

Multidimensional Family Therapy HIV/STD Risk-Reduction Intervention: An Integrative Family-Based Model for Drug-Involved Juvenile Offenders

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Drug and juvenile justice involved youths show remarkably high rates of human immunodeficiency virus (HIV)/sexually transmitted disease (STD) risk behaviors. However, existing interventions aimed at reducing adolescent HIV risk behavior have rarely targeted these vulnerable young adolescents, and many approaches focus on individual-level change without attention to family or contextual influences. We describe a new, family-based HIV/STD prevention model that embeds HIV/STD focused multifamily groups within an adolescent drug abuse and delinquency evidence-based treatment, Multidimensional Family

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Therapy (MDFT). The approach has been evaluated in a multisite randomized clinical trial with juvenile justice involved youths in the National Institute on Drug Abuse Criminal Justice Drug Abuse Treatment Studies (www.cjdats.org). Preliminary baseline to 6-month outcomes are promising. We describe research on family risk and protective factors for adolescent problem behaviors, and offer a rationale for family-based approaches to reduce HIV/STD risk in this population. We describe the development and implementation of the Multidimensional Family Therapy HIV/STD risk-reduction intervention (MDFT-HIV/STD) in terms of using multifamily groups and their integration in standard MDFT and also offers a clinical vignette. The potential significance of this empirically based intervention development work is high; MDFT-HIV/STD is the first model to address largely unmet HIV/STD prevention and sexual health needs of substance abusing juvenile offenders within the context of a family-oriented evidence-based intervention.

Keywords: HIV/STD Prevention; Juvenile Offenders; Adolescent Substance Abuse; Multidimensional Family Therapy

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MULTIDIMENSIONAL FAMILY THERAPY HIV/STD RISK-REDUCTION INTERVENTION: AN INTEGRATIVE FAMILY-BASED MODEL FOR DRUG INVOLVED JUVENILE OFFENDERS

Human immunodeficiency virus (HIV) infection rates continue to increase among adolescents, with nearly 6,000 young people worldwide becoming infected with HIV every day (Joint United Nations Programme on HIV/AIDS, 2004). Incarcerated adolescents may represent the largest concentration of youth infected with or at high risk for HIV/sexually transmitted diseases (STDs), given frequent drug use and unsafe sexual behaviors. Drug and juvenile justice involved youths increase risk for acquiring HIV and STDs through early age at first intercourse, having unprotected anal, oral, or vaginal intercourse, multiple partners, more permissive attitudes about sex, and low self-efficacy to practice safe sex (Rosengard, Anderson, & Stein, 2006). The development of effective HIV/STD prevention for these youths is a significant and urgent public health priority (Teplin et al., 2005). Unfortunately, the juvenile justice system is now the primary source of intervention for many juvenile detainees (American Academy of Pediatrics: Committee on Pediatrics, 2001), yet existing services designed to decrease risk behaviors among incarcerated youth tend to be woefully inadequate (National Institute on Drug Abuse [NIDA], 2002; Shelton, 2001).

ADOLESCENT HIV PREVENTION INTERVENTIONS

Overview

HIV prevention strategies with teens improved considerably in the 1990s, as comprehensive programs began to address safer-sex intentions, perceptions of risk, skills building in condom use, and assertive communication, in addition to increasing HIV/STD knowledge. Some of these behavioral interventions have demonstrated effects in decreasing adolescents' high-risk sexual behaviors, yet most have been validated on school samples or in community health clinic settings, and have rarely been

tested with clinically referred youths at the highest levels of risk for HIV and STD acquisition. Only four published studies report on interventions targeting substance abusing juvenile offenders (Magura, Kang, & Shapiro, 1994; Shelton, 2001; Waters, Morgen, Kuttner, & Schmitt, 1996; Watson, Bisesi, & Tanamly, 2004). The strongest of these studies (Magura et al., 1994) integrated HIV prevention and drug abuse treatment for incarcerated teens and demonstrated modest effects on youths' attitudes about risky sexual behaviors and some self-reported high-risk sexual behaviors. Considered together, these interventions have not markedly reduced sexual risk-taking or produced long-term behavioral changes with juvenile offenders (Malow, Rosenberg, & Devieux, 2006; Pedlow & Carey, 2003), presumably because important risk factors for HIV acquisition have not been addressed, including family influences (Donenberg, Paikoff, & Pequegnat, 2006).

