

CHAPTER SEVEN

The Anatomy of Cognitions in Multidimensional Family Therapy

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Decades of research documents that adolescent substance abuse is part of a complex of problem behaviors that has its roots in mutually reinforcing risk and protective factors. As the child develops, risk factors at the individual level interact with parental, familial, and extrafamilial processes to increase vulnerability for substance abuse and related problems during adolescence. Given that substance abuse is multiply determined, it is logical that effective intervention must reduce risk and promote resilience across developmental life domains. In fact, the empirical evidence clearly supports the efficacy of models that are comprehensive, multisystemic, and broad enough to create change not only at the individual level but in other interconnected systems as well (Hawkins, 2009). Family, parenting, and couples approaches are consistently shown to be among the most potent interventions for treating both adolescent and adult substance abuse (Rowe, 2012).

Cognitive processes play an important role in adolescent substance use problems, particularly a teen's positive expectancies about its social and emotional effects, yet these beliefs are largely shaped by parents. Parents' norms against substance use have been shown to have a strong direct link to teens' beliefs about use, as well as an indirect effect on future use

(Sieving, Maruyama, Williams, & Perry, 2000). Children tend to internalize their parents' norms about drinking by early adolescence, which, once internalized, directly influence their own drinking (Brody, Ge, Katz, & Arias, 2000). Thus interventions aimed at changing only the adolescents' cognitions tend not to be powerful enough to reduce their substance use. In fact, in showing the strong effects of parents' drinking on adolescent alcohol expectancies, Martino, Collins, Ellickson, Schell, and McCaffrey (2006, p. 971) concluded: "attempts to alter adolescents' alcohol expectancies are likely to fail unless they address the influence of immediate social models on these beliefs."

We describe a rigorously studied and consistently supported family-based treatment model for addressing adolescent substance abuse, multidimensional family therapy (MDFT; Liddle, 2002, 2010, 2014, 2016). As a companion to our previous publication (Liddle, 1994), this chapter isolates a particular aspect of the approach—cognitions—as a target of change, as well as an instigator of change in other areas. Through the case presentation, MDFT's theory of change, intervention targets, and treatment methods are detailed. Although it is impossible to separate completely the cognitive, emotional, behavioral, and relational changes targeted in a comprehensive approach, it is our intention to show how cognitions are conceptualized and targeted for change in a multisystemic family-based approach.

Theoretical and Empirical Foundations

MDFT is a family-based, comprehensive treatment system for adolescent substance abuse and behavioral and emotional problems (Liddle, 2002, 2010, 2014). It is theory driven, combining aspects of several theoretical frameworks (i.e., family systems theory, developmental psychology, ecological approaches, and risk/protective factors), and incorporating key elements of effective adolescent treatment: comprehensive assessment, integrated interventions, family involvement, developmental specificity, specialized engagement protocols, attention to therapist development, gender and cultural competence, and focus on a range of outcomes. It is a model that effectively and simultaneously reduces adolescent substance abuse, delinquency, and comorbid mental health problems (Hawkins, 2009; Liddle, 2016).

The MDFT Treatment System

MDFT is both a tailored and a flexible treatment delivery system. MDFT teams consist of an MDFT supervisor, two to four certified MDFT therapists, and a therapist assistant (case manager). Treatment duration averages

3–6 months (depending on severity) of one to three weekly sessions, with additional case management services and phone calls. Therapists work simultaneously in four interdependent domains: adolescent, parent, family, and community. Sessions may include one-on-one time with the teen or parent, as well as the family together. Sessions are held in the homes, as well as in clinics, schools, and other community settings.

Tables 7.1 and 7.2 detail the work in MDFT's three stages, as well as the goals for each intervention domain. Briefly, Stage 1 builds a foundation for change, Stage 2 facilitates individual and family change, and Stage 3 solidifies changes. At various points, therapists meet alone with the teen, alone with the parent(s), or conjointly with the adolescent and parent(s), depending on the domain, goals, targeted interventions, and specific problem being addressed.

MDFT through the Lens of a Clinical Case Example

In the case example that follows, we illustrate key cognitive interventions in different domains as the case progresses through the three stages of treatment. Where relevant, we highlight other avenues of change in MDFT

TABLE 7.1. MDFT Stages of Change

Stage	Description
Stage 1: Build a foundation for change	Therapists create an environment in which the youth and parents feel respected and understood. Therapists meet alone with the adolescent, alone with the parents, and with the family, depending on the session's goals. Stage 1 goals are to develop strong therapeutic relationships, to achieve a shared developmental and contextual perspective on problems, to enhance motivation for individual reflection and self-examination, and to begin the change process.
Stage 2: Facilitate individual and family change	Goals for youth, parent, and family functioning (see Table 7.2) are established, evaluated, and revisited throughout. Accomplishments in each individual domain activate and support change in the others.
Stage 3: Solidify changes	The last few weeks of treatment strengthen the accomplishments parents and teens have achieved. The therapist amplifies changes and helps families create concrete plans for responding to future problems, such as substance use relapse, family arguments, or disappointments. The family members reflect on the changes made in treatment, see opportunities for a brighter future, and regain hope.

TABLE 7.2. Goals within the Four MDFT Domains

Domain	Goals
Adolescent domain	<ul style="list-style-type: none"> • Increase self-awareness and enhance self-worth and confidence • Develop meaningful short-term and long-term life goals • Improve emotional regulation, coping, and problem-solving skills • Improve communication skills • Promote success in school/work • Promote prosocial peer relationships and activities • Reduce substance use, delinquency, and problem behaviors • Reduce and stabilize mental health symptoms
Parent domain	<ul style="list-style-type: none"> • Strengthen parental teamwork • Improve parenting skills and practices • Enhance parents' individual functioning
Family domain	<ul style="list-style-type: none"> • Improve family communication and problem-solving skills • Strengthen emotional attachment and connection among family members • Improve everyday functioning and organization of the family unit
Community domain	<ul style="list-style-type: none"> • Improve family members' relationships with social systems such as school, court, legal system, workplace, and neighborhood • Build families' capacity to access and utilize needed resources

relative to cognitive interventions and how the therapist uses interventions in one domain to prompt change in another area (e.g., individual sessions with a parent or with an adolescent both follow family sessions and set the stage for future family interviews).

