Title: Helping Adolescents Just Say No to Drugs: A Multidimensional Family Therapeutic Approach

Activity Date: This activity will be available as an online learning module starting July 12, 2013, and will be available for one year.

Activity Location: Online

Target Audience Statement: This CME activity is intended for psychiatrists.

Accreditation: Lippincott Continuing Medical Education Institute, Inc. is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit Designation: Lippincott Continuing Medical Education Institute, Inc. designates this enduring material for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Learning Objectives: After completing this activity, the learner should be better able to:

- Evaluate patients using the theory of Multidimensional Family Therapy (MDFT)
- Treat adolescents with substance abuse problems using the three stages of MDFT
- Identify the limitations of MDFT

Faculty Credentials and Disclosure Information

Shelly F. Greenfield, MD, MPH
Editor in Chief
Harvard Review of Psychiatry
Harvard Medical School
Boston, MA

Dawn E. Sugarman, PhD
Communications Editor
Harvard Review of Psychiatry
Harvard Medical School
Boston, MA

Joshua L. Roffman, MD, MMSc
Deputy Editor
Harvard Review of Psychiatry
Harvard Medical School
Boston, MA

Graham Danzer, ASW, PPSC, MRAS
Senior Clinician
Abode Services
Fremont, CA

Stephen Scher, PhD, JD
Senior Editor
Harvard Review of Psychiatry
Harvard Medical School
Boston, MA

All faculty members in a position to control the content of this CME activity have disclosed that they and their spouse/life partners (if any) have no financial relationships with, or financial interests in, any commercial companies pertaining to this educational activity.
LCMEI Staff and Planning Committee Members

All LCMEI staff members and planners in a position to control the content of this CME activity have disclosed that they and their spouse/life partners (if any) have no financial relationships with, or financial interests in, any commercial companies pertaining to this educational activity.

Method of Physician Participation in the Learning Process/Evaluation Method

Successful completion of this activity includes reading the entire article and successfully completing the postquiz and an evaluation form.

Getting the Most out of the Activity

As you prepare to participate in this activity, please reflect on your practice and your patients and identify clinical challenges you hope to have addressed.

While participating in the training, identify ways you can use newly acquired knowledge, strategies, and skills to enhance patient outcomes and your own professional development.

Disclaimer

Clinicians should ensure that all diagnostic and therapeutic modalities are prescribed and used appropriately, based on accepted standards of care. Use of any drugs, devices, and imaging techniques should be guided by approved labeling/full prescribing information, best available evidence, and professional judgment.

Faculty have been instructed that their content should be fair balanced and based on best available evidence. The information presented in this activity is the responsibility of the faculty and does not reflect the opinions of the provider.
Helping Adolescents Just Say No to Drugs: A Multidimensional Family Therapeutic Approach

Graham Danzer, ASW, PPSC, MRAS

Learning Objectives: After participating in this educational activity, the psychiatrist should be better able to
1. Evaluate patients using the theory of Multidimensional Family Therapy (MDFT).
2. Treat adolescents with substance abuse problems using the three stages of MDFT.
3. Identify the limitations of MDFT.

Multidimensional Family Therapy (MDFT) is reviewed, both in theory and as an evidence-based approach to treating adolescent substance abuse and related risk factors. The primary objectives of MDFT are to improve functioning in the four domains that centrally influence the course of adolescent development—the adolescent himself or herself, the parents, family interactions, and extrafamilial relationships. In MDFT, functioning in each domain is conceptualized as a risk or protective factor for problematic adolescent behavior and overall development; adolescent substance abuse is thus understood as a deviation from healthy, adaptive development and as indicative of impaired family systemic functioning. Improved functioning in the four domains is expected to place adolescents on healthier developmental trajectories, which decreases risk for substance abuse. Previous reviews of treatment approaches for adolescent substance abuse have surveyed multiple models. Previous articles specifically on MDFT have addressed a defined range of issues—whether theory, technique, or research. This review comprehensively synthesizes MDFT in theory, research, and practice, and suggests directions for future research.