Family-Based HIV Prevention Interventions

Evidence-based HIV prevention approaches with adolescents have been almost exclusively targeted toward the individual level, and most are delivered in peer groups. However, several reviews have concluded that individual-level interventions have been unable to sustain behavioral changes, thus more comprehensive and powerful interventions are urgently needed (DiClemente, Salazar, & Crosby, 2007; Malow et al., 2006; Pedlow & Carey, 2004). Recognizing the importance of parents as the primary sexuality educators and influences for their children, family context has emerged as a prominent focus for researchers and health educators (DiClemente, Crosby, & Salazar, 2006; Donenberg et al., 2006).

Family-based interventions currently have the most consistent empirical support in the treatment of challenging problems such as adolescent drug abuse and delinquency (Williams & Chang, 2000), yet high-risk sexual behavior remains an underdeveloped and insufficiently addressed target problem with these interventions (Perrino, Gonzalez-Soldevilla, Pantin, & Szapcznik, 2000). Families are critically important in shaping adolescents' decision-making skills and involvement in high-risk behaviors, and they are a potential source of influence in HIV prevention and intervention (Pequegnat & Bray, 1997). For Donenberg et al. (2006), families influence adolescents' HIV risk in four ways: (a) instrumental characteristics (parental monitoring, control); (b) affective parenting behavior (warmth, support); (c) parental attitudes about sex; and (d) parent-teen communication. Accordingly, family-based HIV prevention interventions generally target inadequate monitoring, parent-adolescent conflict, and parental disengagement, all of which have been consistently associated with the constellation of behaviors associated with HIV/STD risk (St. Lawrence, Jefferson, Alleyne, & Brasfield, 1995). Family-based HIV prevention also aims to facilitate supportive family relationships and parent-adolescent communication, which significantly reduce HIV risk (Perrino et al., 2000; Kotchick, Dorsey, Miller, & Forehand, 1999).

The few existing family-based HIV prevention programs in school and community settings show significant outcomes in HIV-associated risk factors, including increases in condom use (DiIorio, McCarty, Resnicow, Lehr, & Denzmore, 2007), parent-adolescent communication and skills (Tapia, Schwartz, Prado, Lopez, & Pantin, 2006), parenting skills (Murray, Berkel, Brody, Gibbons, & Gibbons, 2007), decreased illicit drug use (Prado et al., 2007), and intent to or engagement in sexual activity (Dancey,

Crittenden, & Talashek, 2006; McBride et al., 2007). Additionally, family-based approaches can be delivered over a range of ages (11–18), settings, delivery formats, and have been successfully adapted for different cultural groups (e.g., Prado et al., 2007). However, none of these interventions have been developed for or tested with youths in juvenile justice settings, and they have generally focused only on changing HIV-associated risk behaviors. There are strong recommendations from public health experts about the importance of concurrently addressing substance abuse, HIV risk, and criminal activity among juvenile offenders (Drug Strategies, 2005; Teplin et al., 2005).

The “Detention to Community” Drug Abuse and HIV/STD Risk Reduction Study

To address these gaps in the existing research on comprehensive family-based interventions to reduce drug abuse, delinquency, and HIV/STD risk among incarcerated youths, the “Detention to Community” study was initiated as part of the NIDA Criminal Justice Drug Abuse Treatment Studies cooperative research program (Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2008). This study is a two-site randomized trial, which tests a cross-systems, family-based, drug abuse, delinquency, and HIV/STD intervention for juvenile offenders in detention and as they return home. HIV/STD-focused multifamily groups were embedded within an established family-based adolescent substance abuse and delinquency treatment, multidimensional family therapy (MDFT; Liddle, 2009). MDFT was considered a promising approach for this kind of intervention development based on its demonstrated efficacy in a series of randomized clinical trials in reducing substance use and delinquency with juvenile justice involved adolescents (Dennis et al., 2004; Liddle & Dakof, 2002; Liddle et al., 2001; Liddle, Dakof, Turner, Henderson, & Greenbaum, in press; Liddle et al., 2009). Based on MDFT intervention principles of change and clinical techniques, the intervention taps the power of families to reduce teens’ risk for HIV/STD infection. For this study, the treatment varied from previous versions of MDFT in three critical dimensions: (1) service delivery commenced in detention; (2) MDFT treatment coordinated services across justice and community treatment systems; and (3) the MDFT-HIV/STD prevention module was integrated during the course of MDFT.