Eric was 16 and had been using drugs—mainly marijuana, but also “harder” hallucinogens and stimulants—regularly for 2 years when he was referred to MDFT by his probation officer, Mr. Williams. He lived with his parents, Ron and Sarah, and younger brother, Michael, in a middle-class neighborhood of an urban area in the Northeastern United States. He had been placed on probation for possession of marijuana and was monitored closely by his probation officer for possible placement due to the severity of his substance use and history of self-harm. He had been hospitalized in the months before his treatment referral for a suicide attempt. His probation officer was also very concerned about his pattern of leaving home for days or weeks at a time. He was shy and had few friends growing up, which was partially a function of living in inner-city neighborhoods with limited opportunities to explore independently or socialize with people his age.

At the time of his treatment referral, he was going to an alternative school program and taking medication for attention-deficit/hyperactivity disorder (ADHD), but he stopped both when summer began and he left home for several weeks. His drug use was often triggered by feeling lonely, hurt, and angry; although he found it possible to let all of the harder drugs go after a certain amount of experimentation, “there was something about pot” for him that he could not give up.

Stage 1 Interventions

Entering the Teen’s World

In early MDFT sessions, the therapist is primarily focused on engagement and motivation and spends considerable time in individual sessions with teens to “get into their world” and “show them there’s something in this for them.” Engagement is achieved by showing genuine interest in the adolescent’s life, emphasizing that the therapy is for him or her (even if the adolescent was referred by probation or forced to go by parents) and that he or she is the expert on his or her life. The therapist works hard to convey that it truly is up to the teen who he or she wants to be and that the therapy is a collaboration to make his or her dreams possible. Motivation is simultaneously increased by focusing on the things the teen wants for him- or herself (e.g., “getting probation/parents off my back”), drawing discrepancies between the life he or she wants and current circumstances, and amplifying the teen’s distress about what isn’t working or what he or she seems unhappy about.

In the following account of early sessions with Eric, several cognitive interventions are highlighted as the therapist engages, motivates, and helps the teen build a developmental and contextual sense of himself and his life through self-examination and clarifying what he really wants for himself.

Deepening Engagement and Motivation

THERAPIST: These 2 years have been really bad for you. You think about all that, don’t you?

ERIC: Uh huh.

THERAPIST: A lot of things have happened in these 2 years for you.

ERIC: A lot of good, a lot of bad.

THERAPIST: What are the good things?

ERIC: I’ve learned a lot of lessons. . . . I did a lot of things. Satisfied my curiosity and left it at that.

THERAPIST: That’s interesting. I wonder if your mom and dad would be

surprised to hear that part. You're saying, "I'm not out of control." If somebody says what you said, they're saying, "I did many things, and part of it was about curiosity and now I've just let it go." You're disagreeing with your parents then . . . seems like you're saying, "I am not out of control." (*Eric nods.*) . . . You said you learned a lot. What kind of lessons?

ERIC: Don't get high and play with guns!

THERAPIST: And to learn *that* you went through hell!

ERIC: I should have known that already, but I'm even more careful now.

THERAPIST: All that scared you. (*Eric nods.*) . . . I would imagine. It would scare anybody. . . .

In this brief exchange, the MDFT therapist pulls out an aspect of Eric's experience that could be a strength. The youth looks back, reflects on what he's been involved in, and says "there were lessons learned," and perhaps that he has decided to leave those activities behind. The therapist highlights the intensity and negativity of his experiences—his cognitive appraisals of those events—underscoring a bottom line that might include assertions about not being out of control, as his parents think he is, and the potential conclusion, worthy of more discussion and reflection, that the curiosity is over, he has learned lessons, what happened was intimidating, and it's not for him.

An important aspect of Stage 1 work with teens is helping them see that there is something "in it for them," which often has to do with getting a better deal with parents or probation. Next, the therapist uses what's right in front of him to motivate the teen concerning the issue of curfew, proposing that they work with the probation officer for something more reasonable. The therapist also elicits distress and the adolescent's fear about losing his freedom to increase motivation and assesses and explores the adolescent's readiness to change.

THERAPIST: So this is a real problem now, I mean, how's this going to get better? How are you going to start feeling like you're connected with others and getting to do things outside the house?

ERIC: Well, I can't do anything because of probation now.

The therapist here focuses on the issue of external pressure from probation. What to do about it is preceded by attempts to get acknowledgment from Eric, an appraisal of it as an issue of worry and importance, and, of course, something that, in addition to his thinking about it and drawing certain conclusions, has emotional aspects. Here we see how Eric's cognitive appraisal of his circumstances, as well as, of course, his emotional

reactions to those circumstances, are brought into focus in a certain way (note the steps to this process). The circumstance is pinpointed and framed in a certain way. Confirmation is sought from Eric—not for insight but as a foundation for taking action—for acting in relation to that circumstance in a way that raises self-efficacy and reflection, challenges cynicism and passivity, and begins a new process for Eric. This effort is something that will hopefully have concrete behavioral outcomes, but also outcomes concerning how Eric experiences himself and how others (parents and those outside the family) see him, which is not unimportant. Outcomes are approached in small, pinpointed, and collaborative ways, and focal areas must be something of interest to Eric.

Therapists' cognitions are always at play as well. The clinician is capable of having big-picture systems and intersystem (subsystems) interactions in mind, as well as individual-level dynamic processes. Knowledge about the importance of different aspects of functioning, cognitive appraisals, emotions, and behavior in different social environments and situations is key to changing human behavior. In this approach, practical, change-oriented thinking that organizes this knowledge within developmental and dynamic systems is a fundamental cognitive process that therapists use to decide what to focus on and what to do in sessions.

