinical focus; devising multidimensional and multisystemic alternatives; providing thematic focus and consistency throughout treatment; prompting behavior change; evaluating the ongoing success of interventions; and revising the interventions as needed according to the outcomes of the interventions.

10 *Therapist attitude and skill are fundamental to success.* Therapists advocate for both the adolescent and the parent. Extreme positions as either “child savers” or proponents of the “tough love” philosophy are avoided. Therapists are optimistic but not naïve about change. They understand that their own ability to remain positive, committed, creative, and energetic in joining with all family members and important extrafamilial persons is instrumental to therapeutic success.

The Interdependence of Assessment and Intervention

Multidimensional assessment

Assessment creates a therapeutic blueprint. This blueprint directs therapists as to where to intervene in the multiple domains of the teen’s life. A comprehensive, multidimensional assessment process involves identifying risk and protective factors in all relevant areas and then targeting specific areas for change. Information about functioning in each target area comes through individual and family interviews, observations of both spontaneous and directed family interactions, and observation of family member interactions with influential others outside of the family as well (see Chapter 10, this volume). The approach has four target areas: (1) adolescent, (2) parent, (3) family interaction, and (4) extrafamilial social systems. In their investigation of the target areas, therapists explore life details and current functioning on the basis of research-derived knowledge about the multifaceted development of adolescent substance abuse and related problems. We attend to deficits and hidden areas of strength, so as to obtain a complete clinical picture of the unique combination of assets and weaknesses in the adolescent, family, and ecosystem. A full picture of the adolescent and family includes a formulation of how the current situation and behaviors are understandable, given the adolescent’s and family’s developmental history and current risk and protection profile. Interventions aim to decrease risk processes known to be related to dysfunction development or progression, and enhance protection, first within what the therapist finds to be the most accessible and malleable domains. An ongoing process rather than a single event, assessment continues throughout therapy as new information comes forward.

Family assessment. The assessment process typically begins with a meeting that includes the entire family. Therapists observe family interaction and note how individuals contribute differentially to the adolescent’s life and current circumstances. We meet individually with the adolescent, the parent(s), and other members of the family within

the first session or two. Individual meetings clarify the unique perspective of each family member, their different views of the current problems, how things have gone wrong (e.g., legal and drug problems, neighborhood and peer influences, school and family relationship difficulties), what they have done to address the problems, and what they believe needs to see change with the youth and family.

Adolescent assessment. Therapists elicit the adolescent's life story, an important assessment and intervention strategy, during early individual sessions. Sharing their life experiences contributes to the teen's engagement. It provides a detailed picture of the severity and nature of the teen's drug use and circumstances and trajectory of drug use over time, family history, peer relationships, school and legal problems, and important life events. One useful technique involves asking the adolescent to draw an ecomap that represents his or her current life space. This would include the neighborhood, indicating where the teen hangs or goes to buy and use drugs, where friends live, the location of school or work, and, in general, where the action is in his or her environment. Therapists inquire about the adolescent's health and lifestyle issues, including sexual behavior (Marvel, Rowe, Colon, DiClemente & Liddle, 2009). The presence and severity of comorbid mental health problems is determined through the review of previous records and reports, the clinical interview process, and psychiatric evaluations. Particular adolescent substance abuse screening devices are psychometrically sound and clinically useful. They can be invaluable in one's quest to obtain a comprehensive picture of the teen's and family's circumstances.

