Multidimensional Family Therapy – MDFT for Adolescent Substance Abuse and Delinquency

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Center for Treatment Research on Adolescent Drug Abuse

About the Center

Research Projects

Multidimensional Family Therapy

The Joseph Samuel Isicoff Program

Publications

Presentations

Our Team

Shared Resources

1120 NW 14th Street
Miami, FL 33136
Tel: 305-243-6434
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CENTER FOR TREATMENT RESEARCH ON ADOLESCENT DRUG ABUSE

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Faculty

Howard A. Liddle, Ed.D.
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Interests: Development and empirical refinement of family-based interventions for adolescent drug abuse and conduct disorder, process and outcome studies, and research on the adaptation and adoption of empircally-supported treatment in non-research, community settings.

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Investigator, Center for Treatment Research on Adolescent Drug Abuse; Research Assistant Professor, Department of Epidemiology & Public Health, UM Medical School

Interests: Adolescent drug abuse and delinquency, development and testing of family-based interventions for female adolescent drug abuse, drug court evaluation.

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Interests: Psychiatric comorbidity and typologies of adolescent substance abuse; family-based interventions for youth with substance abusing parents.

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multidimensional

FAMILY THERAPY

www.mdft.org

Themes

- Evidence based therapy and therapies
- Research evidence
- Conceptual framework and clinical thinking
- Organized approach, principles, core areas of work, core sessions, and core interventions
- Illustrate application in DVDs and practice activities
- Therapist factors are keys to success

The New York Times
Published: August 15, 2011
Health

Cancer's Secrets Come Into Sharper Focus

For the last decade cancer research has been guided by a how a single cell, outcompeting its neighbors, evolves into a malignant tumor.

Through a series of random mutations, genes that encourage cellular division are pushed into overdrive, while genes that normally send growth-restraining signals are taken offline.

Recent discoveries have been complicating the picture with tangles of new detail. Cancer appears to be even more willful and calculating than previously imagined.

Most DNA, for example, was long considered junk - Only about 2 percent of the human genome carries the code for making enzymes and other proteins. These days "junk" DNA is referred to more respectfully as "noncoding" DNA, and researchers are finding clues that "pseudogenes" lurking within this dark region may play a role in cancer.

This spring, at the annual meeting of the American Association for Cancer Research, Dr. Pier Paolo Pandolfi, a professor of medicine at Harvard Medical School, described a new "biological dimension" in which signals coming from both regions of the genome participate in the delicate balance between normal cellular behavior and malignancy. He described how genes in this microbiome exchanging messages with genes inside human cells may be involved with cancers of the colon, stomach, esophagus and other organs.

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Lymph Node Study Shakes Pillar of Breast Cancer Care

By DENISE GRADY
Published: February 8, 2011

Q. & A.: Breast Cancer and Lymph Nodes

Denise Grady, is taking questions about this study and its implications for breast cancer treatment.

· Submit your question.

Multimedia

Less Surgery for Breast Cancer?

A new study finds that many women with early breast cancer do not need a painful procedure that has long been routine: removal of cancerous lymph nodes from the armpit.

The discovery turns standard medical practice on its head. Surgeons have been removing lymph nodes from under the arms of breast cancer patients for 100 years, believing it would prolong women's lives by keeping the cancer from spreading or coming back.

Now, researchers report that for women who meet certain criteria — about 20 percent of patients, or 40,000 women a year in the United States — taking out cancerous nodes has no advantage. It does not change the treatment plan, improve survival or make the cancer less likely to recur. And it can cause complications like infection and lymphedema, a chronic swelling in the arm that ranges from mild to disabling.

Removing the cancerous lymph nodes proved unnecessary because the women in the study had chemotherapy and radiation, which probably wiped out any disease in the nodes, the researchers said. Those treatments are now standard for women with breast cancer in the lymph nodes, based on the realization that once the disease reaches the nodes, it has the potential to spread to vital organs and cannot be eliminated by surgery alone.

Do We Have the National Will to Fight Cancer?

Published: April 4, 2007

To the Editor:

As the articles in "Humans vs. Cancer: Who's Winning Now?" illustrate (Op-Ed, April 1), **there is no shortage of ideas for how to deal with cancer. What appears to be missing, however, is a sense of urgency -- an appreciation of cancer as the grave and growing crisis it is -- and the national will to confront it.**

If terrorists unleashed a biological attack on American soil that started killing more than 1,500 Americans every day, as cancer does, wouldn't we mobilize every national resource to find an antidote or a cure?

It is a national shame that many Americans -- racial and ethnic minorities, the poor and those with little or no health insurance -- are less likely to receive quality cancer care and therefore more likely to die.

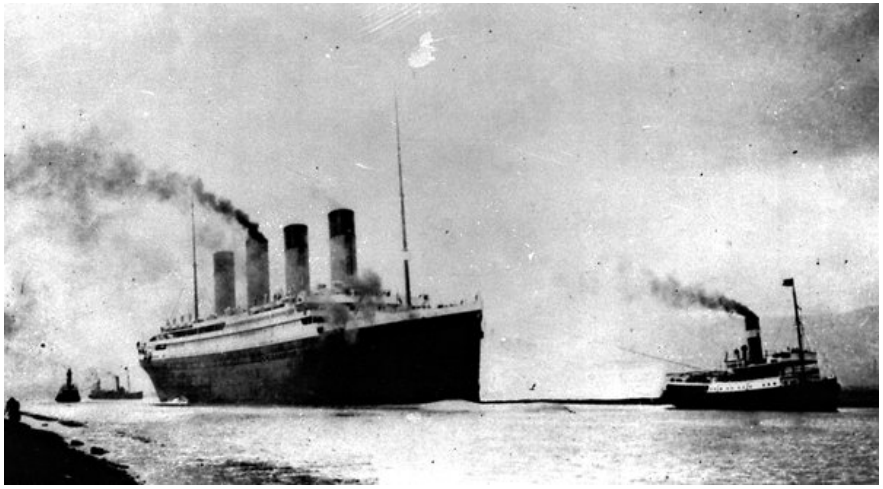
As the American public and both political parties did when launching the war on cancer more than three decades ago, we need to summon the will to make cancer a national priority once again.

Nancy G. Brinker
Founder
Susan G. Komen for the Cure

Palm Beach, Fla., April 2, 2007

The New York Times Science
Published: April 9, 2012 By WILLIAM J. BROAD

The Iceberg Was Only Part of It



What doomed the Titanic is well known, at least in outline. On a moonless night in the North Atlantic, the liner hit an iceberg and disaster ensued, with 1,500 lives lost.

Hundreds of books, studies and official inquiries have addressed the deeper question of how a ship that was so costly, and so well built could have ended so terribly. Now, a century after the liner went down in the early hours of April 15, 1912, two new studies argue that rare states of nature played major roles in the catastrophe.

The first says Earth's nearness to the Moon and the Sun — a proximity not matched in more than 1,000 years — resulted in record tides that help explain why the Titanic encountered so much ice, including the fatal iceberg. And a second, put forward by a Titanic historian from Britain, contends that the icy waters created ideal conditions for an unusual type of mirage that hid icebergs from lookouts and confused a nearby ship as to the liner's identity, delaying rescue efforts for hours.

Scholars of the Titanic, as well as scientists, are debating the new theories. Some question whether natural factors can outweigh the significance of ineptitude. Others find the mirage explanation plausible — but only in limited scenarios. Over all, though, many experts are applauding the fresh perspectives. "It's important new information that can help explain some of the old mysteries," said George M. Behe, author of "On Board R.M.S. Titanic," a 2010 book that chronicles the letters, postcards and accounts of the ship's crew and passengers.

By TODD NEALE
Dec. 12, 2009

Is Your Doctor Outdated?

Doctor's Orders is a feature in the collaboration between MedPage Today and ABC News. In this monthly segment, we explore medical issues of interest to physicians and patients alike. This month, we look at the difficulties physicians face in incorporating evidenced-based medicine into their practice.

With the amount of research being published in medical journals and presented at meetings, it should not be surprising when a new finding slips by a busy physician. Nor should it be surprising, then, that some decisions about patient care might be made without benefit of the most recent evidence.

Although experts interviewed by MedPage Today agreed that keeping up with the most current information is challenging, it's unclear exactly how widespread the phenomenon of the outdated doctor is. "To some degree or another, I think it's very widespread," said Richard Deyo, MD, a professor of evidence-based family medicine at Oregon Health & Science University in Portland.

But he added that it's not a black-and-white issue, because physicians can be up to date in one area and lagging behind in another. Lori Heim, MD, president of the American Academy of Family Physicians, agreed that it's difficult to put a solid number on how many doctors are practicing outdated medicine.

She said a good place to start would be with the numerous studies that have found that many patients do not receive recommended care for various conditions. One such study, released in the New England Journal of Medicine in 2003, reviewed the care received by surveyed adults in the two years preceding a telephone interview. A review of their medical records found that only 54.9 percent of the time did they get the care recommended for their condition.

Adolescents

- Individuals
- Family members
- Peer group participants
- Involved in multiple settings impacting development
- Societal, media images
- The clinician's contribution

Extra! March/April 1994

Bashing Youth

Media Myths About Teenagers

By **Mike Males**

During the 1980s and 1990s, various public and private entrepreneurs realized that the news media will circulate practically anything negative about teens, no matter how spurious. A few examples among many:

* In 1985, the National Association of Private Psychiatric Hospitals,defending the profitable mass commitment of teenagers to psychiatric treatment on vague diagnoses, invented the "fact" that a teenager commits suicide "every 90 minutes"--or 5,000 to 6,000 times every year. Countless media reports of all types, from the **Associated Press** (4/4/91) to **Psychology Today** (5/92), continue to report this phony figure, nearly three times the true teen suicide toll, which averaged 2,050 per year during the 1980s (*Vital Statistics of the United States*).