THERAPIST: What do you mean?

ERIC: I can only hang out until 7, and then I have to be home.

THERAPIST: Well, we have to talk about that. You have to feel like there's a way to work your way out of that, no? If you don't feel that, you're going to get really pissed off and do something stupid.

ERIC: I think it's true though, all that pressure from probation, you know?

This interaction shows an intervention, stemming from a therapeutic principle, being formed in the usual way in a session: The therapist's idea comes from something said by the client. It could be something related to the client's thinking, but it does not need to have cognition-related or schema-related content. The content triggers a cognitive process in the therapist about the client's actual situation and an aspect of it and the client's participation in it (or response to it or response to others in it, for example). Here the cognitive process in the therapist seems to be about change; it appears that it was something that relates to a change principle or even the potential application of a change principle. The therapist realizes that this circumstance (Eric's frustration with probation restrictions) might be used to channel motivation and change, or at least used as a context to shape competent problem solving on Eric's part. The sequence starts to show the gradual and systematic homing in on details of personal circumstances and the meaning or the interpretation Eric gives to them. The therapist is not

simply reflecting at this point as much as shaping, or sharpening a point—a point about Eric’s interpretation of the probation strictures. A rationale is also connected to the sharpening: “if you don’t feel that there’s a way to work your way out of all this, you’ll be angry and may do something stupid.” Eric agrees that pressure is felt, which is a good thing, as the external pressure is used within the therapy and as one element of motivation.

THERAPIST: Agree. But it doesn’t have to last forever. Can I invite your probation officer here for a meeting—to really talk about your probation, curfew, the whole thing?

ERIC: Oh, I want to do that. Definitely. I want to do that.

THERAPIST: OK. ‘Cause I don’t think it’s good for you to be moaning every day, week in and week out, “I got a seven o’clock curfew. . . .” You’ve got to have something you can look at down the road.

ERIC: Right, even if I could work something out like . . . staying out late one night a week. Then if I manage to stay out of trouble, make it two, and then three . . . you know, if I’m still coming up clean, after like 2 months? I don’t see why he wouldn’t let me go.

The therapist’s actions focus on agency, problem solving, collaboration, and partnering with Eric on something important to him. Eric’s receptivity to the problem-solving session is taken as an alignment of different dimensions of his possible response, and, as such, he is responsive to the therapist’s suggestion and participating in moving it ahead and planning for the meeting.

“Good, you’re thinking ahead and being practical about it. You’re starting to deal directly and work out something with probation. That’s also dealing with your parents by doing that—you should be able to get something good back from them if you keep going down that road, right?”

Cognitive interventions include naming aspects of Eric’s response—his initiative, its problem-solving orientation, and its capacity to influence the negative mindset his parents have developed after many previous attempts in and out of therapies to help their son. Identifying small movements or areas of progress is important, as they allow the therapist to use these steps forward as stepping stones toward broader change and also as touchstones to come back to in discussions about related topics or as positive markers of change when relapses occur.

THERAPIST: I would just hate to see you lose your freedom. You’re in a situation where the very thing that you hate the most, having people run

your life . . . well, that's happening, isn't it? I think it's really scary, you know? Are you scared about what's happening? Sometimes it's good to be a little scared . . . not too scared, a little bit. You can see things differently. What do you think?

ERIC: (*Quietly, looking down, almost to himself.*) I'm scared. If I wasn't scared, I wouldn't care. . . .

The therapist's stance as an advocate is seen within an intervention that seeks to establish, and then in the next sequence use, the reality of a difficult situation—a situation that is going to be “bad for me,” and, moreover, an intimidating situation that arouses fear.

THERAPIST: Do you ever think about how you're gonna feel if you really start to change things? I mean, do you ever think, like, “Geez, wouldn't that be great? Wouldn't I feel good? Wouldn't I just feel better day-to-day? I'm working, I have a certain kind of life, relationships, friends, less hassles with Mom and Dad. . . .” Do you ever envision that? We're talking about this probation thing now. We've got to get Mr. Williams over here to talk about something that's good for you. Do you ever think about your life like that—working towards those things that are down the road?

ERIC: I think about it every day.

THERAPIST: How do you envision it? Like “It's there,” “I can see it . . .” —like that?

The previous exchange is a foundation or a springboard for an exploration of what changes are needed, or what change might be like. This is not done in a problem-solving intervention mode just yet. The journey to finding and shaping alternatives that can be developmentally beneficial and, importantly, thought of as useful and interesting to the client occurs through conversation—interchanges that help Eric's exploration and reflection.

ERIC: I'm scared to think what my life would be like if I stopped doing this or started doing that . . .

THERAPIST: How come?

ERIC: It's new. I don't know what's gonna happen. In my usual routine I know what'll happen.

THERAPIST: So you're saying “no, I can't visualize it.”

ERIC: Right, I can only see a little.

THERAPIST: OK, so what is the little that you do see? I was just using my words before. I don't know if it's those things you see or want to see.

Those things that I said—is that what you’re trying to see out there?
What do you see when you look out there, down the road for yourself?

ERIC: Sometimes I try . . . I wonder what would happen if I stopped this or started doing that. . . .

THERAPIST: You get scared? (*Eric nods and looks down.*) So all right. Track it down. What comes up?

ERIC: Just fear. . . .

THERAPIST: Of the unknown? Or of failure or getting hurt or . . .

ERIC: If I try it, am I gonna succeed? And if I don’t, what’s that gonna be like? What was the point in trying? What if I do it? What’s it gonna be like?

THERAPIST: Uh huh . . . and what is it about the alternative, the sliding back or staying in a bad spot? It’s what, familiar, comfortable or something?

ERIC: Yeah, there I just know what’s gonna happen.

THERAPIST: So, when you say that, what do you mean? I have an image of that, but what do you mean?