While 9-month follow-up data collection is still ongoing, interim analyses have been conducted on the 154 study participants on the following HIV related outcomes: (1) proportion of times using a condom to times having sex, (2) STD incidence, and (3) HIV-related communication skills. Participants entered the study at relatively high risk for exposure to STDs, with 74% of participants at intake engaging in moderate to high-risk behaviors over the previous 90 days before their detention stay, and 11% of the sample testing positive for an STD at detention release. Preliminary results of intake to 6-month follow-up data suggest that MDFT-HIV is a promising HIV risk reduction intervention (Liddle et al., in press). For example, between intake and the 6-month follow-up assessment, youths randomly assigned to MDFT reported more open conversations with their sex partners about HIV/AIDS and safe-sex practices than participants who received services as usual ($d = .40$, moderate effect). Adolescents in MDFT also reported a greater increase in protected sex acts ($d = .65$, moderate-large effect), and MDFT participants’ risks for STD exposure decreased more rapidly than for youths receiving services as usual ($d = .80$, large effect). Most importantly, decreased risk for exposure in MDFT translated to decreases in STD incidence rates (measured by biologically analyzed urine samples, $d = .53$, moderate effect). If these

trends persist through the study's duration, this would be the only family-based intervention to demonstrate a reduction in laboratory-confirmed STD incidence (DiClemente et al., 2004; Jemmott, Jemmott, Braverman, & Fong, 2005). Although preliminary, these interim analyses suggest that the MDFT-HIV/STD approach has promise.

This article describes the development and piloting of this innovative family-based HIV prevention approach and illustrates its implementation in practice.

TREATMENT DEVELOPMENT PHASES OF MDFT-HIV/STD PREVENTION INTERVENTION

Phase 1: Developing and Piloting the MDFT-HIV/STD Intervention

MDFT has been recognized as an effective intervention in a new generation of comprehensive, multicomponent treatments for adolescent drug abuse and delinquency. This multidimensional approach assumes that reductions in target symptoms and increases in prosocial target behaviors occur via multiple pathways, in differing contexts, and through different mechanisms. The format of MDFT has been modified to suit the clinical needs of different clinical populations. A full course of MDFT is delivered in several sessions each week over 4–6 months. Sessions may be held in a variety of contexts including in the home, clinic, detention center, other community settings (school), or phone. The MDFT treatment system assesses and intervenes into four main areas: the adolescent as an individual, the parents as a subsystem, the family interactional system, and the extrafamilial system (family members' interactions and relationships with influential systems outside of the family like the court). Assessment of functioning in each of these areas is followed by interventions into these same domains. Interventions are developmentally based and oriented, targeting a realignment of normative developmental processes in the individual, family, peer, and other systems. They all aim to address risk and protection within each domain, and as functioning in each of these areas improves, new behaviors are used to promote further change in other areas (Liddle, 2004).

MDFT-HIV/STD intervention development had two main steps: first, to develop the new HIV/STD prevention multifamily groups focusing specifically on reducing sexual risk taking behaviors (the first multifamily groups developed in MDFT); and second, to integrate this work into the ongoing MDFT adolescent, parent, and family sessions. Over a 6-month collaborative, iterative process, we worked to develop protocols based on our collective clinical (family-based interventions and HIV prevention interventions) and research experience. We developed the manual for the new HIV/STD multifamily component to train and pilot the intervention with community therapists.

Phase 2: Training, Piloting, and Recalibrating MDFT-HIV/STD Intervention and Training Protocols

Training

Therapists from community-based drug treatment agencies who were already trained to deliver MDFT received additional training in the MDFT-HIV/STD protocols. Training sessions provided a review of the session activities, group facilitation techniques, cultural considerations, resources on current sexual health issues, and the basic background in STDs and HIV and STD testing procedures.