* In a 1991 campaign to promote school-based clinics, the American Medical Association (AMA) and the National Association of State Boards of Education published a report that inflated the 280,000 annual births to unmarried teenaged mothers into "half a million," and claimed a "30-fold" increase in adolescent crime since 1950. In fact, 1950 youth crime statistics are too incomplete to compare, and later, more comprehensive national reports show no increase in juvenile crime rates in at least two decades. (Contrast, for example, the FBI Uniform Crime Reports for 1970 and 1992.) The facts notwithstanding, the national media (e.g., **AP**, 6/8/90) dutifully publicized the organizations' exaggerations.

* In the early '80s, officials hyping the "war on drugs" orchestrated media hysteria about "skyrocketing" teenage drug abuse at a time when, in fact, teenage drug death rates were plummeting (down 70 percent from 1970 to 1982). In the late '80s, the same media outlets parroted official claims of a drug-war "success" when, in reality, youth drug death rates were skyrocketing (up 85 percent from 1983 to 1991--see **In These Times**, 5/20/92).

Today, official and media distortions are one and the same. Who's to blame for poverty? Teenage mothers, declares Health and Human Services Secretary Donna Shalala in uncritical news stories (see **Los Angeles Times**, 12/12/93) that fail to note that teenage mothers on welfare were poor before they became pregnant.

Who's causing violence? "Kids and guns," asserts President Clinton, favorably quoted by reporters (**AP**, 11/14/93) who neglect to mention that six out of seven murders are committed by adults. Who's dying from drugs, spreading AIDS, committing suicide? Teenagers, teenagers, teenagers, the media proclaim at the behest of official sources, even though health reports show adults much more at risk from all of these perils than are adolescents.

"The easiest thing about being a teenager is still having a sort of romantic perspective or outlook on the world: not being jaded or disillusioned; and knowing — hoping — that you have time to do what you want and to achieve what you want.“

Maybe I was wrong that that's specific to being a teenager. I think you have to work ard, though, not to let yourself forget that feeling of having dreams and aspirations nd knowing that there's nothing that can stop you."

Patrick Roberts, 19, of Lawrence, Kan.

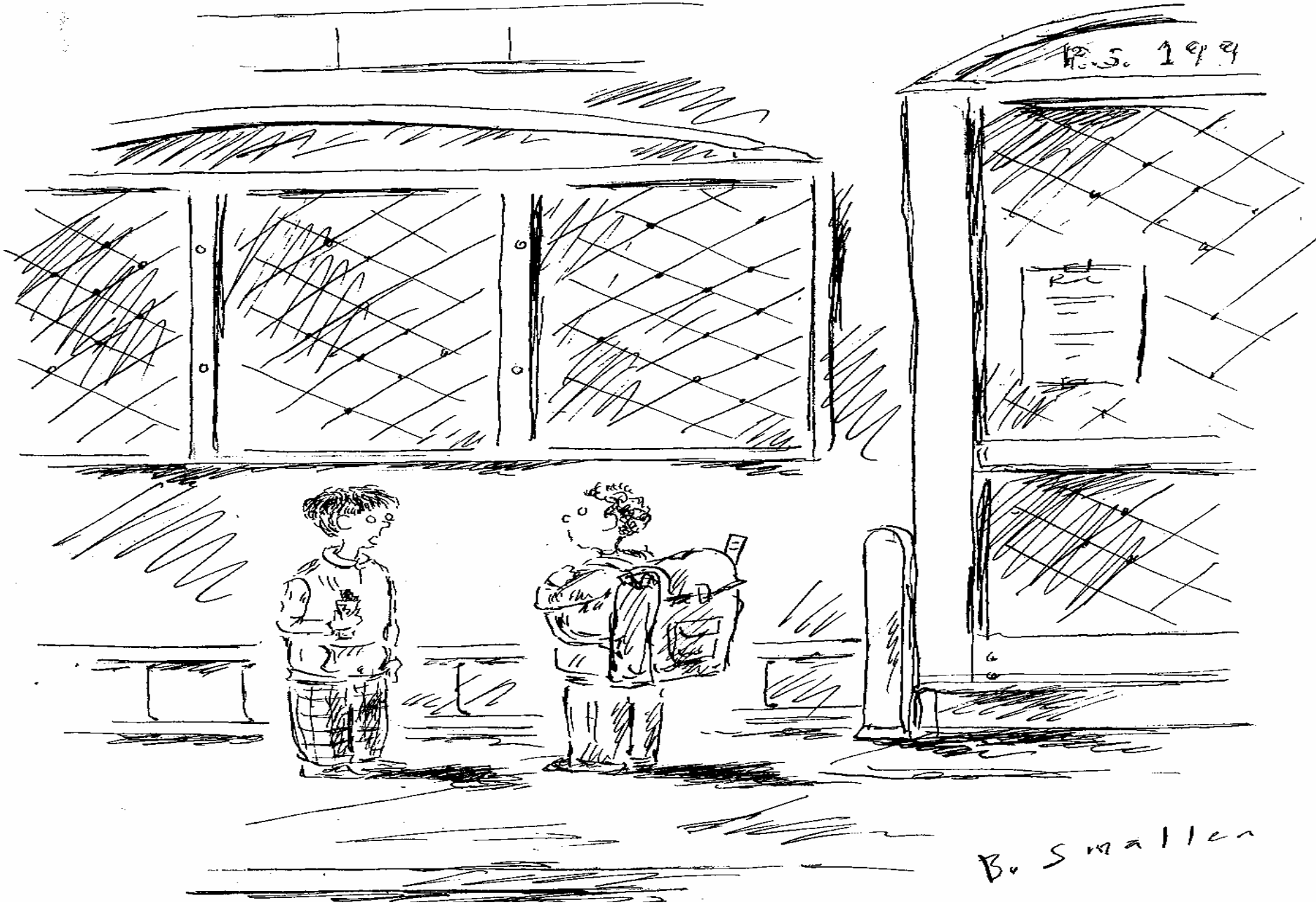
Beyond the self…

In wolves and dogs there is a close association between mothers and puppies during the first three weeks of like. After this period, and at the time when the mother leavers the litter for long periods, the strongest relationships are formed with litter mates. This is the basis of pack organization of adult dogs and wolves.”

John Paul Scott

Animal Behavior (1958)

"Gee, Tommy, I'd be lost without your constant peer pressure."



"No one's last words were 'I wish I'd done more homework.'"

"You know you've got it right when your parents can't look at you without wincing!"

"Your mother and I are feeling overwhelmed, so you'll have to bring yourselves up."

"What's this they say, Billy, about a new, more virulent strain of teen-ager?"

“…everybody should have a chance to do well and they shouldn’t be picked on because they’re not rich enough to afford stuff.”
Stewart McAdams, 16, and Ray Mowrer, 18 of Jolo, W. Va;
Jeremy Ball, 17, of Bradshaw, W.Va; Mathew Phillips, 17, of Paynesville, W.Va.

“I guess I always knew I would be a debutante…”
Amy Heldenfels, 19, of Austin, Texas

“My parents don’t know, but I have a little television.”
Noami Sue Kramer, 18,
and Marjorie Lynn Kramer, 17, of Jamesport, Mo.

“I would kill my sister if she was in a gang … I don’t want her following what I do.”

Ebony Wilson, 15, of the Bronx, N.Y.