ERIC: Like I know if I fight with my parents, and I get high, it’s not gonna bother me that much. But what happens if I fight with them and I don’t get high? That’s just something little, but . . .

THERAPIST: Mmm hmm . . . getting high is like medication. But the house and all the bad feelings there. . . . Do you ever think about the option that says, “I don’t have to fight with them so much”?

ERIC: Not usually.

THERAPIST: You’re not optimistic about them changing . . . ? (*Eric shakes his head “no.”*) Eric, I think the main thing is for you to be thinking clearly right now. I think that’s the most critical thing. What are you thinking about day-to-day? Are you able to look at yourself over there and visualize a future for yourself? I think that’s where it’s at. We’ve got to talk about this more . . . about what happens when you visualize it and you get afraid. OK? So, good luck with your work and things at home. I’ll call you about the meeting with Mr. Williams.

Fear of change, the unknown, and failure prevail but are expressed in somewhat nonconcrete terms. The therapist converses with goals of increasing the specificity and helps to craft a workable aspect of Eric’s situation. A common clinical construction, supported by research, is the “adaptiveness” or “helpfulness” of getting high. Eric’s example has to do with the atmosphere in his home, his relationship with his parents, and their responses to him. A critical cognitive aspect of this segment concerns Eric’s progression toward clarity about his conflict with his parents. Here he is clear about what usually happens and how he copes with the day-to-day conflict.

Getting high is understood as something that relates to those environmental and relationship circumstances, and the prospect of changing drug-taking behaviors presents the possible loss of a means of coping. Again, cognitive aspects of the therapist's formulation are present, but, as usual, they are complimented by the multidimensional focus that includes emotion and behavior (planning/anticipating) aspects that address individual *and* familial (interpersonal) dimensions. Sorting through and naming different aspects of the individual and relationship aspects takes time, and not too many aspects of complex conflicts like this can be addressed in useful ways all at once. The work proceeds systematically in stages.

Stage 2 Interventions

The Journey of Self-Examination

As the therapy enters Stage 2, deeper self-examination and behavioral change are sought. Here, more direct attention is placed on the substance use and problem behaviors in order to initiate Eric's own reflection about what the substance use/problem behavior is about, the meaning it holds for him, what it does for him, and ultimately the costs relative to the gains.

ERIC: I didn't get high yesterday, and I didn't get high today.

THERAPIST: Nice. What do you think goes into it for you?

ERIC: Working has been good for me. 'Cause when I got nothing to do I get high. And I don't get high at work.

THERAPIST: So let's trace through a day like that, when you're not doing anything.

ERIC: Well, if I'm not doing nothing, I probably worked the day before, which means I was high that night. So I wake up, and maybe in an hour and a half or two hours I get high.

THERAPIST: So when you don't have work you're feeling worse about yourself? (*Eric nods.*) On those days, what do you think about? What's going on with you?

ERIC: I don't know . . . just nothing to do, so I get high. It's like, "There's nothing to do today." I'm up early, nobody else is up. Nowhere to go. Either everybody I know is working or out or something. I don't have anybody to hang around with.

THERAPIST: How does it help you to get high?

ERIC: It relaxes me. I say, "screw it, I don't have anything going on right now."

THERAPIST: You're less likely to think about problems or bad stuff then.

ERIC: Yeah, like, "Nothing to do," feeling bad. When I get in a fight with my parents, I'll get high.

THERAPIST: Eric, let me ask, do you ever think about, sort of look at yourself from outside? Like now, make believe you're over there in that chair (*points at empty chair*), and you look back at where you are now, and you say, "What's going on with this guy? Who is this person?"

ERIC: Yeah, every once in a while I do. Like, I don't know, for some reason I just have to stop and think and say, "What the f—k are you doin'?" (*Therapist nods, encouraging Eric, and pauses.*) I say to myself, "You gotta slow down."

THERAPIST: Yeah, see, I think the way to think about using is, what's going on in your life? For you to have more moments or more days when you're able to do what you said you sometimes do. Like you were thinking the other day, "Who is this kid?" 'Cause it's unlikely for you to be thinking about yourself when you're using. You can't do those two things at the same time. It's more unlikely for you to be using when you're in a spot of thinking about yourself. (*Eric nods.*) The other thing is, what has to be in your life, or what's not in your life? Usually if a kid is using a lot, then there are other things that are not in your life. If those things were there, you probably wouldn't be using so much, or even using at all. So what's missing?

ERIC: Well, I thought about this a lot . . . that I think has to do a lot with the way I was brought up. . . .

Crisis as Opportunity

About 2 months into treatment, Eric hit a crisis point when his drug use escalated, the conflict with his parents worsened, and he left home to live with an adult family friend. In MDFT, these kinds of crisis points are seen as opportunities to increase focus, attention, and motivation for change. In the sessions during this crisis, the therapist increased the intensity of the treatment, maintained close contact with the probation officer, and used the phone between sessions to create continuity and maintain focus with Eric and his parents. Eric was willing to meet with the therapist, probation officer, and his parents, so the therapist used this crisis to deepen Eric's self-examination about himself and in relationship to his parents.

THERAPIST: So where you're living, I think it becomes a problem if it goes on too long, if you're out of touch with Mr. Williams . . . certainly if you get in trouble. I want to talk about the living situation. I mean, there are some things we just can't clarify now, but it seems we ought to have a plan. You and me ought to have a plan that we start talking about today about at least in your mind, how long you want to stay over there and when you want to make a move back home.

ERIC: I think that depends on how things go in here.

THERAPIST: With your parents in here? (*Eric nods yes.*) . . . So say more about that.

ERIC: I don't know. I was just thinking yesterday, that I noticed I keep getting into a pattern. Like I get into a fight and things just keep going with it and I do something to make a change, like a drastic change, like moving out and trying to kill myself or something like that. Which tells me I want to change, but no changes are happening.