Assessment with the parent(s). Assessment with the parent(s) includes their functioning both as parents and as individual adults, with an individual, unique history and concerns. We assess the parents' strengths and weaknesses in terms of parenting knowledge, skills, and general parenting style, as well as parenting beliefs and emotional connection to their child. In assessing parenting knowledge and competencies, the therapist inquires in detail about parenting practices and observes and takes part in parent-teen discussions, looking for things like supportive expressions and communication skills in their ways of relating with the adolescent. In discussing parenting style and beliefs, the therapist asks parents about their own experiences, including their family life when they were growing up. Considerable attention is paid to the parent's commitment and emotional investment to the adolescent. If parental abdication exists, therapists work diligently to elicit and rekindle even modest degrees of hope about helping their teen get back on track. Parents need to be responsive to having a role in facilitating the needed changes. A parent's mental health problems and substance abuse are also evaluated as potential obstacles to parenting, and, when indicated, referrals for individual treatment of drug or alcohol abuse or serious mental health problems are appropriate and sometimes used in MDFT.

Assessment of relevant social systems. Finally, assessment of extrafamilial influences involves gathering information from all relevant sources. This information is combined with the adolescent's and family's reports in order to compile the fullest possible picture of each individual's and the family's functioning relative to external systems and current

circumstances. The adolescent's educational/vocational placement is assessed thoroughly. Alternatives are generated in order to create workable alternatives to drug use and to build bridges to a productive lifestyle. Therapists build relationships and work closely and collaboratively with the juvenile court and probation officers in relation to the youth's legal charges and probation requirements. They focus the parents on the potential harm of continued negative or deepening legal outcomes, and, using a non-punitive tone, they strive to help teens face and deal with their legal situation. Assessment of peer networks involves encouraging the adolescent to talk about peers, school, and neighborhood contexts in an honest and detailed manner, and this is used to craft focal treatment areas. The creation of concrete alternatives that provide pro-social, developmentally enhancing, day-to-day activities using family, community, or other resources is a driving force for the extrafamilial domain, and of course, of MDFT generally.

Multidimensional interventions facilitate adolescent, parent, and family development

A multidimensional perspective suggests that symptom reduction and enhancement of pro-social and appropriate developmental functions occur by facilitating adaptive, risk-combating processes in important functional domains. We target behaviors, emotions, and thinking patterns implicated in substance use and abuse, as well as the complementary aspects of behaviors, emotions, and thought patterns associated with development-enhancing intrapersonal and familial functioning (Hawkins et al., 1992).

Change targets are prioritized. The focus for change begins in certain areas first, and then changes in these areas are used as departure points for the next, usually more difficult, working areas for change. All roads must lead to changing drug use and abuse and related problem areas. When development-enhancing interventions are effective, they create everyday outcomes that are incompatible with previous drug-using behaviors and ways of moving through life. New developmental competencies emerge, sponsoring progress toward completing previously compromised developmental tasks.

We assess and intervene in four interdependent and mutually influencing subsystems with each case. While other family-based interventions might address parenting practices by working alone with the parent for much of the therapy, MDFT is unique in its way of not only working with the parents alone but also focusing significantly on the teen alone, apart from the parent sessions, and apart from the family sessions. These individual sessions have enormous strategic, substantive, and relationship-building value. They provide vital point-of-view information and reveal feeling states and historical events that are not always forthcoming in family sessions. The individual meetings establish one-on-one relationships with each family member. Family-based treatment means establishing multiple therapeutic relationships rather than single therapeutic alliances, as is the case in individual treatment. They actualize the kinds of therapeutic processes from which positive clinical outcomes emerge. A therapist's relationships with different people in the mosaic that forms the teen's and family's lives are the starting place for inviting and instigating change attempts. There is a leveraging that occurs in the individual sessions

as they are worked to create content, motivation, and readiness to address other family members in joint sessions.

Interventions with the adolescent. Establishing a therapeutic alliance and relationship with the teenager, distinct from but related to identical efforts with the parent, builds an essential foundation (Diamond, Liddle, Hogue, & Dakof, 1999). We conceptualize and apply alliance-building techniques, called adolescent engagement interventions (AEI), sequentially. They present therapy as a collaborative process, define therapeutic goals that are personally meaningful to the adolescent, generate hope, and attend to the youth's experience and evaluation of his or her life. We aim to have treatment attend to these "big picture" dimensions. Problem solving, elimination of drug use and a drug-taking lifestyle, and all of these remediation efforts should exist in the context of work that connects to a teen's conception of his or her own life, its direction, and its meaning. Success in one's alliance with the teenager does not go unnoticed by most parents. We find that parents both expect and like the fact that the therapist reaches out to and assertively tries to form a distinct relationship and therapeutic focus with the teen. Considerable work occurs in individual sessions with parents and teens to prepare them to come together to discuss matters that need to be faced, improved, or resolved.