Point of View

Three Worlds

M. C. Escher 1955

Multiple contexts

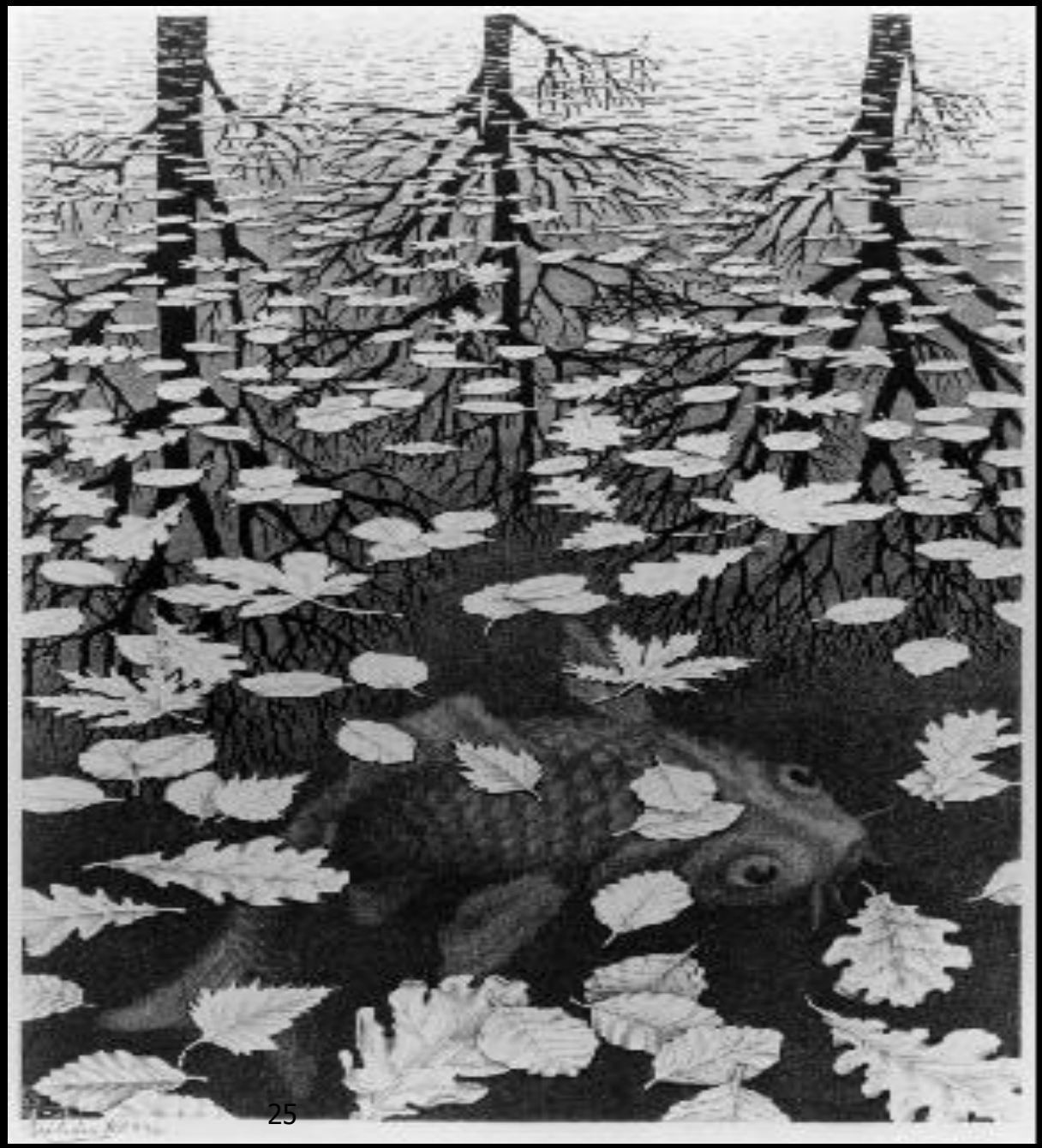
Holon – Both whole and part

- *Self*
- *Family*
- *Peers*

Interdependent

Interactive

Changing relationship over time



“O chestnut tree, great rooted blossomer,
Are you the leaf, the blossom, or the bole?
O body swayed to music, O brightening glance,
How can we know the dancer from the dance?”

William Butler Yeats (1928)

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Drug abuse and developmental psychopathology

MEYER D. GLANTZ AND ALAN I. LESHNER
National Institute on Drug Abuse, National Institutes of Health

"There is little question that drug abuse results from both intraindividual and environmental factors. For this reason, unidimensional models of drug abuse are invariably inadequate and multidimensional research and intervention approaches are necessary. For example, multidimensional treatment of drug abuse is more effective and has become common practice."
(Glantz & Leshner, 2000, p. 796)

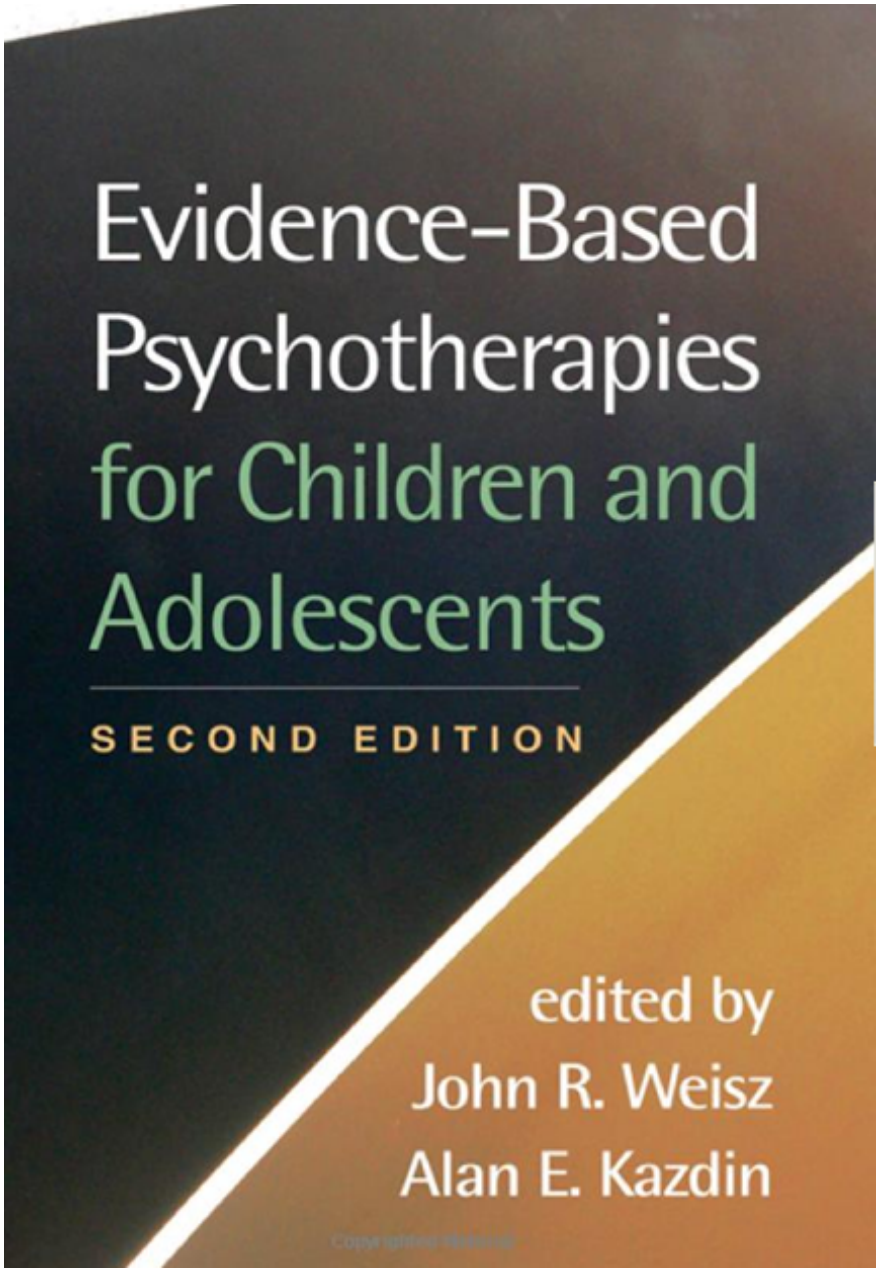
"You' d better start swimmin'
or you' ll sink like a stone
For the times they are a-changin' "

Developmental Stage

- Renaissance of adolescent treatment
- New treatments and methods exist
- Feasibility and efficacy has been established
- Mechanisms are being investigated
- Generalizability has been addressed
- Treatment manuals are available
- Training models and materials exist
- Full generalizability has not been established

New Generation of Interventions

- Integrative
- Connected to basic research on development and dysfunction
- Diverse approaches
- Expanded in scope: Multiple systems of assessment & intervention
- Brief interventions as well
- Context of service delivery
- Well specified protocols
- Programs of work



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Treating Adolescent Substance Abuse Using Multidimensional Family Therapy

HOWARD A. LIDDLE

OVERVIEW OF THE CLINICAL PROBLEM

The nature of a clinically referred adolescent's presenting problems makes treating teen drug abuse challenging. These problems are multivariate, such as the often secretive aspects of drug use; involvement in illegal and criminal activities with antisocial or drug-using peers; despairing, stressed, and poorly functioning families; involvement in multiple social agencies; disengagement from school and other prosocial contexts of development; and lack of intrinsic motivation to change. Many new developments in the drug abuse and delinquency specialties provide guidance and hope. We have witnessed an unprecedented volume of basic and treatment research, increased funding for specialized youth services, and a burgeoning interest in the problems of youths from basic research and applied prevention and treatment scientists, policymakers, clinicians and prevention programmers, professional and scientific societies, mass media and the arts, and the public at large. Developmental psychology and developmental psychopathology research has revealed the forces and factors that combine and contribute to the genesis of teen drug experimentation and abuse. Perhaps a consensus about a preferred conceptualization and intervention strategy has been reached. Leading figures in the field now conclude that drug abuse results from both intraindividual and environmental factors. For this reason, unidimensional models of drug abuse are inadequate and multidimensional research and intervention approaches are necessary.

This chapter summarizes multidimensional family therapy (MDFT), a family-based therapy with considerable empirical support for its effectiveness with teen drug abuse and delinquency (Liddle, 2004). Three frameworks help therapists use the research knowledge base on teen drug use. The *risk and protective factor* framework informs clini-

http://www.amazon.com/gp/product/1593859740/ref=pd_lpo_k2_dp_sr_1?pf_rd_p=486539851&pf_rd_s=lpo-top-stripe-1&pf_rd_t=201&pf_rd_i=1572306831&pf_rd_m=ATVPDKIKX0DER&pf_rd_r=1TD61YG07RH8CA8J8HZ9#_

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Treating Adolescent Substance Abuse Using Multidimensional Family Therapy

HOWARD A. LIDDLE

Overview of the Clinical Problem

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MDFT Research Program - Features & Themes

- Began in 1985 - NIDA 90%; CSAT 8&; Private Foundations 2%
- Defining and testing different versions - MDFT as treatment system
  - Variations (versions) according to stage & nature of dysfunction, age, gender, cultural / ethnic factors, clinical setting
- Research-based knowledge about development and dysfunction
  - Own and others use; delinquency; school problems
- Therapeutic ingredients and processes
  - Alliance, parenting, culture, in-session conflict
- Therapist competence and development
  - Stages and methods of training, context factors
- Efficacy: Rigorous treatment evaluation under “ideal” conditions
- Effectiveness: Rigorous treatment evaluation in regular clinical settings
  - Drug court, residential vs. intensive outpatient, community clinics
- Economic / cost studies
- Transportation / implementation studies

MDFT Outcomes: 2012 12th RCT

Outcome Domain	Finding
Substance Use/ Delinquency	▪ MDFT more likely to abstain from drug use ▪ MDFT more significant decrease in frequency of drug use ▪ MDFT less likely to report drug use problems ▪ MDFT more significant decrease in # of drug use problems ▪ MDFT decreases delinquency more significantly ▪ MDFT less likely to be arrested or placed on probation
Individual **Externalizing** **Internalizing**	▪ MDFT more significant decrease in parent and adolescent reports ▪ MDFT more significant decrease in self-reports
Family	▪ MDFT more significant increase in positive family interactions (self report and behavioral ratings)
Peer	▪ MDFT more significant decrease in affiliation with delinquent peers
School	▪ MDFT more significant improvements in academic and conduct grades ▪ MDFT more significant decreases in absences