Keywords: adolescent development, adolescent substance abuse, evidence-based practice, family therapy, juvenile justice system, Multidimensional Family Therapy

ADOLESCENT SUBSTANCE ABUSE

Adolescent substance abuse is an ongoing social and public health problem that is deserving of national priority.1 It is related to adolescent accidents, suicide, and violent crime (the leading causes of death for this age group), depression, anxiety, PTSD and other comorbid affective disorders, poor academic performance, increased risk for contracting HIV and sexually transmitted diseases and for developing other physical health problems, self-esteem deficiencies, severe conduct problems, sexual acting out, and intergenerational transmission of risk factors, a particular concern in inner city communities.1–6 According to research, 62% of incarcerated juveniles meet criteria for a substance or alcohol abuse disorder; the prevalence and severity of substance abuse disorders among juvenile justice populations has steadily increased over time; 60% to 80% of incarcerated juveniles need treatment; and substance abuse–related costs to the juvenile justice system are approximately $14 billion annually.1,7,8

Eight percent of the nation’s population ages 12 and over used an illicit drug in the past month; almost 8000 young people try illicit drugs for the first time every day; and adolescence is when drug abuse typically begins.7,9 These statistics are of particular concern because of the relative brevity between first use and the onset of addiction, at which point related problems become significantly more intense, ingrained, and difficult to treat.7,9 Negative effects of adolescent substance abuse, including problems relating to behavior, physical and mental health, and employment, often progress in severity and chronicity as adolescent substance abusers mature into substance-abusing adults.5,9 These considerations underscore the importance of developing preventive and early-onset treatment strategies.

ADOLESCENT SUBSTANCE ABUSE TREATMENT

Long-term prognosis is generally better if treatment begins early, and close to the first incident of substance abuse.1,2 However, less than 10% of adolescents in the community
who meet criteria for a substance abuse disorder actually receive treatment, and over 50% who receive community-based treatment drop out or terminate with unsatisfactory progress.3 Research supports that adolescent substance abusers frequent multiple systems of care, including juvenile justice, hospitals, child welfare, and schools—where the adolescents encounter significant discrepancies between the services they need and the services actually provided.10 Until their problems become severe, adolescent girls with substance abuse issues are particularly underserved by health care and juvenile justice providers.4

Many evidence-based treatments for adolescent substance abuse are available, including group therapy, cognitive-behavioral therapy, multifamily educational intervention, multisystemic family therapy, Strengthening Families Program, brief strategic family therapy, and Multidimensional Family Therapy (MDFT).1,2,11,12 Family-based treatments are the most thoroughly researched and empirically validated treatments for adolescent substance abuse and related risk factors, including poor school performance and attendance.10

This article reviews MDFT in theory, research, and practice.9 Doing so is important because recent research has concluded that adherence to its techniques predicts positive outcomes.7,10 Older articles more fully describe those techniques. Whereas recent literature reviews on adolescent substance abuse treatment briefly cover both MDFT and other approaches, this review more comprehensively synthesizes the theory, technique, and research findings in support of MDFT.

MDFT has consistently achieved superior results in comparative studies of adolescent treatment approaches, and some studies have found that positive results have been maintained long after termination of treatment (though other studies disconfirm this finding).1,10,11,13 Maintained positive outcomes have included decreased substance abuse, delinquency, and internalized distress.10 MDFT has resulted in significant reductions in substance-abusing adolescents’ high-risk sexual behavior, academic and behavior problems at school, mental health problems (including depression and anxiety), involvement with antisocial peer groups, and more favorable juvenile justice outcomes such as fewer days incarcerated.5,10 MDFT has been found to be effective for adolescents who are younger and older, African American, Latino, white, lower-income, referred from the criminal justice system, and suffering from severe comorbid conditions.1,6,7,11 In a variety of U.S., Canadian, and international locations, research on MDFT has yielded positive outcomes as a brief treatment model in outpatient, residential, hospital day treatment, urban, suburban, rural, and juvenile justice settings.1,6,10,11,14,15

Some attempts have been made to empirically integrate MDFT with skills-training interventions to treat adolescents with more severe personality impairments, and to integrate MDFT with trauma-specific interventions for substance-abusing adolescents who were affected by Hurricane Katrina.7 Research on integrating MDFT with trauma treatment is important because as many as 90% of incarcerated juveniles have experienced one or more traumas.6 The results of these studies suggest that adolescents with more severe comorbid conditions require a treatment approach that multi-targets the various dimensions of their developmental trajectory—which is consistent with the original hypothesis about multiplicity that inspired the name Multidimensional Family Therapy.5,7,15

As will be explained below, the theory underlying MDFT is based on a research-supported relationship between adolescent development and substance abuse. This relationship, which is mediated by family systemic functioning, forms the basis of family therapeutic strategies for engaging resistant youth and family members, and for helping them build communication and problem-solving skills—which they can then learn to apply in a multiplicity of scenarios, thereby decreasing adolescent substance abuse and related risk factors.