THERAPIST: That's interesting, because actually that's what I wanted us to talk about most of all today—how you make sense of these things. You know, you try and kill yourself, you try and hurt yourself, you mess yourself up in various ways 'cause you're feeling so bad. This time you leave home, and I'm trying to understand and have you understand before you start dealing with them. . . . I think it's important for you to have decent clarity about what those things mean to you.

The therapist aims to deepen Eric's understanding of himself to be in a better position to talk to his parents. Here we see more clearly that self-examination is not sought only as a target in and of itself but also as a means for healing the relationship with his parents. The therapist defines "moving out" as making a drastic change but mentions the suicide attempt as well in order to increase urgency, focus, and clarity and to stimulate Eric to look at himself.

THERAPIST: For sure—you tried to hurt yourself, you could have fallen off the edge there. You could be dead. You had this thing with the gun. You got shot. You've been involved in very extreme stuff. Being out of the house is extreme and potentially dangerous, so here you go again. You're in another situation where you felt like you had to do something.

ERIC: Something had to change. It just ain't working. . . .

THERAPIST: Right, but what are you telling them about who you are and how you are? If a baby cries in the middle of the night, it's saying something to the world and whoever's there to hear, right? What are the things that it says? "I'm wet, I'm hungry, I can't sleep through the night." You're 16 years old. You do certain things in your life and you're telling everybody what's going on with you. So what are the things that you tell the world with all these things? (*Eric shrugs.*)

The extreme behaviors have an attempted solution aspect, and it is that side of the situation (Eric's experience at this time with his parents) that the therapist is attempting to expand first with Eric alone, and then in conversation with Eric and his parents.

THERAPIST: I'm interested to see what you think of this, but I think it's important to do two things with all of this. First, we'll talk about what those things mean to you. Then, you can speak to your parents about it, and I can help them listen to you and respond to you and so on. What do you think?

ERIC: That makes sense to me, but what will change?

THERAPIST: Let's not jump right into practicalities and problem solving about you and your brother fighting and other day-to-day things. I think there are things that are more basic—things in your soul, things inside of you. You don't feel good. Day to day, you don't feel good. Right or wrong?

ERIC: Right.

THERAPIST: Right. And you think, sometimes when things really go bad, you feel that you have to do something. This is an extreme step. You know, leaving, taking money . . . what's that gonna yield? I'm not talking good or bad behavior now, and I know a lot of the discussion with your parents goes to good boy/bad boy. This time, we'll start with what's going on with you. There are some hurtful things you're feeling. You've been on the edge for a while. So let's talk about this. You've been thinking about this, what this means to you. In a way you're telling them something every time something like this happens. What kinds of things are you telling them?

ERIC: Something's got to change?

THERAPIST: But what are you telling. . . .

ERIC: That there was no way to solve anything between me and them, and I felt lousy so I left.

THERAPIST: What kinds of things are you talking about?

ERIC: Just getting along with my parents, all of us together. . . . (*Therapist nods, encouraging him.*) Favoritism between me and my brother and privacy . . . is probably the biggest . . . respect.

THERAPIST: Did you ever succeed with them around any of these things? (*Eric shakes his head no.*) . . . Did you ever influence them? Did you ever win an argument?

ERIC: Yeah, I have but. . . . Not about the big things, no.

THERAPIST: These are big things. I feel it's important for your parents to understand what's going on with you. But that's hard to talk with them about, huh? (*Pauses. Eric looks down.*)

ERIC: I get upset if I think about all that.

THERAPIST: You're just not there now, are you?

ERIC: I don't know. I think it's just how I am.

THERAPIST: See, I'm trying to present this from a point of view of what's going to reach them. You want them to change, right? (*Eric nods.*)

Here the therapist shifts and slows down his response. He is distinguishing a few issues here: Eric's readiness, his clarity with himself, and his capacity to speak to his parents.

THERAPIST: You want them to change because you're not happy over there. You're not happy in general. I would imagine it's hard for you just in terms of who you are and how you do things, I guess, but it's also hard 'cause you're worried about how they'll react?

ERIC: I know I have to stay with it but I don't know if I can do it.

THERAPIST: OK, stay with it, talk about whatever is there. The thing about leaving home, that would be a good thing to talk about. Let's say you go back home and things get bad again. You start thinking about leaving again or worse. . . . I think that's what we ought to be talking about, no?

Here the therapist starts troubleshooting possible negative outcomes with Eric.

ERIC: Yeah, then I think about it before I talk about it.

THERAPIST: Yeah, but I mean *really* think about it. I mean like go back and forth about it, struggle with it. . . . Everybody worries about kids lying to other people. Sure, but I also worry if people lie to themselves. You've heard me say, "What's going on with this guy?" OK, fine, you took your stand with them. You got their attention . . . your parents. You said, "Things are not good there." You have their attention now, and that's what we're going to try to do—get something done. So tell me what you think about what I'm telling you here. Talk to me about this.

He repeats attempts to help Eric focus on his core experiences of day-to-day living.

ERIC: I've gotta stop using.

THERAPIST: OK, fine, but what are the basics here? Remember we talked about thinking clearly. "What's bothering me? What's wrong? I left home. Why?" You did that the other day. You said something like, "There's a cycle. There's this thing. I do these really extreme things to try and change things. Nothing changes." That's what I mean about being clear. That was fantastic!

Here the therapist is not only positive but also connecting substance use with psychological processes and feeling states, as well as conclusions about Eric's life at present.

THERAPIST: Eric, do you realize how good that was when you say something like that or no?

ERIC: No.

THERAPIST: OK, well, I'll tell you. That was fantastic. That's what I mean by thinking clearly.

ERIC: I don't know . . . but I think you're right. I gotta stop doing it.

THERAPIST: Are you thinking about yourself lately? Are you coming back to earth with stuff? (*Eric nods.*) So tell me about your using these days. Is it an automatic thing?

ERIC: Yeah, I just do it.

THERAPIST: OK, then that means you don't think you have a grip on yourself. Do you know what that expression means? (*Eric nods his head yes.*) "Get a grip on yourself." What does it mean to you?