Piloting and Recalibrating

The original MDFT-HIV/STD intervention was pilot-tested by these community-based MDFT therapists with adolescents and families in Miami, FL, and Tampa, FL, to determine the feasibility of conducting this intervention in the community and to recalibrate and improve the protocols. Several key modifications included providing more skills-based condom activities and additional condom skills/knowledge activities designed to elicit and dispel misconceptions. The intervention was adapted to provide more in-depth information about HIV/STDs—not just the basics—because we found that these juvenile-justice-involved, drug-using adolescents already had fundamental HIV/STD knowledge from health class/sex education. Pilot testing also showed that in addition to discussing long-term consequences such as risk for sterility, cancer, or death, the short-term consequences needed to be emphasized as much if not more so—such as the need to see doctors and take pills if one contracts an STD, the physical symptoms, and “unattractive” immediate consequences of STDs (e.g., visible sores). Refinements of the approach also included increased use of multimedia (videos) for interactivity and emotional engagement.

Phase 3: Integrating Cultural Sensitivity and Competence into MDFT-HIV/STD

Because cultural considerations have been a core focus in the development, testing, and implementation of MDFT, they also are important in the MDFT-HIV module. MDFT has been extensively tested with African Americans, and the key cultural themes found to be important in working with African Americans were translated into the integrative family-based HIV prevention approach. For example, a core cultural theme important in MDFT treatment with African American boys is using the youth’s journey “from boyhood to manhood” (Jackson-Gilfort, Liddle, Tejada, & Dakof, 2001; Liddle, Jackson-Gilfort, & Marvel, 2006), and this theme also became salient in discussions about sexuality, intimacy, and having more mature, responsible relationships that demonstrated respect for themselves and their partners.

Developing and testing MDFT-HIV in South Florida also necessitated the creation of a culturally congruent Spanish version of the MDFT-HIV/STD prevention intervention. All facilitator protocols, participant handouts, videos, and materials were translated into Spanish. Facilitators who were bilingual were trained to deliver this culturally competent HIV/STD prevention to Hispanic American adolescents and families. Facilitators were trained to be responsive to treatment barriers. For instance, many Hispanic parents felt uncomfortable talking with their children about sexual health matters. In piloting, facilitators found that Hispanic families needed more assistance to break the silence about sexual risk-taking and also needed to be updated and more knowledgeable about teens’ sexual health and relationships. Facilitators were sensitive to these issues and conscious about parents’ potential difficulties participating in the discussions and activities.

MULTIDIMENSIONAL FAMILY THERAPY HIV/STD RISK-REDUCTION INTERVENTION

Overview

Next we describe the final protocols that were integrated within the MDFT intervention. Youth and their parents *who have already been engaged in MDFT and have been in therapy for 1 to 2 months* participate in three 2-hour multifamily groups de-

signed to: (1) enhance adolescents' and parents' awareness about the nature of STDs and HIV, (2) personalize their sexual and drug-associated risk behaviors that increase adolescents' likelihood for exposure and infection with HIV/STDs, and (3) provide communication (parent(s) and partner) and condom-use skills for HIV/STD prevention. Homework is given at the end of multifamily group sessions 1 and 2 for the parents and teens to do together between sessions to bridge and provide continuity between the groups. The third session assists families in developing an action plan to reduce risk based on their new knowledge, skills, and open lines of communication, and ends with a "pledge for life," which is a commitment from both parents and teens to do everything possible—together—to help the teen remain safe from HIV/STDs.

Session 1: Be Real About Your Risk

The first multifamily group begins with an introduction ("Getting Started") where the facilitators engage families with the MDFT "what's in this for you" technique and create a friendly and comfortable environment. The second activity ("What do you know about HIV/AIDS and other STDs") addresses gaps in HIV/STD knowledge, dispels myths and misconceptions about transmission and treatment, encourages abstinence and, for those youth who are sexually active, promotes STD/HIV-preventive sex and drug practices. Following the introduction and psycho-educational content, facilitators focus on personalizing teens' risk for HIV and STDs. Although most teenagers say they know that unprotected sex carries a high risk of infection, they feel confident that they are not at risk (likewise parents think "this couldn't happen to my child") so it is important to make the risk personal for the teens and parents. This is achieved by watching a stirring documentary (*Bloodlines*; Jako & Guberman, 2005) produced and directed by HIV-positive youth who share their personal stories about life with HIV. It is culturally, gender, and age appropriate; it clarifies, amplifies, and reinforces prevention education. Using the emotional momentum from the *Bloodlines* video, the next activity ("Be Real About Your Teen's Risk") provides a concrete way for the adolescents and parents to recognize which risky behaviors the adolescent is engaging in currently or has engaged in the past. This written activity also prepares them for the next group activities focused on improving parent-adolescent communication and working as a family to keep the teen safe and healthy.