**MULTIDIMENSIONAL FAMILY THERAPY**

MDFT is a traditional (i.e., structural) family therapeutic approach that was developed from clinical research and refined through ongoing therapy studies; it was originally introduced as a weekly clinic-based intervention and, since 1985, has been tested in federally funded research projects.12,16,17 MDFT integrates principles of individual therapy, drug counseling, family therapy, and multisystems intervention into an approach that targets functioning in the four domains, or dimensions, that centrally influence the course of adolescent development—the adolescent himself or herself, the parents, family interactions, and extrasocial relationships.5,7,14,17

The adolescent domain encapsulates adolescent academic and social functioning, including adolescents’ behavior, communication, social skills, drug refusal skills, academic prowess, and problem-solving abilities.5,16 The parent domain denotes parenting skills and parenting practices, including monitoring, the use of age-appropriate rules for the adolescent, and enforcement of those rules.7,16 The family-interactional domain pertains to interfamilial communication and the strength of familial relationships.16 The extrasocial domain refers to the relative health of family members’ interactions with outside systems such as schools and juvenile justice providers.16 Research has shown that improved functioning in this last domain increases adolescent academic success and participation in pro-social peer networks, and decreases adolescent conduct problems and delinquency.5,18

Functioning in each domain is conceptualized as a risk factor for problematic adolescent behavior and overall
MDFT has roots in the ecological perspective and in developmental psychology. Treatment is ecologically oriented to the broader environmental influences of neighborhood, culture, peer group, and family on adolescent maturation toward, or away from, important developmental milestones. MDFT is a treatment system for adolescent substance abuse because it not only addresses the most prominent, observable symptoms but also targets larger, systemic factors that mitigate or aggravate symptom severity and are at play in creating therapeutic change.

Recent studies have identified the importance of parenting as a mediating factor in adolescent substance abuse, and therapeutic alliance studies have explored how the therapist’s alliance with parents may work as a mechanism for changing the behavior of a substance-abusing adolescent. These studies reinforce the view that multiple mechanisms are a work both etiologically and in efforts to provide effective treatment.

**THE MDFT APPROACH TO ADOLESCENT SUBSTANCE ABUSE TREATMENT**

In the first stage of treatment, the engagement and alliance-building stage, the therapist focuses primarily on gathering and integrating central details of family history and on building therapeutic alliances with all participating family members and influential members of extrafamilial systems. This assessment is conducted through multiple interviews with the adolescent and his or her parents and family members, mental health professionals, school officials, and juvenile justice officials. The process should yield a detailed history of the following: the adolescent's drug abuse history, sexual behavior, and peer group; the parents’ histories of being parented when they were children, and their current parenting practices; family dynamics; and patterns of interpersonal communication and interactions with outside agencies. Key protective/risk factors for adolescent substance abuse also need to be assessed, including the adolescent's academic success or failure, social bonding or alienation, and pro-social or anti-social behavior, and the parents’ level of monitoring and involvement. Determining the extent of youth engagement with, or alienation from, family and school is particularly important; since such disengagement is a significant risk factor for heavier substance abuse and for developing other serious problems in adulthood, it is crucial to design and implement interventions focusing on parents and on education. This more comprehensive assessment strategy coincides with research-based recommendations that family-based treatment programs extend assessment beyond substance abuse and psychiatric and behavioral impairments, and that they consider broader, ecological indicators of adolescent development.