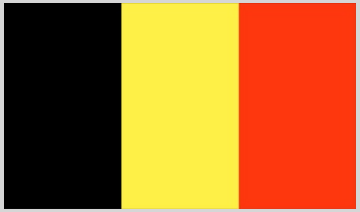
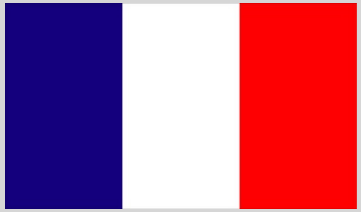
p's all <.05; d's range from .27-.83; most effect sizes in medium-large range

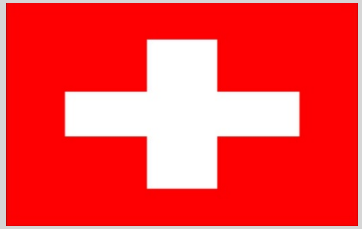
Treatment Outcome Studies

- MDFT, Group, Multi-Family Clinical Trial
- MDFT - Individual CBT Clinical Trial
- MDFP Prevention Trial
- CYT Multisite Clinical Trial
- MDFT - Group Early Adolescent Clinical Trial
- Alternative to Residential Treatment
- Transporting MDFT to Day Treatment
- Brief Version of MDFT (NIDA)
- Long Term Follow Up (NIDA)
- Cost Outcomes (NIDA)
- Juvenile Drug Court (NIDA)
- Dependency Drug Court (NIDA)
- Detention to Community (DTC) & DTC-I (in Conn. 2009-2012)
- INCANT (5 European Health Ministries)

INCANT (INternational CAnnabis Need of Treatment)

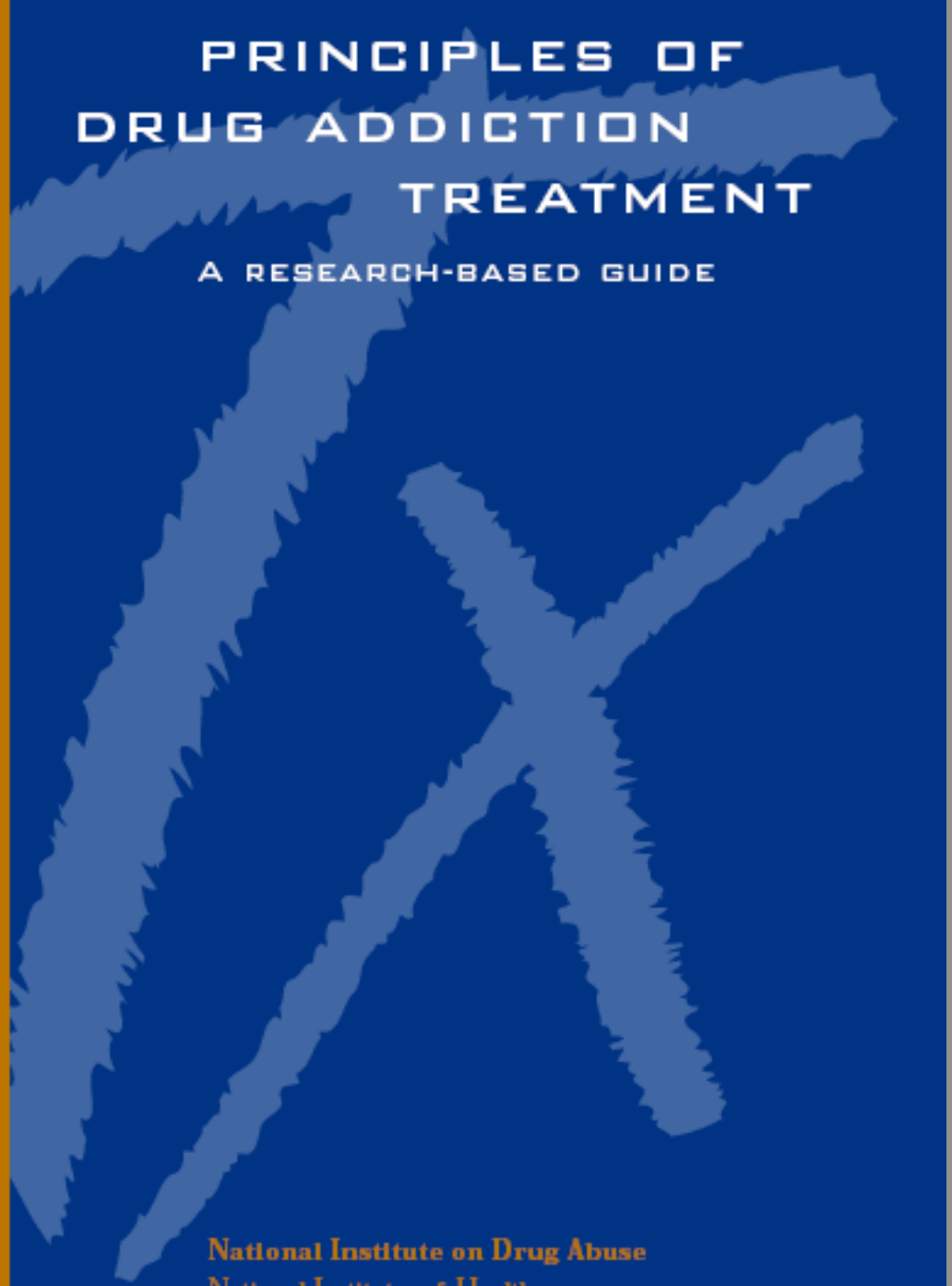
H. Rigter, Erasmus U., Rotterdam, The Netherlands



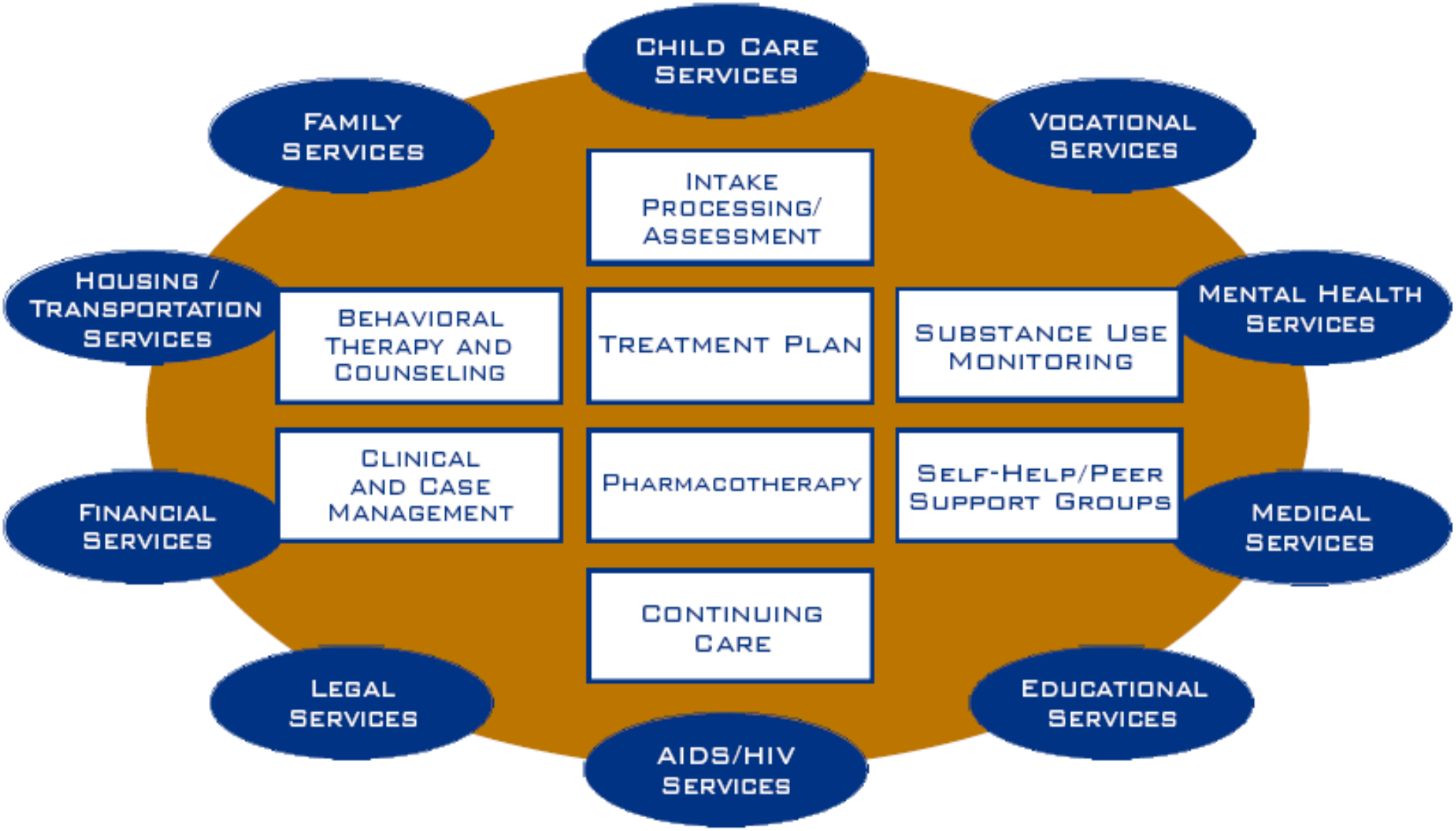
PRINCIPLES OF DRUG ADDICTION TREATMENT

A RESEARCH-BASED GUIDE



National Institute on Drug Abuse
National Institutes of Health

Components of Comprehensive Drug Abuse Treatment



The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

Multidimensional Family Therapy (MDFT) For Adolescents

is an outpatient family-based drug abuse treatment for teenagers. MDFT views adolescent drug use in terms of a network of influences (that is, individual, family, peer, community) and suggests that reducing unwanted behavior and increasing desirable behavior occur in multiple ways in different settings. Treatment includes individual and family sessions held in the clinic, in the home, or with family members at the family court, school, or other community locations.