Session 2: Family Makes a Difference

Multifamily group 2 focuses on opening lines of communication between teens and parents about sexual risk behaviors and practical ways to reduce risk. The session begins with a review of session 1 and the homework ("It could happen to you"), an assignment that further personalizes the teen's risk by having parents and teens read together an interview with Magic Johnson about his experience living with HIV and discussing structured questions. Teens and parents then think back to the first session, specifically the "be real about your risk" activity and they discuss how parents can help teens understand and deal with risky situations. After this short discussion, teens think about a risky situation that they commonly face and develop a realistic plan with their parents to reduce their risk. The remainder of the second multifamily group focuses on how to improve communication about sexual practices and risky situations, and defining barriers to open communication about these difficult topics. Parents and teens discuss strengthening family communication, tools for effective

communication, common barriers and how to circumvent them, and what to expect from each other in dialogue. At the end of the session, families are asked to complete a Family Plan to address the most significant barriers to their communication. Their assignment is to put this plan into action before the next session and come prepared to discuss what did and did not work in implementing their plan.

Session 3: Let's Make it Happen

In session 3, activities focus on reinforcing the youths' positive sexual health behaviors, attitudes, and skills, and formalizing a clear family plan that will help teens make healthy choices "in the heat of the moment." A major focus is further strengthening parent-adolescent communication and, for teens, improving partner communication about safer sex practices. The parents and teens participate in a hands-on activity with penis models to learn and apply proper condom use skills, emphasizing parental support of these attitudes and skills. The hands-on work with condoms using penis models breaks down barriers to openly discuss issues. Parents sometimes express discomfort at the outset, but afterward, many have stated, "if I can do that [work with penis models in front of my child], I can do and talk about anything!" Parents have also described increased comfort with their teenagers; they are able to talk openly about sex and ask their son/daughter questions. Adolescents begin to understand that parents are not interfering, but want them to be safe in sexual relationships. Teenagers acknowledge that parents cannot be around "24/7," but they may feel better knowing that they can talk about sex, their questions and uncertainties, and the inherent risks. Teens then participate in another action-oriented activity called "In the Heat of the Moment" using a video vignette of a risky sexual encounter to stimulate role playing (two young teens who are drinking at a party struggle with the decision of having unprotected sex). This activity encourages better decision-making skills and assertive communication as adolescents practice their newly learned skills. The final activity ("Pledge for Life and Certificate of Achievement") reviews the core themes and formalizes the family's commitment to change. These identified plans for action are brought into the ongoing MDFT work.

Integration of MDFT-HIV/STD intervention into the MDFT Core Approach

MDFT aims to promote adolescents' healthy development in all domains of functioning, including sexual relationships and behavior. Adolescents are encouraged to take responsibility for their sexual practices and protect themselves from contracting HIV and other STDs. The focus on the adolescents' sexual practices is conceptualized as part of a movement toward health and respect for self in both body and mind, and this is consistent with our stance regarding drug use. Building on the HIV/STD multifamily groups, MDFT therapists address HIV/STD prevention in ongoing adolescent, parent, and family sessions (the entire course of therapy ranges from 4 to 6 months), deepening the knowledge and skills learned in the groups. Therapists reinforce and role-play how teens will apply their new knowledge in new or difficult situations. This work is linked to other aspects of the adolescent's move toward health and self-care, including a focus on drug use and its consequences. The HIV/STD prevention module attends specifically to the teen's sexual behavior but is organized within the guiding therapeutic plan, which involves the systematic exploration of personally meaningful life themes. Therapists orchestrate multifamily groups,

individual, and family sessions about high-risk behaviors and sexuality in a coherent way to facilitate a movement toward a healthier lifestyle.

There are three main aspects of integrating the MDFT-HIV/STD focus into ongoing MDFT. First, approximately 1 month into treatment, the therapist explains in family and individual sessions the rationale of the MDFT-HIV/STD multifamily group sessions to prepare the adolescent and parent for maximum benefit. Families need to understand the group objectives and what to expect (working with penis models, having conversations about risky behaviors, etc.) and how these sessions are different from standard health education classes. The therapist emphasizes that the groups will empower parents and enhance their ability to influence their child, that there may be generational differences in sexual activity they need to better understand, and also that substance abuse heightens a teen's risk for HIV/STD. Second, the three multifamily group sessions described above are delivered between 1 and 2 months into treatment. Finally, between the multifamily groups and following the third group, therapists integrate the themes and experiences into ongoing adolescent, parent, and family sessions, tracking progress and the family's behavior change plan. See Figure 1 for a flow diagram of the overall MDFT-HIV/STD intervention within MDFT treatment.