In conducting the assessment, the therapist lets family members engage in focused communications, listens for important details of family history, identifies how family members attempt to resolve conflicts, and determines the extent to which their communication strategies are effective. The therapist should be continually hypothesizing about what seems to be missing from family members’ conversations. Overall, the assessment will indicate how each participant functions, which suggests who will be targeted for individual interventions oriented toward behavioral change—once sufficiently strong therapeutic alliances have been built.

Therapeutic engagement and alliance with adolescents, their parents, and influential members of extrafamilial systems have an impact on therapeutic retention and outcomes. Therapeutic engagement can be considered a function of family members’ willingness to participate in treatment, though it is the therapist’s job to increase motivation through techniques and interventions that address family members’ presenting problems; the therapist thereby helps otherwise resistant family members engage in treatment and, in the process, builds therapeutic alliances that increase receptivity to interventions (in the present case, for decreasing the risk factors for adolescent substance abuse).

At the threshold, the therapist’s arguably first priority is to build an alliance with the parents, for it is they who must bring (presumably resistant) adolescent substance abusers into treatment. Parents are often reluctant to participate in an adolescent’s treatment because they have been in treatment with their adolescent multiple times, doubt that treatment will be effective, expect to be blamed for the adolescent’s problems, and feel hopeless and frustrated. Parents may also face severe life stresses such as socioeconomic problems; their own struggles with substance abuse; depression and other psychopathology; divorce; and discord within their own relationship. According to research, 40%–53% of youth involved with the criminal justice system have parents with mental health or substance abuse problems (per youth report), and 70% of their parents have prior justice system involvement. Parents’ personal struggles make it understandably difficult for them to be fully present, emotionally available, and responsive to adolescents, which is why their individual issues are a priority in adolescent treatment. Indeed, providing individualized treatment for participating family members explains, in part, why MDFT has been found to have superior engagement
rates to CBT and multifamily education—treatments that, though supported by research, could be considered less individualized.\textsuperscript{10,13}

Family therapists should allocate individual session time to parents, help them process their stressors and frustrations (which would otherwise render problem-solving interventions ineffective), make genuine efforts to understand their struggles, and co-create mutually acceptable therapeutic goals for the adolescent.\textsuperscript{17} While parents are expressing painful feelings (e.g. hurts, disappointments) in reference to the adolescent, the therapist should listen for, and be prepared to reinforce, slivers of hope that can begin to restore love and attachment. The presence of these forms of emotion are likely to increase adolescents’ participation in therapy, whereas their absence is likely to maintain adolescent resistance.\textsuperscript{17}

Parents should eventually be asked to honestly and thoroughly examine what they have done in the past that has helped the adolescent and what has not been helpful, and to consider trying new, possibly more effective parenting approaches.\textsuperscript{17} This part of family therapy is usually the most difficult for the parents to accept, though it is more likely to be accepted if the therapist assures the parents that the adolescent will also have individual sessions, that areas for improvement will be identified, and that the therapist will not be manipulated by the adolescent.\textsuperscript{17} Parental engagement also increases when the adolescent and parents are informed that the adolescent will be randomly drug tested and that the results will be shared with the adolescent, parents, and juvenile justice providers (for youth on probation).\textsuperscript{17}

In this respect, MDFT therapists do not take a neutral stance about adolescent substance abuse and related choices in lifestyle.\textsuperscript{17} More generally, though the parents are not being asked to do all of the work themselves (of which they need to be openly assured), both adolescents and parents are held accountable for making the needed changes identified in therapy. In effect, the multidimensional family therapist functions as a benevolent parent for the entire family, including the parents.

Since adolescents are usually involuntarily brought into treatment by their parents, they are typically resistant.\textsuperscript{20} It is nevertheless important to get off to a good start with adolescents; reversing the effects of an initially weak alliance can be difficult.\textsuperscript{17} The quality of the therapist-adolescent alliance is at least partially a function of how much individual session time is afforded to the adolescent.\textsuperscript{19} The quality of the alliance has also been linked to specific alliance-building techniques, which include the therapist attending to the adolescent’s experiences, advocating for the adolescent with parents or other involved adults, emphasizing honesty, trust, and confidentiality, and intervening in ways that coincide with the adolescent’s developmentally appropriate desires for emotional closeness and autonomy.\textsuperscript{10,16} Practice-focused research recommends a family therapeutic approach that is respectful and supportive yet demanding of the adolescent—which creates a setting that will help him or her identify and clarify important thoughts, feelings, and goals.\textsuperscript{19}