ERIC: Get control of yourself.

THERAPIST: Yeah, like here, let's do this. Go and sit over there in that chair. Take a look at who's here, look at yourself. Nobody can do this for you, Eric. A therapist can't do this. Your parents can't do this. Nobody can do this, Eric. I'm not talking about "straightening out." I'm not talking about "being good" or "being bad." I'm talking about something more basic than that. How you're thinking . . . and I think using gets in the way right now of getting a grip on yourself, no?

ERIC: Obviously!

This intervention is a simple method to dramatize the questions: "Who am I? What is going on in my life? Do I know? Can I specify the issues in useful ways?"

THERAPIST: What's the way that you're gonna re-enter that home? What's the way that you're going to go back? If that's where it's going, sooner rather than later, it seems like you have to use your time and start thinking about things. It's like we were talking about the other day about focus, right?

The therapist is helping Eric by doing several things in this segment: thinking ahead, moving beyond impulsiveness, using rehearsal, and troubleshooting potential challenges.

THERAPIST: I said to you the other day, “Are you ready to start talking to them?” You said, “There’s some big things between me and talking to them.” So it seems to me we gotta get to these things.

ERIC: I don’t know. I just know I gotta do it. I just got to do it.

THERAPIST: But what goes into it? (*Pauses, thinking, and looks down.*)
What’s a recipe?

ERIC: A whole bunch of ingredients.

THERAPIST: Any old ingredients? (*Eric shakes his head no.*) Right, specific things. What are the ingredients here—from your point of view?

ERIC: I don’t know. We just gotta work it out.

THERAPIST: Come on, that’s too vague. Think ingredients. Think: What’s on my mind? The starting place is talking to yourself first and then eventually with them about when you left—what that’s about for you and what that means to you. We will get to the practical things about going back, but first we’ve got to get clear. So let’s practice some of this. Moving out—what’s it about?

The therapist here is breaking down the elements of attacking and improving on a distressing interpersonal situation in Eric’s relationship with his parents.

ERIC: About running away?

THERAPIST: Wait, is that what it was? I don’t think it was “running away.” I don’t think that’s the phrase to use with your parents, right? It’s what they said, but what was it for you?

ERIC: I guess I took a stand.

THERAPIST: OK, I think that’s closer. Better to start talking about what’s wrong and what you think.

ERIC: Yeah, what’s wrong . . . what’s wrong with me?!?!

This line of exploration is a simple reframing on one level; but, more than that, it is a frame or interpretation that the therapist feels is more hopeful and positive in terms of Eric’s agency. The therapist aims to develop more complexity for Eric concerning the parents’ interpretation of his leaving the house as troublemaking and impulsiveness by an “out-of-control son.”

THERAPIST: What’s wrong in that house for you? That’s what we gotta talk about. You left to give them a message. You left to try some stuff out. You left because you were angry, because you’re hurt about the way things go there. That’s the stuff we’ve got to get on the table with them.

ERIC: I think trust is one thing that has to change. They’ve never trusted

me! (*The therapist nods, encouraging Eric to continue.*) . . . I can't explain it. It just pisses me off. I get so mad.

THERAPIST: Right, it pisses you off. Say more. This is what we were talking about—staying with things.

ERIC: Right . . . they don't respect me, they don't treat me my age, they're unfair about my brother.

THERAPIST: And that makes you think what? See, there's even a more basic level. You worry about what? Whether they love him more than you? Care about him more than you? (*Eric nods.*)

The therapist is very persistent to promote active thinking and expression by Eric.

THERAPIST: Yeah. What's more basic than that in life? Not much. See, that's basic. That hurts to think that, doesn't it? That hurts. See, now why can't they deal with that with you? They have to deal with that. They have to. They do. It's not easy for them to deal with that. You left that house and you pushed them. You pushed on them in a certain way. But you didn't push on them to deal with that. They have a lot of reactions to you, but they don't deal with this. This is one thing, and it comes up a lot, and it hurts you a lot. So you leave, you hurt yourself, you try and kill yourself, and they have to deal with you. They have to deal with you in some way, but they don't deal with you around this thing that hurts you a lot. See what I'm saying? They have to deal with you about that and other things. How are we going to help you push them to deal with you about this?

ERIC: I don't know. I guess just keep talking about it.

THERAPIST: I would imagine it hurts to talk about this. It's upsetting. I mean, if we started talking about this now, wouldn't it be easier to put the headphones on? It's impossible if you had the headphones on and you turned it on, even softly, and I said, "Let's talk about this, let's talk about how you feel," it would be hard to do. Yeah? (*Eric nods his head yes.*) Right now, when you use, you can't think about that, can you? You can't deal with yourself or with them when you're high.

ERIC: Right, I think that's one of the points of doing it.

THERAPIST: Sure. When you're out of that house, when you leave, when you try and hurt yourself, you also are not dealing with that. I mean you are in a real indirect way, but the basics of it, "Hey, this is how I feel, this really hurts me, this is what I think about things," you aren't dealing with. Do you believe this, really? Are we focused in on something now that's really important? Is this very important, or is it not so important? I want to make sure. . . .

This segment illustrates more expansion of what the issues are from Eric's point of view. The therapist is attempting to help him clarify and express, and then become ready to discuss, these issues with his parents in a new way—a more competent and more readily receivable way.

ERIC: I think it's very important.

THERAPIST: But even to say it's very important is hard, isn't it? [*Eric nods his head yes.*] Yeah. See, that's why this is all going to be hard. I hope you can push them. I hope we can find a way to start to help you deal with this with them. You can't talk to them about things because . . . why?

ERIC: I did talk to them. Nothing ever happened.

THERAPIST: But do you think you talk in a good way?

ERIC: Sometimes.

THERAPIST: If you were to get better in the way that you talk about these particular things . . . how would you get better? How would we know you're getting better? What would you do differently?

ERIC: I don't know. I guess just stop getting so angry.