CASE ILLUSTRATION

Background and Overview

This case study illustrates how the MDFT-HIV/STD interventions are integrated into the overall flow of the MDFT therapy with substance abusing juvenile justice involved teens. Danny, one of three children, was a 16-year old African American male who was in juvenile detention. When he started treatment, Danny was drinking heavily, truant from school, fighting, selling drugs, and associating with negative peers. He had violent fights with his brother, prompting his mother to call the police, and leading to his arrest and incarceration. Danny had experienced severe physical discipline from his father throughout his childhood. The violence and conflict within the family prompted Danny to run away from home on several occasions. Danny's feelings of anger and helplessness about his family conflict were compounded by deepening academic and social failure. Increasingly he turned to alcohol and drugs for relief.

Mrs. Williams, Danny's mother, divorced Danny's father when he was 12 and the violence in the home had become severe. She was heavily burdened by the demands of raising three adolescents alone and working long hours as a nurse in a busy inner-city hospital. She felt exhausted and drained from the competing demands of single parenthood and her career, and was overwhelmed by Danny's worsening problems in school and his increasing involvement with drugs and crime. She had almost given up on Danny by the time they started treatment.

Case Formulation

As Mrs. Williams and Danny shared their different perspectives during family sessions, the therapist thought that the severe mother-son disconnection, father's absence, and violence within the family had seriously compromised Danny's development. Danny's disposition had become more negative, angry, and distanced from his mother, who had virtually given up any attempts to influence him. His father had no contact with the family at all after the difficult divorce 4 years before the start of