Interventions with the parent. We focus on reaching the teen's caregiver(s) as both adults each with her or his own needs and issues, and in their position as a parent who may have lost motivation or faith in their ability to raise and influence their adolescent. Parental reconnection interventions (Liddle, Rowe, Dakof, & Lyke, 1998) include such things as enhancing feelings of parental love and emotional connection, validating parents' past efforts, acknowledging difficult past and present circumstances, and generating hope. When parents enter into, think and talk about, and experience these processes, their emotional and behavioral investment in their adolescent grows. And this process, the expansion of a parent's commitment and investment to their child and his or her welfare, is basic to the MDFT change model. These thoughts, feelings, and behaviors on the parent's part are fundamental and necessary developmental/therapeutic tasks that must be actualized before mid-therapy and are fundamental ingredients for later changes to occur and be sustained. These interventions take the first step toward change, and grow parents' motivation and, gradually, their willingness to address relationship improvement and parenting strategies. Increasing parental involvement with the adolescent (e.g., showing an interest, initiating conversations, creating a new interpersonal environment in day-to-day transactions) provides a new foundation for behavioral and attitudinal change in parenting strategy. Parenting competency is fostered by teaching and coaching about normative characteristics of parent-adolescent relationships, consistent and age-appropriate limit setting, monitoring, and emotional support – all research established parental behaviors that enhance relationships and individual and family development.

Interventions to change the parent-adolescent interaction. Family therapy originally articulated a theory and technology about changing particular dysfunctional family transactional patterns that connect to the development of problem behaviors. Following

in this tradition, MDFT interventions also change development-retarding transactions. Direct, in-session changes in the parent–adolescent relationship are made through the structural family therapy technique of enactment (Minuchin, 1974). Typically, enactment involves elicitation, in a family session, of topics or themes that are important in the everyday life of the family, and preparing and/or assisting family members to discuss and try to solve problems in new ways (Liddle, 1999). The method actively guides, coaches, and shapes increasingly positive and constructive family interactions. In order for discussions between parent and adolescent to involve problem solving and relationship healing, parents and adolescents must be able to communicate without excessive blame, defensiveness, or recrimination (Diamond & Liddle, 1996). We help teens and parents to steer clear of extreme, inflexible stances as these actions create poor problem solving, hurt feelings, and erode motivation and hope for change. Skilled therapists direct and focus in-session conversations on important topics in a patient, sensitive way (Diamond & Liddle, 1999). Although success in individual and interaction work with the adolescent and parent(s) is central to changing the teen's drug use, other family members can also be important in the change process. Thus, we include siblings, adult friends of parents, or extended family members in the assessment and interventions. These individuals are invited to be a part of the family sessions, and meetings are held with them alone as well per MDFT session composition guidelines. Cooperation with the involved adults is achieved and motivation is grown by underscoring the serious, often life-threatening circumstances of the youth's life, and establishing an overt, discussable connection between that caregiver's involvement in treatment and the creation of behavioral and relational alternatives for the adolescent. This follows the general procedure used with the parents – the attempt to promote caring and connection through several means, first through an intense focusing and detailing of the youth's difficult and sometimes dire circumstances and the need for his or her family to help.