THERAPIST: Maybe, but I'm not convinced that the getting angry is the culprit here. Tell me if I'm wrong. You say something, your mom or your father might say something, it goes back and forth, and somebody gets mad, and then it sort of ends. I think the thing about getting mad is it doesn't continue. Like, "Oh, OK, screw you." Is it possible for you to be mad in any situation and to keep the thing going? (*Eric shakes his head no.*) No? I think it is. You don't think it is?

Again, the therapist attempts to help Eric unpack the multidimensionality of the intrapersonal, interpersonal, historical, and current family conflicts—to change his cognitive processing of these conflicts.

THERAPIST: They're gonna come over here in the morning. Getting back home is very, very important for them, for you. Do you think this is important? I think there's a lot at stake this time around. Do you agree with me? I think we have to meet with them tomorrow. What do you think?

ERIC: All right.

THERAPIST: I'd like you to think about starting to talk to them about this stuff. I'm gonna say, "Look, this coming back home thing, it can't be like before. Everybody's got to feel like we're entering into this with reasonable spirits." You have to feel that they're going to be reasonable with you, and they have to feel that you're gonna be reasonable with

them. You want them to change something, and I think the medicine to help them start to deal with you is these things.

ERIC: Me talking?

THERAPIST: You talking about those sorts of things: “Well, let me tell you why I left. Let me tell you what was going on. Let me tell you how I feel about it. Let me tell you how I feel in that house. Let me tell you how I feel about myself. Let me tell you how I feel about my life. . . .” That’s gonna get their attention, I mean *really* get their attention. That’s gonna move them. It is. I’m talking about doing this for you. I’m talking about doing this for you, for your life, not for them. I mean it will affect them, but I think mainly this is for you. This is the medicine for you to get a grip on what’s going on with you. Tell me what you think about what I’m saying.

ERIC: In order for things to get better, I have to deal with them.

THERAPIST: Do you know that it’s also dealing with you?

ERIC: I gotta do it for myself, not for them.

THERAPIST: Yeah, and do it for yourself, but see it’s *dealing* with yourself, see. . . . It’s . . . if you have the headphones on, it’s hard to think clearly about yourself. You’re distracted. If you’re using, you’re distracted. You go through a lot of your life miserable right now, very unhappy. That’s no good. You hear me talk about taking care of yourself. I think you doing this is taking care of yourself. You left that house for valid reasons. I think things are not at all in a good spot for you and I’m saying, “What are you going to do, Eric? What are you going to do?” Use this to do something. Use this thing to get a grip on yourself—for you. OK, see you in the morning.

The next morning, Eric and his parents meet for a family session. When the parents bring up an episode regarding Eric leaving school after being dropped off, the therapist keeps the focus on the theme of creating a “road back home” and avoids haggling over details and parents voicing their doubt and lack of trust in Eric. The therapist shapes them to communicate their love to Eric.

THERAPIST: I mean, some of these things are not winnable . . . are not resolvable. In the grand scheme of things, in the bigger picture of things, this would be one. This would be one, OK, you see something, you bring it up, it looks fishy, you think it is reasonable to ask for an answer about something. But how is it ever going to get through to him in a way that’s acceptable to him? There’s something there that is inevitably going to lead to a stalemate and more bad feelings. That’s what I was trying to say to Sarah in a way, that too much focus on the

negatives. . . . I'm not saying to sweep things under the rug, but I am saying that too much focus, taking that road too far to the exclusion of other things, won't help. There's one thing that you want to say to him over and over and over, and it's about wanting him home with you. It wouldn't be about things like where did you go after being dropped off at school, or we can't trust you or we doubt you. . . .

MOTHER: But there's a real safety issue. I'm sure it doesn't look to him like a safety issue, but a couple years ago, a female teacher was stopped by a policeman because she parked over where he wandered off, in the same area. She heard this car coming along and slowing down—it was the police. And they said, "It's not safe to walk here. Don't walk over here by yourself." So I might be a worrisome parent, you know, but seeing him going over into that area, alone. . . .

THERAPIST: Uh huh, well, OK, that's a different discussion now. But that's not, "We don't trust you," or "We think you're doing bad stuff." That's about, "We're worried sick about you and we want you to be safe because we love you so much. We have to keep you safe." That's a different message. Eric, does that sound different to you? Does that sound more reasonable?

ERIC: A little bit. . . .

FATHER: We're not saying you're in danger, but. . . .

THERAPIST: Right, a little bit more reasonable, right? Well, let's leave that for now, because I don't see a resolution to exactly what happened, and I don't think that's where things are right now. What I want to say again, Ron and Sarah. . . . When he first left and you were frantic about him being gone, I kept saying to you over and over, there is one thing that you have to tell him, that you have to get through to him, and that's that you want him in that house. I said, above everything else you say to him, you want him home. You don't want to pick on him about how he looks or about how he doesn't do chores, or you can't trust him. . . . If a more basic message does not get through to him . . . my own feeling is that that's a problem. Eric, is that right? Is that what you were saying the other day when we talked about what's in the way of creating this road home?

ERIC: Yeah, it's a problem for me. I get to where it's too much. . . .

THERAPIST: 'Cause I think what you need to hear from them loud and clear over and over is that it is important to them, that your parents want you home now. That you can live there, not where Mr. Williams fills out a piece of paper in Pittsburgh or wherever it's going to be if you can't make it back home. I was on their back about saying to you in very clear terms, regardless of what else goes on day to day, "We want you to live in our house." Do you get that from them?

ERIC: Sometimes. . . .