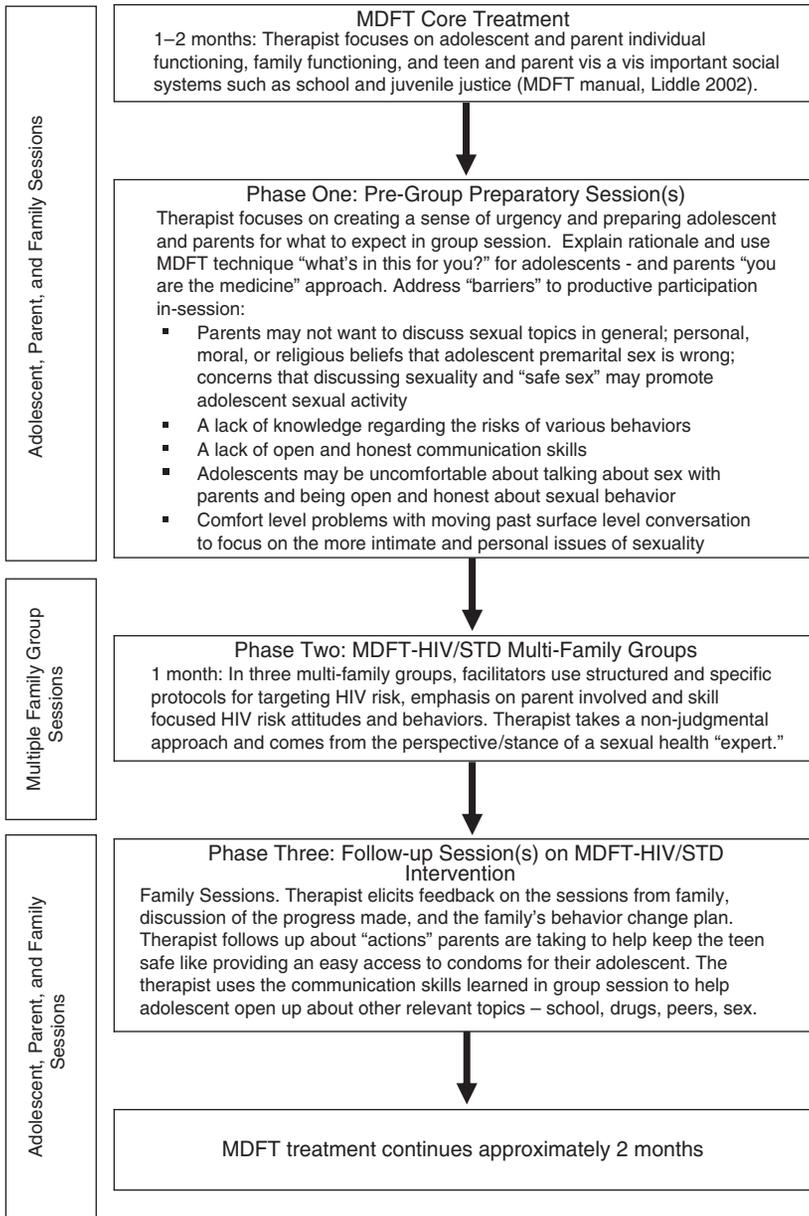


FIGURE 1. Integration of MDFT-HIV/STD Component in MDFT Treatment. MDFT, Multidimensional Family Therapy; HIV, Human Immunodeficiency virus; STD, Sexually Transmitted Disease

treatment. Danny had managed to take care of himself in some ways, but he was also drinking, selling drugs, and associating with drug using, delinquent friends. His hopelessness about having any kind of positive relationship with his parents or sense of acceptance in his family was exacerbated by serious difficulties in school. This downward spiral of mutually reinforcing negative risk factors worsened when he was transferred to an “alternative school” for behavior problem teens. Danny skipped classes, fought frequently, and increased his cannabis use.

Treatment Goals

Primary goals with Danny were to transform his alcohol use and drug selling lifestyle into a more adaptive, prosocial, and developmentally normal life. This included helping Danny to practice safer sex and adopt better self-care skills, changing his involvement with drug using friends, improving his school performance and behavior, facilitating more mature and deeper self-examination and self-expression to more effectively get his needs met, and generating hope that his life could change. For both Danny and his mom, main goals of treatment were reducing the emotional distance and negativity in their relationship and facilitating open communication about core issues (i.e., sexual health, peers, substance abuse, family conflicts, and school). Treatment goals also included reducing the conflict between Danny and his brother, and the therapist brought Danny's brother into sessions to directly address the tension between them. In working with Mrs. Williams individually, an important goal was to help her change her negative perceptions of and interactions with Danny by resuscitating more positive, hopeful feelings and appreciation for him. The therapist used time alone with Mrs. Williams to help her reclaim positive memories of her son, amplify expressions of her love for him, and explore her dreams about the man he could be. These discussions helped Mrs. Williams recommit to helping Danny. The therapist could then help Mrs. Williams improve her parenting practices, including monitoring, limit setting, and persistence in being actively involved in his life.

MDFT-HIV/STD Intervention Phase 1: Preadmission Preparatory Sessions

Mrs. Williams, a practicing nurse, knew the dangers of STDs and the incidence rates among young people, and realized it was important to open up lines of communication with Danny about his sexual practices. She was concerned that Danny's girlfriend Tina was promiscuous and lacked safe sex skills and knowledge, and could put her son at risk for contracting STD/HIV infection. At the same time, given their conflict in so many areas, she felt uncomfortable communicating with Danny about his sexual health and his relationship with Tina.

At first, Danny was not open to learning about HIV/STDs or safer sex behaviors. Danny resented his mother's mistrust of Tina and believed that she would not cheat on him. When the therapist introduced the idea of participating in multifamily groups focusing on sexual health, Mrs. Williams immediately recognized the opportunity the multifamily groups offered to talk to her son and influence him to take better care of himself. The therapist taught Danny that there were valuable tips he could learn to reassure himself and his mother that he was taking better care of himself. Individual sessions with the adolescent and parent were used to prepare them for the multifamily HIV/STD groups, and in family session the week before the first multifamily group, the therapist went into detail about the structure, format, and activities of the group. Due in part to positive changes in the relationship between Danny, his mother, and his school situation, both agreed to give the groups a try.