Interventions with social systems external to the family. MDFT also facilitates changes in the ways that the family and adolescent interact with systems outside the family. Success or failure in negotiating these systems has considerable impact on the teen's and parent's life course. Close collaboration with the school, legal, employment, mental health, and health systems influencing the youth's life is critical for initial and durable change. For an overwhelmed parent, help in dealing with complex bureaucracies or in obtaining needed adjunctive services not only increases engagement, but also improves his or her ability to parent effectively by reducing stress and burden. Therapists help to set up meetings at school or with juvenile probation officers. They regularly prepare the family for and attend youth's juvenile justice disposition hearings, understanding that successful compliance with the juvenile justice supervision requirements is a core therapeutic focus and task. School or job placements are also basic aspects of the therapeutic program since they represent real-world settings in which the youth can develop competence, succeed, and build a pathway away from deviant peers, drugs, and antisocial behavior. In some cases, medical or immigration issues or financial problems may be obvious and urgent areas of need and stress. Our approach understands the interconnection of all of these life circumstances to the improvement of family life, parenting, and a teen's reclaiming

of his or her life from the perils of the streets. Not all multisystem problems can be solved, but in every case, our rule of thumb is to assess all of them, make priorities, and as much as possible work actively and directly to help the family achieve better day-to-day outcomes relative to the most consequential and malleable areas.

Using drug screens

We integrate the drug urine screening procedure and the results of the drug screen directly into the therapeutic context of parent–teen sessions (Liddle, 2002b). Results from weekly urinalyses are shared with both the adolescent and the family, creating an atmosphere of openness and honesty about drug use from the beginning of therapy. The MDFT therapist, as a part of ongoing work with the youth, will often say, “So, tell me what the (drug screen) results are going to be” prior to conducting the urine screen. This context shift sets the stage for a teen’s forthright communication with parents and others. When the teen produces a drug-free urinalysis, this outcome creates a context for adolescents and parents to communicate differently. Parents may rediscover hope and believe that their lives may begin to be less disrupted by drug use and its consequences. With the therapist’s help, family agreements about restrictions and privileges, as well as shifts in emotional interactions, occur.

When teens do not want to complete the drug test, it may be a sign that their drug use persists. The therapist may ask, “Are you afraid of what the results might be?” The therapist discusses a positive drug test from a non-punitive stance: “What we’re doing isn’t working and we’re not helping you enough. What do we have to do to avoid continued use?” This process begins by eliciting the critical details of the social context of use, as well as the teen’s intrapersonal functioning prior to and after drug use: “Can you talk about what happened; when did you use; what time and place; how much and what did you use; how many times; what were your thoughts and feelings before, during, and after using; which friends were present; could that use episode have been prevented?” These details help the therapist determine the next steps.

While parents want the problem fixed, therapists help parents to understand that, given the nature of the adolescent’s problems, recovery from serious drug use can be a roller-coaster ride, not problem-free continuous progress. The therapist’s work is to shift the parents’ fear to a developmental perspective of their adolescent, where they understand that the teen has several areas of impairment needing attention, and that the development of a drug-free, more adaptive lifestyle takes time, and depends on several areas of progress meeting and reinforcing each other (individual outcomes, parent outcomes, family changes, school improvement, juvenile justice involvement decreased or stabilized).

Decision rules about individual, family, or extrafamilial sessions

MDFT is a therapy of subsystems. Treatment consists of working with parts (subsystems) to larger wholes (systems) and then from wholes (family unit) back down to smaller