THERAPIST: And if there's anything that you can do to help them. . . . See, sometimes people need encouragement to say things, too. I happen to think that that's very important for you to hear that from them, but *you* have to let them know that. Am I wrong? (*Eric shakes his head no.*) I mean I just think this. . . . I feel really strongly about this, knowing you to the degree that I do. So I kept saying to your mom and dad, you must communicate this to him. That's the first thing, and everything else comes after that. We've gotta be talking about what's gonna keep you in some sort of stabilized spot so that you can make it back home and you don't feel like you have to do extreme things. We've talked about this many times. When you start to feel too pressured and too panicked, you start to think about extreme solutions, don't you? We just talked about this. You start hanging around with really funky people, you try and kill yourself, and you start messing up at school and you leave the house, right? When you get very upset and pushed against the wall, you can take matters into your own hands and do things like we talked about in terms of impulsive things and extreme things. So I kept saying to them that they have to find it in their hearts to tell you this, OK? But they might need your encouragement.

THERAPIST: (*To the parents.*) So you heard it here from the horse's mouth. If there's one thing that I'm really standing behind, you know, it's that one: that you want him home, period. I think that's gonna stabilize him now. I think that's gonna make him available to deal with the stuff that he's gotta deal with in his life now. I want him to feel solid about that. Are you with me?

FATHER: Yes. Eric, we love you, and we want you home. We'll work things out. We'll work it out.

MOTHER: Yes, of course, that's what we want. That's all we want, Eric. . . . (*Wipes away tears.*)

Of course there are many aspects of the situation, and different members of the family interpret events differently. The therapist brings the concern, worry, commitment, and love for their son to the forefront with the parents, making the case that those matters can and should be discussed and, moreover, that those aspects are central to helping Eric stabilize, come back home, and begin to express his concerns more directly. Problem-solving aspects of their day-to-day lives, matters of curfew, what seems fair or unfair, and the negotiations around those important topics are all vital, of course. However, this approach first centers on relationship topics as a way of reestablishing an atmosphere of trust in which family members make good-faith efforts and promote compassion and empathy and family love

and connection—all of which create motivation that sponsors reasonable give-and-take even after very conflictual and hurtful events have occurred.

Stage 3 Interventions: Sealing the Changes

The last phase of therapy seals the changes that have been made during therapy, anticipates “bumps in the road” (healthy expectations), and helps parents and teens be as optimistic as possible about launching their next life chapter. For Eric and his parents, day-to-day life had become more stable, less conflicted, and Eric had a period of clean time in which he was back home and going to school. Probation was still monitoring him but had eased up on his restrictions, given his good progress. In a family session at the end of treatment, the therapist helped Eric and parents address remaining issues. After the family negotiated some new rules that gave Eric more freedom, the therapist highlighted their changes and new ways of relating.

THERAPIST: You’ve come in here more than most kids come here. You’ve done a lot, you know. You’ve done a lot. Your parents have done a lot. You should get a lot of credit for that. You know, I said to your parents last week how good they were doing, and I think of how good you’re doing with this, too, you know, as I said. You’re doing your best and that’s really good. So all right, so let’s do this. Ron and Sarah, I’ll trust you to relay all this to Mr. Williams.

FATHER: OK, I think that’s a good plan.

THERAPIST: It is. You’ve come a long way, all of you. And my mode with you and I’ve told you this a hundred times. . . . I think, Eric, you’ve got to get the message by now that regardless of everything that’s happened in the past and regardless of the stuff you do not like day to day, that there’s one thing that comes in front of all that, and that’s that they want you, they want you home, they want you to live with them. I think that’s what’s going to keep you reasonable with them, on the beam, not moving to any extremes. So my mode is that things had to improve between you and them before we could start talking about anything else, or working out anything else.

Discussion

This chapter has attempted to detail the ways MDFT, an empirically supported treatment for adolescent substance abuse and delinquency, works with the adolescent’s and parents’ cognitions as a target of change, as well

as an avenue for prompting change in other areas. Through the case of Eric and his parents, we illustrated intrapersonal and interpersonal aspects of the change process through the exploration of beliefs and attributions about oneself and others. We have also attempted to illustrate the inextricable links and the ongoing interplay between cognitions, emotions, and behaviors in a multisystemic therapeutic approach.

Designed with adolescent development and developmental psychopathology research on adolescent problems at its core, MDFT was developed specifically to target multiple, mutually reinforcing risk and protective factors. This approach has changed the lives of countless youth and families in both research and clinical applications. Specifically, MDFT has been evaluated and found to have significant effects in randomized controlled trials (RCTs) using active treatment comparisons with a range of clinical populations (Dennis et al., 2004; Hogue, Liddle, Becker, & Johnson-Leckrone, 2002; Liddle et al., 2001; Liddle, Dakof, Turner, Henderson, & Greenbaum, 2008; Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009; Rigter et al., 2012). These RCTs have adhered to methodological criteria, including randomization, fidelity to manuals, sound measures, and high data capture rates at follow-ups (Austin, Macgowan, & Wagner, 2005; Becker & Curry, 2008).

The results of RCTs evaluating MDFT have shown positive effects in comparison with individual cognitive-behavioral therapy, peer group therapy, and multifamily group therapy in reducing adolescent substance use, delinquency, and emotional and behavioral problems and improving school performance and parent/family functioning (Liddle et al., 2001; Liddle et al., 2008; Liddle et al., 2009; Rigter et al., 2012). The data suggest that MDFT treatment gains hold up over time, showing durable effects on substance use at 1-year follow-up (Brannigan, Schackman, Falco, & Millman, 2004) and may even strengthen further after treatment completion (Vaughn & Howard, 2004). MDFT is less expensive than standard outpatient and residential treatments across the United States (French et al., 2003; Zavala et al., 2005) and has been applied with African American, Hispanic, and white non-Hispanic youth and families (Huey & Polo, 2008). Based on the empirical support, the model is recognized as an exemplary best practice for adolescent substance use disorders and delinquency (e.g., National Institute on Drug Abuse, 1999; National Registry of Evidence-Based Programs and Practices, 2008) and is widely disseminated in community-based organizations.

Identifying MDFT's effective ingredients, such as the focus on cognitive interventions, has been a primary focus in process research on adolescent and parent interventions. Current directions include the refinement and testing of the approach for other challenging issues and populations (e.g., transitional age drug abusers).

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