MDFT-HIV/STD Intervention Phase 2: Multifamily Group Intervention

Throughout the multifamily group sessions, Danny and his mother actively participated, but the turning point came in an activity called "Be Real about Your (Your Teen's) Risk." In this activity, the adolescent indicates his/her level of personal risk based on the number of their HIV high-risk activities such as "I have had vaginal and/

or anal sex *without* a condom.” The parent rates the adolescent’s risk on the same items (e.g., “My teen has had unprotected vaginal and/or anal sex *without* a condom.”) and the teen and parent then share their assessments with each other. This activity was challenging for Danny and his mother, given that they had rarely talked openly about his sexual attitudes and behaviors. Mrs. Williams assumed he was at risk for several of the risky activities, but it became clear to her that she did not know the full extent of his serious HIV/STD-associated risk behaviors. When Mrs. Williams examined Danny’s responses, she realized that he was being open and honest with her about his sexual risk behavior, and she knew it would have been easier for him to keep it hidden, like he did with so many problems in his life, to avoid confrontation. She was frightened by his involvement in such high-risk sexual behaviors and, based on this concern, was able to communicate in a loving and caring way, rather than taking a blaming or critical stand. She told him in the group that these behaviors were not good for him and that she wanted to help him. Her son appreciated his mom’s nonjudgmental and caring response. Thus “personalizing the risk” had the intended impact on both Danny and his mother, establishing a level of emotional reconnection that would be necessary for them to start problem solving and working together to reduce his risk.

MDFT-HIV/STD Intervention Phase 3: Follow-Up Family Sessions

After completing the multifamily groups, Danny and his mother experienced a new level of connection. The more positive, accepting, and receptive atmosphere between Danny and his mother enabled more constructive interactions around Danny’s drinking, the negative peers in the house, his girlfriend, and school. Sessions were more productive because the family had experienced each other in a new, more loving and caring way; this reduced the blame and negativity of previous sessions. Danny reported feeling his mom genuinely cared and wanted to help him, thus he *let her* help him and opened up his world to her. Likewise, his mother felt like she could help him and that he would listen and respect her. When Danny and his mother slipped back into previous critical patterns, the therapist could reclaim the momentum established in the groups and subsequent sessions, helping them stay in a productive place.

As follow-up on the risk behaviors uncovered in the groups, ongoing sessions focused on reducing these risk behaviors. The first step was to challenge Danny’s conviction that Tina had been faithful and that he could not have been exposed to an STD. Danny agreed to be tested and in fact was positive for an STD. Unlike in the past when he would have been secretive about his problems and personal life, Danny immediately (and on his own volition) brought this situation to his mother for her help and guidance. Mrs. Williams used a distinctively different communication style, not blaming or attacking him but being compassionate, supportive, and proactive about Danny’s STD infection. After helping Danny receive the appropriate STD treatment, she used this “teachable moment” to discuss condom-use skills and trust issues in relationships with her son. At Danny’s request, the therapist provided him with condoms and his mother was fully supportive of this new health conscious behavior. Danny also came to realize that the relationship with his girlfriend had jeopardized his health and broken his trust, both of which were grounds for him to end the relationship, which he did. Danny and his mother continued to make excellent progress for the final 2 months of therapy, and the therapist leveraged Mrs. Williams’ proactive

stance about the STD with his other risk behaviors, including his alcohol and drug use. The family conflict decreased, problems at school decreased significantly, and by the end of treatment Danny was not using drugs and free of STD infection.

CONCLUSIONS

Given juvenile offenders' vulnerability for a range of negative outcomes, including STD and HIV infection, and the inadequacies of the care they receive in the juvenile justice system, there is an urgent and well documented need to implement effective evidence-based interventions with these adolescents (CASA, 2004; Teplin et al., 2005). Research shows that effective interventions for young offenders incorporate: (1) comprehensive attention to the diversity of clinical needs with which justice-involved youth present; (2) services, support, and supervision that "wrap around" an adolescent and family in an individualized way; and (3) family involvement (Drug Strategies, 2005). Unfortunately, existing interventions with youth in the juvenile justice system rarely incorporate these elements (CASA, 2004; Lederman, Dakof, Larrea, & Li, 2004; Nissen, Butts, Merrigan, & Kraft, 2006). Comprehensive family-based treatments have shown their effectiveness in clinical studies with drug abusing and delinquent teens in a range of practice settings (Henggeler et al., 1997; Liddle et al., 2006). However, previous to the development of this approach and its testing in the DTC study, existing evidence-based family-focused models had not systematically incorporated HIV/STD prevention. This article described the latest advances in developing more effective HIV/STD prevention for juvenile justice-involved, substance-abusing teens utilizing a concept and process with a strong tradition in family therapy—the healing power of families to reduce the behavioral risk in their children.

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