units (individuals). Systematic decision rules specify how to constitute any given session or piece of therapeutic work. Session composition is usually not random or at the discretion of the family or extrafamilial others, although sometimes this is the case. When therapists are new to MDFT, one of their main questions is, “When is it appropriate to meet with the adolescent alone, the parent alone, or the parent and the adolescent together?” Clinicians want to know about the inclusion of extrafamilial people in treatment as well. Composition of sessions (i.e., who attends/is included in that meeting) depends on the goals of that particular piece of therapeutic work, the stage of treatment, and the goals of that particular session. Goals may exist in one or more categories. For example, there may be strategic goals at any given point that dictate or suggest who should be present for all or part of an interview. The first session, for example, from a strategic and information-gathering point of view, suggests that all family members and even important people outside of the family be present, at least for a large part of the session. Later in treatment, individual meetings with parents and the teen may be needed because of estrangement or high conflict. The individual sessions build relationships, acquire information, and also prepare for joint sessions (working parts to a larger whole). Session composition may be dictated by therapeutic needs pertaining to certain kinds of therapeutically essential information. Individual sessions are often required to uncover aspects of relationships or circumstances that may be impossible to learn about in joint interviews. Therapeutic goals about working a particular relationship theme in vivo, via enactment for instance, may be another compelling rationale for decisions about session composition.

If decisions about session composition flow from therapeutic goals, it should be emphasized that not all goals are set a priori. For instance, some goals are at smaller operational levels than an objective such as increase of parental competence. Therapeutic feedback from any and all parts of the therapeutic system and environment is sought and used constantly to answer the following core questions:

- How is this therapy going?
- What have I accomplished in terms of addressing and successfully attending to MDFT’s core areas of work – the four domains of focus? (For example do I know the teen’s hopes and dreams? Do I know the parents’ burdens? What am I working on extra-familially – in the natural environment of the teen and family?)
- What are we working on and is this content and focus meaningful?
- Are we getting results, progressing reasonably?

Thus, while core pieces of work in MDFT, such as engagement of the teen and working on parent issues (e.g., parenting practices, the shaping of the parent–teen relationship through the interpersonally and behaviorally oriented technique of enactment), may dictate session composition and participation because of the obvious nature of their work, other aspects of therapy, such as working a given therapy theme, may require feedback to be read before session composition can be determined or decided. A therapist’s realization that his relationship with the adolescent is slipping after a rough session or negative outside-of-therapy event (e.g., a tense court hearing where a decision went against

the adolescent) must be used quickly (i.e., reading of feedback) to right the therapeutic course. An individual meeting, in the clinic, in the home, at school, or at a restaurant, is needed, and it is in the therapist's best interest to act quickly in relation to feedback of this type. The therapist's ongoing and naturally occurring assessments of multiple domains of functioning always provide a trustworthy answer to where he or she needs to go and what needs to be focused on.

Research Evidence

Four types of MDFT studies have been conducted: (1) efficacy/effectiveness controlled trials, (2) process studies that identify ingredients and therapeutic processes related to clinical progress and outcomes, (3) economic analyses, and (4) implementation or transportation studies that test the transfer of the approach to community settings. Independent reviews support MDFT's scientific soundness (Austin, Macgowan, & Wagner, 2005; Vaughn & Howard, 2004; Waldron & Turner, 2008) and identify it as a model program and evidence-based practice (SAMHSA, 2005).

MDFT has been developed and tested primarily in NIDA and other federally funded research projects since 1985. This research program has accumulated considerable evidence in support of the intervention's effectiveness for adolescent substance abuse and delinquency. The studies have been conducted at sites across the United States, among diverse samples of adolescents (African American, Hispanic/Latino, and White youth between the ages of 11 and 18) of varying socioeconomic backgrounds. Internationally, a five-country, multisite trial of MDFT, funded by the health ministries of Germany, France, Switzerland, Belgium, and the Netherlands, is nearly complete. In MDFT studies, all research participants met diagnostic criteria for adolescent substance abuse disorder. Generally, most samples had significant co-occurring problems as well, most commonly delinquency, and secondarily, depression and anxiety.

Randomized controlled trials

Seven completed randomized controlled trials have tested MDFT against a variety of comparison adolescent drug abuse therapies. MDFT has demonstrated superior outcomes to several other state-of-the-art, active treatments, including a psychoeducational multi-family group intervention, peer group treatment, individual cognitive-behavioral therapy (CBT), and residential treatment. These studies have included samples of teens with serious drug abuse (i.e., heavy marijuana users, with alcohol, cocaine, and other drug use) and serious delinquency problems. Next we briefly identify some key areas in which MDFT has yielded favorable clinical outcomes.