The challenge for the therapist is to motivate the substance-abusing adolescent to embrace a therapeutic agenda that is acceptable to the parents.\textsuperscript{16} By the same token, maintaining balanced therapeutic alliances with the adolescent and his or her parents can be difficult since they are usually at odds with each other and are likely to resist interventions that the other might find acceptable.\textsuperscript{14,16,17,22} Family conflicts can lead to therapeutic impasses if they are not resolved, or can ultimately strengthen familial relationships if they are resolved.\textsuperscript{16,19} In the latter case, adolescent symptomology is expected to decrease, which is consistent with the structural theory of family therapy.

Once sufficient assessment data have been gathered and sufficiently strong therapeutic alliances have been built, the adolescent and participating family members advance into the second stage of treatment, the \textit{working stage}, which involves targeting specific problem behaviors for change.\textsuperscript{16} The adolescent is more actively encouraged to use effective communication skills, social skills, and drug-refusal skills, and are helped to make important decisions about peers, family interactions, and the future.\textsuperscript{16} The adolescent should also receive therapeutic assistance to improve his or her academic performance, participation in pro-social peer networks, anger management, and employment readiness.\textsuperscript{10,13} Parents are helped to construct daily household rules about adolescent curfews, homework, household chores, and other developmentally appropriate tasks.\textsuperscript{24} Family members are also helped to engage productively with the adolescent’s school officials, juvenile justice officials, and other outside agency representatives, and to advocate on the adolescent’s behalf.\textsuperscript{16}

Family members’ relational conflicts are addressed more directly in this stage of treatment.\textsuperscript{16} MDFT techniques can help family members to focus on important issues in family sessions, manage conflicts and negativity, prevent the escalation of problems and conflicts, and prevent hasty parental decisions on matters that have potentially enormous consequences, such as referring a quarrelsome child to residential care.\textsuperscript{2} Though conflicts will inevitably arise, they need to be addressed immediately so as to prevent escalation, which can decrease therapeutic engagement and increase the risk that the adolescent will begin using drugs again.\textsuperscript{5,7,17,19}

That said, the therapist should err on the side of caution when attempting to change family members’ relational behavior early in treatment.\textsuperscript{16,17}

When family members engage in negative interchanges, the use of the \textit{shift intervention} is recommended—that is, to shift the therapeutic focus from the adolescent’s problematic behavior to the adolescent’s and parents’ deeper feelings about the parent-child relationship itself.\textsuperscript{24} More generally, this strategy can be used to help the adolescent and parents divert or work through negative emotions,
to draw out feelings of sadness, regret, or loss, and to prompt parent-adolescent conversation on important topics—all of which are associated with the successful resolution of therapeutic impasses.10 Likewise, enactments, a primary intervention in MDFT, can help family members express their feelings about each other to each other, thereby enabling them to work toward resolving the more deeply rooted family conflicts that manifest in everyday parent-child disputes.16 Enactments are usually preceded by individual meetings with family members; these meeting help them to identify problem-solving communication strategies and to understand how they might be put to use in family sessions.16

A strong therapist-adolescent alliance can help to support the adolescent through difficult enactments, as when the adolescent discloses past hurts and disappointments to the parents.19 In particular, a strong alliance may help to modulate the adolescent's feelings, thereby enabling parents be more receptive to his or her concerns and to respond less defensively.19 When an adolescent communicates more clearly and effectively, parents are generally better able to express appropriate remorse or warmth, which is likely to improve parent-adolescent interactions and to increase the adolescent's participation in therapy.19 In addition, effective communication skills provide adolescents with alternatives to substance abuse and antisocial behavior.16

When family function has markedly improved, the family has advanced to the third stage, the maintenance stage, which is oriented toward making positive changes, reinforcing progress, creating new narratives, and helping family members prepare to use outside of therapy what they learned in the therapy itself.16 Families may still experience significant conflict, particularly if the adolescent regresses to problematic behavior, which can, in turn, retrigger the parents' sense of hopelessness and frustration. It is the therapist's job to help parents manage and contain their painful feelings, to help the adolescent learn from his or her mistakes, to figure out how what went wrong and how it happened, and to then create a new household structure that decreases risk factors for ongoing adolescent substance abuse and problematic behavior.16 An engaged and motivated family in later phases of treatment is generally more capable of addressing an adolescent's problems with progressively less therapeutic intervention—which itself suggests that the adolescent and parents are functioning better both by themselves and in relation to each other and to those outside the family (the four domains discussed earlier).1