During individual sessions, the therapist and adolescent work on important developmental tasks, such as developing decisionmaking, negotiation, and problem-solving skills. Teenagers acquire skills in communicating their thoughts and feelings to deal better with life stressors, and vocational skills. Parallel sessions are held with family members. Parents examine their particular parenting style, learning to distinguish influence from control and to have a positive and developmentally appropriate influence on their child.

National Institute on Drug Abuse

Principles of Drug Abuse Treatment for Criminal Justice Populations | A Research-Based Guide

National Institutes of Health
U.S. Department of Health and Human Services

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Treating Teens

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This website is a companion to the Drug Strategies publication *Treating Teens: A Guide to Adolescent Drug Programs*, which was supported by a grant from the Robert Wood Johnson Foundation. The guide is designed to help parents, teachers, judges, counselors and other concerned adults make better choices about teen substance abuse treatment. To order the 60-page *Treating Teens* publication, which includes practical resources for parents such as Ten Important Questions to Ask a Treatment Program,
CLICK HERE.

The PROGRAMS section provides a searchable database with extensive information on how 144 teen substance abuse treatment programs across the country implement the nine key elements of effective adolescent treatment determined by Drug Strategies' panel of specialists.

Internet

Key Elements of Effectiveness

Bridging the Gap:

A Guide to Drug Treatment in the Juvenile Justice System

www.drugstrategies.org

Multidimensional Family Therapy

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Multidimensional Family Therapy (MDFT) outpatient therapy concentrates on the individual adolescent, the parents, the family and youth together, and systems that affect the youth's life, including schools, juvenile justice, peer groups and the community. Based on a strong theoretical structure of developmental psychological principles, MDFT views any interaction between the therapist and the client/family as an opportunity to provide treatment. Three-quarters of the program's clients are referred by the juvenile justice system. The program has been implemented in more than a dozen sites nationwide and six other countries. Federally funded since 1985, MDFT costs one-third less on average than standard outpatient or residential treatment.

FAMILY INVOLVEMENT

MDFT believes that a good parent/child relationship is a powerful protective factor against substance abuse. Therapists work on resolving parents' personal mental health and substance use issues, teaching parenting skills and addressing the family environment as a whole. An MDFT therapist conducts an initial assessment of various risk factors, including familial drug use, family relationships, communication and conflict. Observation, interaction and clinical interviews are used to assess individual and family functioning. In order to gain parental cooperation, therapists acknowledge participants' past efforts and encourage them to express their frustrations with their children's drug use and behavioral problems. Earlier hopes and dreams of parents for their children are discussed, which often motivate parents to try once more. Therapists refer families to any needed services, and remain in close contact with the juvenile justice system, schools, peer groups, and other community services in order to coordinate services and monitor progress.

Family sessions, individual sessions with parents and adolescents, and meetings with relevant social service agencies and the teen and parent occur one to four times a week for four to eight months, depending on the level of treatment intensity. Phone calls are used extensively both to check in on progress and to give new tips on how to effect changes between face-to-face sessions. Topics addressed in family therapy include the family's mental health and substance use, how to adjust parenting strategies based on the child's developmental level, and how family relationships can support the developmental challenges of adolescents and parents. Adolescents and families also work on relapse prevention strategies following completion of treatment.

RESULTS

Located in a research center at the University of Miami, MDFT has been found to be effective in four separate randomized clinical trials as well as several therapy process studies over the past ten years. MDFT participants in one randomized study from 2001 showed a clinically significant reduction of drug use at one year post-treatment and improvement in family functioning when compared to two alternative treatment approaches. Outcome measures were taken at 6 and 12 months post-treatment with abstinence confirmed through urinalysis. At one-year post-treatment, 45 percent of youths who had received MDFT reported clinically significant reductions in drug use, compared to 32 percent and 26 percent of adolescents in the other two groups. Grade point average (GPA) also improved significantly. At intake, 20 percent of the MDFT population had a GPA of 2.0 or better. At one-year follow-up, the percentage increased to 76 percent.

Challenges: MDFT researchers are currently seeking to facilitate the adoption of the program in a variety of non-research clinical settings. The challenges of applying MDFT in real world environments are largely related to staff training issues and providing the necessary time and resources to teach clinicians how to implement MDFT.

Key Elements of Effectiveness

Both treatment research and clinical practice suggest that certain elements are critically important in providing effective drug treatment to adolescents in the juvenile justice system. Drug Strategies, guided by an expert advisory panel, has identified the following eleven key elements:

Systems Integration

Assessment and Treatment Matching

Recognition of Co-Occurring Disorders

Comprehensive Treatment Approach

Qualified Staff

Developmentally Appropriate Program

Family Involvement in Treatment

Engage and Retain Teens in Treatment

Gender and Cultural Competence

Continuing Care

Treatment Outcomes

Adolescents & Families

"I doubt that there is an influence on the development of antisocial behavior among young people that is stronger than that of the family." (Steinberg, 2000)

Families

"The most successful programs are those that emphasize family interactions, probably because they focus on providing skills to the adults who are in the best position to supervise and train the child." (Greenwood, 2009)

Families

"In this era of an increased focus on public sector accountability, one of the important questions posed to policymakers and elected officials may be *'Why are you waiting so long to support families?'* " (Duchnowski, Hall, Kutash, & Friedman, 1998)

"Families play the most important role in determining how children handle the temptations to use alcohol, cigarettes, and illegal drugs."

Protecting Adolescents From Harm

Findings From the National Longitudinal Study on Adolescent Health

Michael D. Resnick, PhD; Peter S. Bearman, PhD; Robert Wm. Blum, MD, PhD; Karl E. Bauman, PhD; Kathleen M. Harris, PhD; Jo Jones, PhD; Joyce Tabor; Trish Beuhring, PhD; Renee E. Sieving, PhD; Marcia Shew, MD, MPH; Marjorie Ireland, PhD; Linda H. Bearinger, PhD, MS; J. Richard Udry, PhD

JAMA, September 10, 1997—Vol 278, No. 10

Context.—The main threats to adolescents' health are the risk behaviors they choose. How their social context shapes their behaviors is poorly understood.

Objective.—To identify risk and protective factors at the family, school, and individual levels as they relate to 4 domains of adolescent health and morbidity: emotional health, violence, substance use, and sexuality.

Design.—Cross-sectional analysis of interview data from the National Longitudinal Study of Adolescent Health.

Participants.—A total of 12 118 adolescents in grades 7 through 12 drawn from an initial national school survey of 90 118 adolescents from 80 high schools plus their feeder middle schools.

Setting.—The interview was completed in the subject's home.

Main Outcome Measures.—Eight areas were assessed: emotional distress; suicidal thoughts and behaviors; violence; use of 3 substances (cigarettes, alcohol, marijuana); and 2 types of sexual behaviors (age of sexual debut and pregnancy history). Independent variables included measures of family context, school context, and individual characteristics.

Resnick et al., 1997: Main findings

- High levels of connectedness to parents and family members were associated with less frequent alcohol use among both [7th-8th and 9th-12th grade] groups of students.
- Among older students, more frequent parental presence in the home was associated with less frequent use.
- With notable consistency across the domains of risk, the role of parents and family in shaping the health of adolescents is evident.
- While not surprising, the protective role that perceived parental expectations play regarding adolescents' school attainment emerges as an important recurring correlate of health and healthy behavior.
- Likewise, while physical presence of a parent in the home at key times reduces risk (and especially substance use), it is consistently less significant than parental connectedness (e.g., feelings of warmth, love, and caring from parents).

Clinical Pediatrics
http://cpj.sagepub.com/

Family Environment Factors and Substance Abuse Severity in an HMO Adolescent Treatment Population

Nancy S. Wu, Yun Lu, Stacy Sterling and Constance Weisner

CLIN PEDIATR 2004 43: 323
DOI: 10.1177/000992280404300403

Summary: To examine how parental limit setting, family conflict, and perception of family experience influence severity of alcohol and drug problems, and important gender differences in these relationships, we interviewed consecutive intakes, aged 12 to 18 years, at 4 chemical dependency programs of a large group-model nonprofit health maintenance organization (HMO) (n=419). The Family Conflict, Limit Setting, and Positive Family Experience scales correlated with substance dependence ($p<0.01$, $p<0.01$, $p<0.05$, respectively). Depression also correlated with family conflict ($p<0.01$), absence of limit setting ($p<0.01$), poor family experience ($p<0.01$) and dependence symptoms ($p<0.01$). Number of substance-using friends correlated with number of dependence symptoms ($p<0.01$). Gender differences included the following: (1) girls scoring higher in family conflict ($p=0.0002$), negative perceptions of family experience ($p<0.0017$), and lower in absence of limit setting ($p<0.0001$); (2) how family environment predicted problem severity: absence of limit setting was significant for boys and girls but family conflict for boys only; (3) girls had more dependence symptoms ($p=<0.0001$), psychiatric diagnoses (e.g., depression ($p<0.0003$), anxiety ($p<0.0002$), conduct disorder ($p=0.07$)), and substance-abusing family members (53 % versus 39%; $p=0.006$). To conclude, family and peers influence severity of alcohol and drug problems in adolescents. *Clin Pediatr.* 2004;43:323-333