Substance use is significantly reduced in MDFT to a greater extent than comparison treatments investigated in the controlled clinical trials (examples include 41% to 82% reduction from intake to discharge). Additionally, substance-abuse-related problems

(e.g., antisocial, delinquent, externalizing behaviors) are significantly reduced in MDFT to a greater extent than in comparison interventions.

Youth receiving MDFT often abstain from drug use. During the treatment process and at the 12-month follow-up, youth receiving MDFT had higher rates of abstinence from substance use than those in comparison treatment. The majority of MDFT youth report abstinence from all illegal substances at 12 months post-intake (64% and 93% respectively). Comparison treatments reported abstinence rates of 44% for CBT and 67% for peer group treatment. And, MDFT's changes are durable. MDFT clients continue to decrease substance use after termination up to 12-month follow-up (58% reduction of marijuana use at 12 months; 56% abstinent of all substances, and 64% abstinent or using only once per month). Other areas of favorable outcome include school functioning (MDFT improves school bonding and school performance, including grades improvements and decreases in disruptive behaviors), family functioning (reductions of family conflict and increases in family cohesion), psychological functioning (psychiatric symptoms show greater reductions during treatment in MDFT than in comparison treatments), including superior improvement for drug-abusing teens with co-occurring disorders, and reductions in high-risk sexual behavior and HIV and STD risk (MDFT reduces HIV risk behaviors and, importantly, laboratory-confirmed STDs).

Economic advantages. The average weekly costs of treatment are significantly less for MDFT (\$164) than for community-based outpatient treatment (\$365). An intensive version of MDFT designed as an alternative to residential treatment provides superior clinical outcomes at significantly less cost (average weekly costs of \$384 versus \$1,068).

MDFT also has studies on the therapeutic process and mechanisms of change, and implementation studies. (See Resources section for website address. A more complete research summary is available from the author.)

Summary

MDFT is an empirically validated, family-based treatment for adolescent drug abuse and delinquency. Its core ideas relied first on family therapy, systems concepts, and eventually family psychology, and other areas of psychology including the community, cognitive, behavioral, and humanistic psychology traditions. Developed first in clinical service and therapist training settings, and then refined, manualized, and tested in rigorous, state-of-the-science clinical trials, MDFT has been included in the national registries of empirically based therapies. It has been evaluated as a therapy of distinction by independent reviews and national entities involved in the science-based therapy movement. Stimulated by opportunity (i.e., federal government focus on adolescent drug problems and the need for new treatments over two decades ago), justified criticism ("Yes, I have heard about family psychotherapy – but opinions are no substitute for data"; Garfield, 1982), professional interest, and normal developmental process (Liddle, 2004; White, Dennis, & Tims, 2002), family-based, drug-abuse-focused therapies have entered a new period of transition. As part of this stage, MDFT continues its clinical expansion into new client

groups and clinical phenomena (e.g., trauma-related clinical problems and trauma-based interventions, brief therapy, adult women at risk of losing their children to child welfare systems, and alcohol problems of youth). At the same time, another burgeoning area of work for MDFT concerns its transportation to non-research clinical settings, and developing effective, efficient, and cost-conscious training for new practitioner groups to do MDFT with competence and fidelity. The challenges in the implementation area are formidable. Despite all of the progress in the family-based treatment area, significant problems exist in the extent to which most regular care settings fail to use evidence-based therapies. The treatment research area has expanded, and given the urgent need to transport effective interventions into non-research settings, it seems destined to continue to grow in complexity, scope, and mission.

Resources

- Center for Treatment Research on Adolescent Drug Abuse: <http://www.miami.edu/ctrada>
- Liddle, H. A. (2008). *Multidimensional family therapy DVD*. Washington, DC: American Psychological Association.
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