LIMITATIONS, CONCLUSIONS, AND IMPLICATIONS FOR THE FUTURE

The literature on the topic of adolescent substance abuse recommends that treatment be easily accessible and that it incorporate procedures to minimize dropout, provide comprehensive intervention services, use empirically validated techniques, include a family therapy component, offer ongoing, abstinence-based support for parents and adolescents, and provide aftercare.13 MDFT offers a therapeutic framework for meeting all of these objectives with the exception of the last. The lack of an aftercare component is noteworthy because studies have found that adolescents with severe comorbid conditions (who often frequent community-care settings) initially respond positively to MDFT but return to baseline levels of substance abuse at one-year follow-up.10 The addition of an aftercare component to MDFT could potentially address this problem.13

Improved parental monitoring—a primary objective in MDFT interventions—has been shown to increase the overall numbers of abstinent youth but not to decrease the frequency of substance abuse for adolescents who continued to abuse substances in spite of treatment.21 These results suggest that MDFT works well with adolescents and families who are amenable to an abstinence-focused model but that it is less effective with adolescents and families who are less interested in abstinence—which is often the case with adolescents with severe comorbid conditions. This last point speaks to research-rooted concerns about treating adolescent substance abuse in isolation from comorbid psychiatric conditions, which average 60% in community-based samples and range from 80% to 90% in treatment and juvenile-justice settings.7 Although the multidimensional focus of MDFT makes it a preferred treatment approach for adolescents with comorbid conditions, confounding factors suggest a need for follow-up study.5 Adolescents with comorbid mental health issues such as ADHD, anxiety, and depression may also require medication and individual psychotherapy.5,10 In this context, MDFT would potentially be more effective, at least for some patients, if it was extended to incorporate a more intensive, chronic care model of treatment.5

Several limitations of MDFT are more pragmatic in nature. Although this treatment costs less than half as much as residential care for substance-abusing adolescents, it also costs approximately $4,500 to train each individual practitioner.7,8 More generally, it has proven difficult to implement family treatment models in community-care settings because they require significant staff training and supervision, agency support, and resources; efforts to implement these models in community care have yielded mixed findings.8,10 It will be an ongoing challenge to find ways to empirically adjust family treatment models to meet the needs and resource constraints of community clinics without compromising the fidelity of the models—a common problem when attempting to bridge the gaps between research and community-based practice.7 It is noteworthy, however, that since many studies of MDFT had treatment administered by trained, non-research, masters-level clinicians, there is reason for cautious optimism that the model can be implemented effectively in clinical settings.7

Many studies investigating the treatment of adolescent substance abuse (through various approaches, including
MDFT) have reported clinically significant outcomes, methodological flaws were common: the use of nonrandomized samples; the absence of control groups or of details about how subjects were selected; and small sample sizes. Although one study, for example, found that MDFT decreased relevant risk factors for many substance-abusing African American, Hispanic, and white youth and that it helped them reintegrate into the community from juvenile detention, the researchers concluded that their results were preliminary and that further study, of better experimental design, was required. This acknowledgment was needed because, among other things, several parts of the treatment had not been incorporated into the study or had to be discontinued due to resource constraints.

Research on adolescent substance abuse is becoming more rigorous methodologically; for example, most studies now report baseline data, use treatment manuals, and supplement adolescent self-reports with collateral reports. But as also made clear in a recent presentation to the New York State Society for Clinical Social Work, there are ongoing changes in the potency of available drugs, in adolescent drugs-of-choice, and in preferred methods of abuse. Further study is therefore needed to establish the efficacy of MDFT (as well as other interventions) against contemporary trends in adolescent substance abuse and what may be a changing culture of adolescent substance abuse.

Declaration of interest: The author reports no conflicts of interest. The author alone is responsible for the content and writing of the article.

REFERENCES