Wu et al., 2010: Family Environment

- Family environment - an important factor affecting adolescent substance use
- Parental substance use correlates with adolescent substance use
- Parental use is also related to an adolescent's choice of friends - adolescents living in families whose members have a drug problem are more likely to have friends who use drugs
- Family conflict is related to greater adolescent substance use
- And, more alcohol use in families goes with greater conflict
- Negative parent-child interactions to be a risk factor for alcohol and drug dependence
- Family conflict mediates the relationship between peer pressure and adolescent drug use and influences the severity of substance use

Wu et al., 2010: Family Protective Factors

- Certain family factors are protective against adolescent substance use initiation and continued use
- Parental support and connectedness, which include emotional support and expressions of interest in the child, affect the development of adolescent substance use behaviors
- Teenagers with a high level of support have a lower incidence of alcohol-related problems and are also less likely to initiate smoking.
- Family bonding and parent-family connectedness are associated with less frequent cigarette, alcohol, and marijuana use

Wu et al., 2010: Parental Monitoring

- Parental monitoring, (knowing where, how, and with whom the child spends time) is an important factor in adolescent substance use
- Adolescents perceiving less parental monitoring were more likely to have a history of alcohol and marijuana use and more frequent use in the past 30 days
- Children in the lowest quartile of parent monitoring initiated drug use at earlier ages
- Parental monitoring is an important predictor of drinking, delinquency, and problem behaviors
- Parental monitoring protects against the selection of substance-using friends
- Positive parental monitoring reduces drug severity at intake, help prevent initiation of drug use, and decreases affiliation with substance-using peers

J Abnorm Child Psychol (2009) 37:749–775
DOI 10.1007/s10802-009-9310-8

The Relationship Between Parenting and Delinquency: A Meta-analysis

Machteld Hoeve · Judith Semon Dubas · Veroni I. Eichelsheim · Peter H. van der Laan · Wilma Smeenk · Jan R. M. Gerris

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Abstract This meta-analysis of 161 published and unpublished manuscripts was conducted to determine whether the association between parenting and delinquency exists and what the magnitude of this linkage is. The strongest links were found for parental monitoring, psychological control, and negative aspects of support such as rejection and hostility, accounting for up to 11% of the variance in delinquency. Several effect sizes were moderated by parent and child gender, child age, informant on parenting, and delinquency type, indicating that some parenting behaviors are more important for particular contexts or subsamples. Although both dimensions of warmth and support seem to be important, surprisingly very few studies focused on parenting styles. Furthermore, fewer than 20% of the studies focused on parenting behavior of fathers, despite the fact that the effect of poor support by fathers was larger than poor maternal support, particularly for sons. Implications for theory and parenting are discussed.

Keywords Child-rearing · Delinquency · Meta-analysis · Moderators · Development

Hoeve et al., 2009: Meta-analysis main findings

- Meta-analysis 161 studies -- the *association between parenting and delinquency*
- The strongest links were found for parental monitoring, psychological control, and negative aspects of support such as rejection and hostility, accounting for up to 11% of the variance in delinquency
- Although both dimensions of warmth and support seem to be important, surprisingly very few studies focused on parenting styles
- Fewer than 20% of the studies focused on parenting behavior of fathers, despite the fact that the effect of poor support by fathers was larger than poor maternal support, particularly for sons

Hoeve et al., 2009: Results

- The strongest mean effect sizes were found for negative aspects of support such as neglect, hostility and rejection or combinations of these parenting behaviors (ESr ranges from 0.26 to 0.33).
- Parental monitoring, either active monitoring by parents, parental knowledge or child disclosure, was relatively strongly linked to delinquency (ESr ranges from –0.23 to –0.31). Furthermore, moderate effect sizes were found for psychological control and overprotection (ESr ranges from 0.21 to 0.23).
- There are significant links between all parenting dimensions and delinquency but the magnitude of the relation depends on the particular parenting dimension. The strongest links were found for psychological control (ESr=0.23) and the weakest links were found for authoritative and authoritarian control (ESr=0.12).
- Analyzing discrete parenting behaviors (i.e., subcategories within parenting dimensions) revealed that differences were even larger. The strongest mean effect sizes were found for negative aspects of support such as neglect, hostility and rejection or combinations of these parenting behaviors (Esr ranges from 0.26 to 0.33
- Parental monitoring, either active monitoring by parents, parental knowledge or child disclosure, was relatively strongly linked to delinquency (Esr ranges from –0.23 to –0.31).
- Results are in accordance with the finding of Loeber and Stouthamer-Loeber (1986) that parental rejection and poor supervision were among the best predictors of delinquency.

Hoeve et al., 2009: Conclusion

- "The results of this meta-analysis have implications for theories on parenting. Analyzing parenting dimensions, we found significant difference between various types of control including authoritative, authoritarian, behavioral and psychological control, with the highest effect sizes for psychological control.

- "Delinquent behavior is inhibited during childhood and adolescence by bonds to the family and school. During (young) adulthood, social ties to labor or marriage and other turning points in life can modify trajectories of criminal offending. Thus, the findings in the present meta-analysis favor dynamic theories."

Chassin et al (2009). Substance use treatment outcomes in a sample of male serious juvenile offenders. JSAT.

- Criminal offending is the outcome of most direct interest in terms of justice system policy implications
- Only interventions with family involvement produced statistically significant reductions in nondrug offending (compared to treatments without family involvement).
- Our findings are consistent with those that have supported the use of family therapy (multidimensional family therapy, multisystemic therapy, functional family therapy) in reducing antisocial behavior among adolescents (Liddle, 2004) and Woolfenden et al, 2002).
- Moreover, some evidence of effect was still detectable 1 year after the termination of treatment. Thus, although alcohol use was reduced in treatments without family involvement, broader impact on important outcomes (cigarette smoking and nondrug offending) was only obtained with family involvement.
- Given the rather low prevalence of family involvement in treatment in our sample (approximately one quarter of the treated cases), justice system policies that help to engage families might be useful in promoting desistance from criminal offending.

Chassin et al (2009). In Journal of Substance Abuse Treatment 36, 183 – 194.

Family, Religious, School and Peer Influences on Adolescent Alcohol Use: A Longitudinal Study*

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ABSTRACT. *Objective*: In this study, the cross-temporal relationship between family social support and adolescent alcohol use was examined. A primary aim was to investigate the mechanisms through which family social support affects drinking among youth. Another aim was to examine reciprocal relationships among the study variables. *Method*: Four-wave (with 6-month intervals) panel survey data collected from 840 middle adolescent boys ($n = 443$) and girls ($n = 397$) attending a suburban school district in western New York were analyzed using structural equation modeling with maximum likelihood estimation. *Results*: Analyses revealed that family social support was indirectly associated with decreased alcohol consumption among the respondents, primarily through variables measuring religiosity, school grades and peer alcohol use. In addition, adolescent alcohol use was directly associated with subsequent increases in peer alcohol use and later decreases in school performance. Results also showed that receiving good grades in school predicted moderate increases in family social support. *Conclusions*: The findings of this study are discussed in terms of the interrelationships that exist among multiple socializing influences and alcohol use among adolescents. (*J. Stud. Alcohol* **62:** 44-53, 2001)

CHARACTERISTICS OF THE family are some of the most consistent correlates and predictors of adolescent alcohol use (Hawkins et al., 1992). Maternal and paternal patterns of substance use, as well as various parenting practices (e.g., monitoring and supervision), have been linked to the drinking behavior of boys and girls (Hawkins et al., 1992; Petraitis et al., 1995; Windle, 1999). Although genetic factors contribute to the association between family influences and adolescent alcohol use (Schuckit, 1987), socialization processes also play a prominent role (Barnes, 1990; Brook et al., 1990). The quality of relationships within the family has been found to be a particularly important element in the development of adolescent behaviors (Maccoby and Martin, 1983). A great deal of research demonstrates that family interactions characterized by parental nurturance, warmth and social support reduce adolescents' risk for involvement in a variety of problem behaviors (Loeber and Stouthamer-Loeber, 1986), including alcohol use and abuse (Barnes, 1990; Hawkins et al., 1992; Petraitis et al., 1995; Windle, 1999).

Despite the preponderance of research examining the relationship between family socialization factors and adolescent substance use, at least two important gaps remain in the extant literature. First, a better understanding is needed of the mechanisms through which family characteristics affect alcohol and drug use among youth. Second, greater attention needs to be directed toward an examination of feedback effects of adolescent substance use on the family and on other socializing influences (e.g., peers, school, religion). The primary aim of this study was to examine the direct and indirect effects of perceived family social support on alcohol use among a sample of middle adolescent boys and girls. Particular attention was given to an investigation of reciprocal relationships among the study variables through the analysis of longitudinal panel data.

Direct and indirect family socialization effects

The family has long been recognized as an early and potent socializing influence on children (Parsons, 1955). Effective socialization is facilitated by close and supportive family interactions (Maccoby and Martin, 1983). Through such interactions, boys and girls develop traditional attitudes and values which, in turn, promote conventional behavior (Hirschi, 1969). Numerous studies indicate that family emotional closeness and support are directly and inversely related to alcohol and drug use among children and adolescents (Barnes et al., 1986, 1995; Brook et al., 1989; Chassin et al., 1986; Coombs and Landsverk, 1988; Coombs et al., 1991; Farrell and White, 1998; Hundleby and Mercer, 1987; Jessor and Jessor, 1977; Johnson and Pandina, 1991; Smart et al., 1990; Vicary and Lerner, 1986).

Of course, there are other important socializing influences in the lives of boys and girls. Peer relationships, in particular, become more influential as children move into

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*This research was supported by National Institute on Alcohol Abuse and Alcoholism grant R37-AA07861 awarded to Michael Windle.

Mason & Windle, 2001: Findings

- "The measure of school grades was another important intervening variable in the relationship between family social support and adolescent alcohol use. A high level of perceived family support was associated, over time, with self-reports of good grades; in turn, academic achievement was associated with decreased alcohol consumption."
- "We found that family social support promoted religious and school commitments and associations with non-alcohol-using peers, which, in turn, decreased alcohol use among the respondents."
- "The findings replicate and extend prior cross-sectional and longitudinal follow-up research by further demonstrating that the family is a primary socializing influence on the lives of boys and girls."

Why Family-Based Interventions?

- Family factors are among the strongest predictors of adolescent substance abuse
- Both relationship factors and parenting styles predict teen substance abuse
- Parenting factors mediate role of peers
- Positive changes in parenting practices and family factors predict reductions in use
- Parenting/ family factors are robust predictors of developmental outcomes across domains and into adulthood
- Providers – Want families involved, don't know how, don't get sufficient training or agency support or training
- Client perspectives – Treatment does not meet mental health or family needs

Ecosystem Recovery

Prognosis for ecosystem recovery following rodent eradication and seabird restoration in an island archipelago

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Abstract. Invasive species are widespread and can have devastating effects on biota, especially insular biota. Invasive species eradications are increasingly employed to promote island recovery to preinvasion states. However, it remains unclear if additional restoration actions may be required on islands that were once heavily reliant on seabird guano for ecosystem functions. Active seabird augmentation has been suggested as necessary to exact ecosystem recovery on contemporary timescales in some cases. I use two experiments on offshore islands in Cook Strait, New Zealand, to test the hypothesis that seabird restoration will restore island ecosystem functioning following invasive rodent removal. The first is a small-scale single-island fertilization experiment that simulates seabird recovery. This experiment tested the recovery potential of offshore islands and was used to infer the density of seabirds needed to elicit ecosystem recovery. The second is a large-scale natural experiment that takes advantage of eight islands with differing rodent eradication and seabird restoration histories. I compared ecosystem functioning variables ($\delta^{15}N$, C:N ratios in soil, plants, and spiders, as well as arthropod abundance and diversity) on two islands that had rodents eradicated and two islands undergoing seabird augmentation with two control islands (never invaded by rodents) and two positive control islands (currently invaded by rodents). The results suggest that islands do have the potential for recovery given nutrient amendments, but that islands with rodents eradicated and islands undergoing seabird augmentation have not recovered most of their ecosystem function. Finer, intra-island analysis showed that seabird restoration projects have the potential to speed the recovery process, but that the projects on the studied seabird restoration islands were not advanced enough to produce island-wide recovery. The results suggest that high seabird densities (5–10 burrows/m^2) are needed to promote recovery to never-invaded control levels. Seabird augmentation, through chick translocation and/or social facilitation with decoys, vocalization playbacks, and/or mirrors can supplement passive seabird recovery on islands where seabirds have been extirpated or extremely reduced by invasive predators. Such restoration efforts may be necessary to promote ecosystem recovery on contemporary timescales.

Key words: Cook Strait, New Zealand; ecosystem recovery; eradication; invasive rodent species; island restoration; seabird restoration; social facilitation; spatial subsidies; stable isotope analysis.

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Wolves May Aid Recovery of Canada Lynx, a Threatened Species

ScienceDaily (Aug. 30, 2011) — As wolf populations grow in parts of the West, most of the focus has been on their value in aiding broader ecosystem recovery -- but a new study from Oregon State University also points out that they could play an important role in helping to save other threatened species.

In research published in *Wildlife Society Bulletin*, scientists suggest that a key factor in the Canada lynx being listed as threatened under the Endangered Species Act is the major decline of snowshoe hares. The loss of hares, the primary food of the lynx, in turn may be caused by coyote populations that have surged in the absence of wolves. Scientists call this a "trophic cascade" of impacts.

The increase in these secondary "mesopredators" has caused significant ecosystem disruption and, in this case, possibly contributed to the decline of a threatened species, the scientists say.

Scientists have concluded that exploding mesopredator populations can be found in oceans, rivers, forests and grasslands around the world.

"In the absence of wolves, coyote densities and distributions generally expanded in the U.S., into the Midwest, to the northeast as far as Newfoundland, and as far northwest as Alaska," the researchers wrote in their report.

Where wolves recovered, as in Yellowstone National Park, coyote populations were initially reduced by 50 percent, Ripple said. Although more sampling will be required, early evidence indicates that a snowshoe hare recovery may be taking place.

As these issues are factored into decisions about how to manage wolves, the researchers said, it's also important to maintain what they call "ecologically effective" wolf populations, the researchers wrote in their study. The full value of these top predators, and the numbers of them it takes to achieve a wide range of ecological goals, should be more thoroughly researched and better understood, they said.

NATIONAL MARINE SANCTUARIES

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SANCTUARY SCIENCE

N-Control Seagrass Restoration Monitoring Report Monitoring Events 2003-2008 Florida Keys National Marine Sanctuary, Monroe County, Florida

Author:
Alicia A. Farrer, Environmental Specialist II
Florida Keys National Marine Sanctuary

This document presents the results of the monitoring of a repaired seagrass area injured by the N-Control vessel grounding incident of May 29, 2001. This grounding occurred in State of Florida waters within the boundaries of the Florida Keys National Marine Sanctuary (FKNMS) and impacted a total of 96.87 m^2 of seagrass habitat, predominantly Turtle grass (*Thalassia testudinum*). Restoration of this site was completed on March 25, 2003 and consisted of forty-four seagrass planting units (*Halodule wrightii* and *Syringodium filiforme*) and 39 bird stakes. The monitoring program of the N-Control site was designed to determine whether the restoration effort provided services in a manner consistent with restoration goals, and to monitor the potential need for mid-course corrections. Monitoring consisted of both quantitative and qualitative methods adapted from Fonseca et al "Guidelines for the Conservation and Restoration of Seagrasses in the United States and Adjacent Waters". A total of six monitoring events were conducted over five and a half years. After 64 months (5.5 years) post-restoration, the percent cover of total seagrass in the restored injury increased from 5.6% to 17%. The target species, *T. testudinum*, increased from 0.5% to 12.1% in the restoration area by the 5.5 year monitoring event. In comparison, the percent cover of *T. testudinum* was 28.5% in the reference area adjacent to the injury during the 5.5 year monitoring event. This restoration effort accelerated the recovery of the injured area but the injury has yet to reach pre-grounding baseline levels. Research on restoration techniques and natural recovery continues, and will provide valuable information on the practicality and effectiveness of seagrass restoration of vessel grounding injuries.

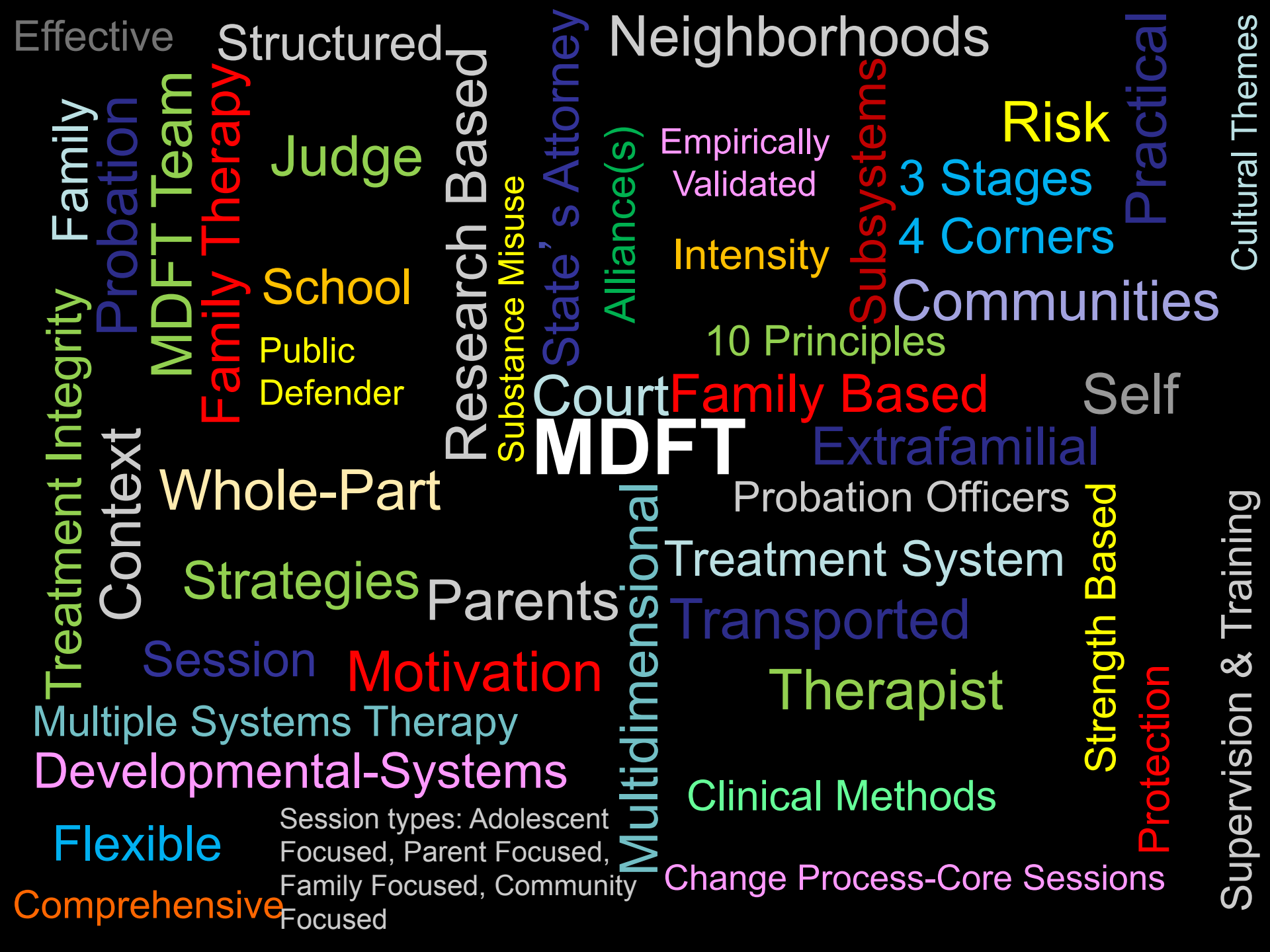
Keywords: *N-Control*, Florida Keys National Marine Sanctuary, seagrass, vessel grounding, restoration, monitoring, planting units, bird stakes

Family Based Treatment as Ecosystem Recovery

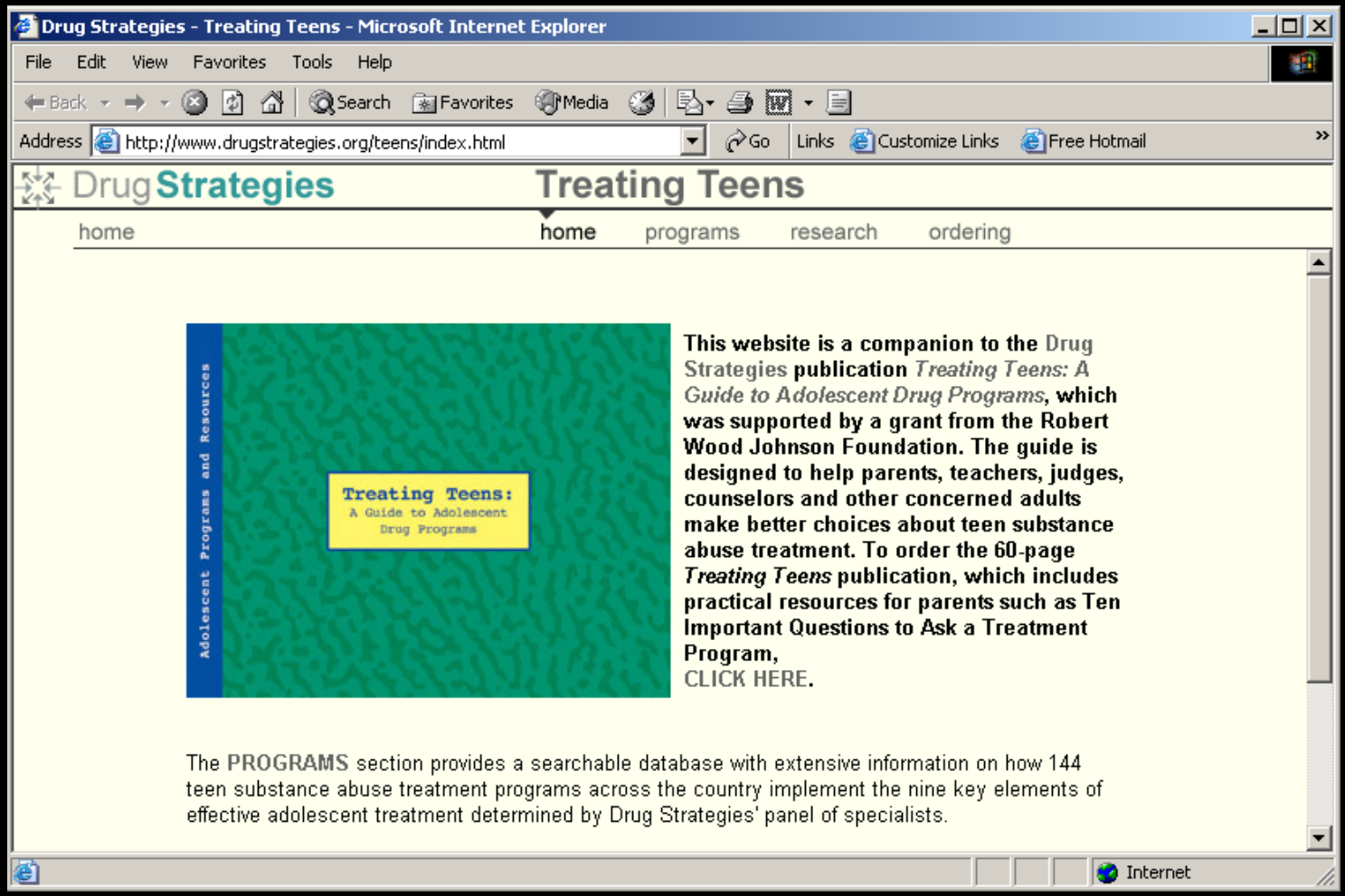
- Relationships are vital to development
- Treatment enables and restores natural healing functions
- Badly damaged ecosystems recover
- New science tells us best payoff targets and methods
- Interveners must be guided by a program theory, ideas about processes of interest and mechanisms of action/change

MDFT

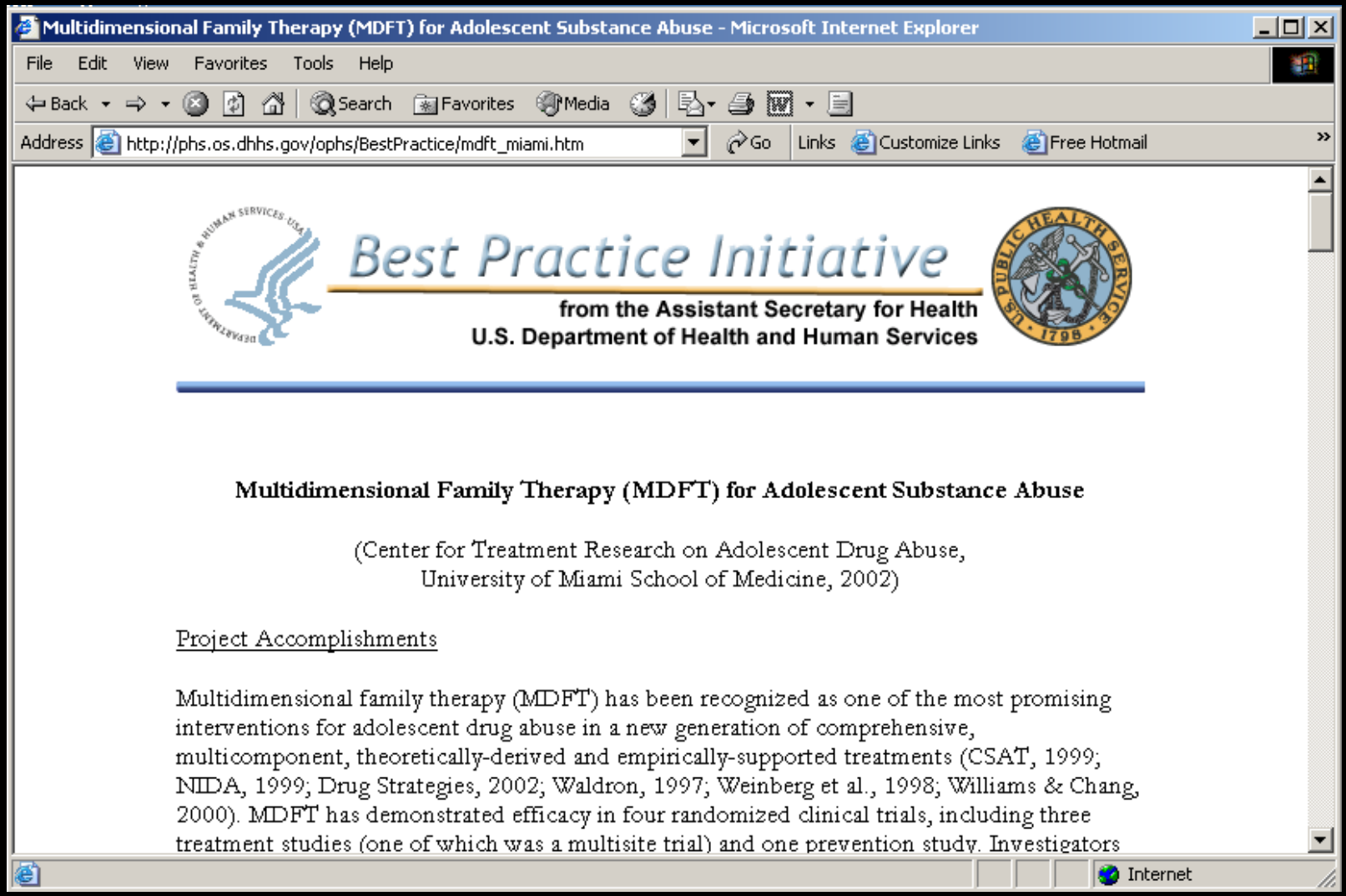
- Multidimensional Family Therapy
- Adolescent substance abuse
- Delinquency and problem behaviors
- Family-based treatment system
- Diversity of studies
- Sample findings
- Clinical thinking & features


Effective
Structured
Neighborhoods
Family
Probation
MDFT Team
Family Therapy
Judge
Research Based
State's Attorney
Substance Misuse
Alliance(s)
Empirically Validated
Subsystems
Risk
Practical
3 Stages
4 Corners
Cultural Themes
Intensity
School
Communities
Public Defender
10 Principles
Treatment Integrity
Context
Court
Family Based
Self
MDFT
Extrafamilial
Whole-Part
Probation Officers
Multidimensional
Strength Based
Treatment System
Strategies
Parents
Transported
Session
Motivation
Therapist
Multiple Systems Therapy
Developmental-Systems
Clinical Methods
Protection
Supervision & Training
Flexible
Session types: Adolescent Focused, Parent Focused, Family Focused, Community Focused
Change Process-Core Sessions
Comprehensive

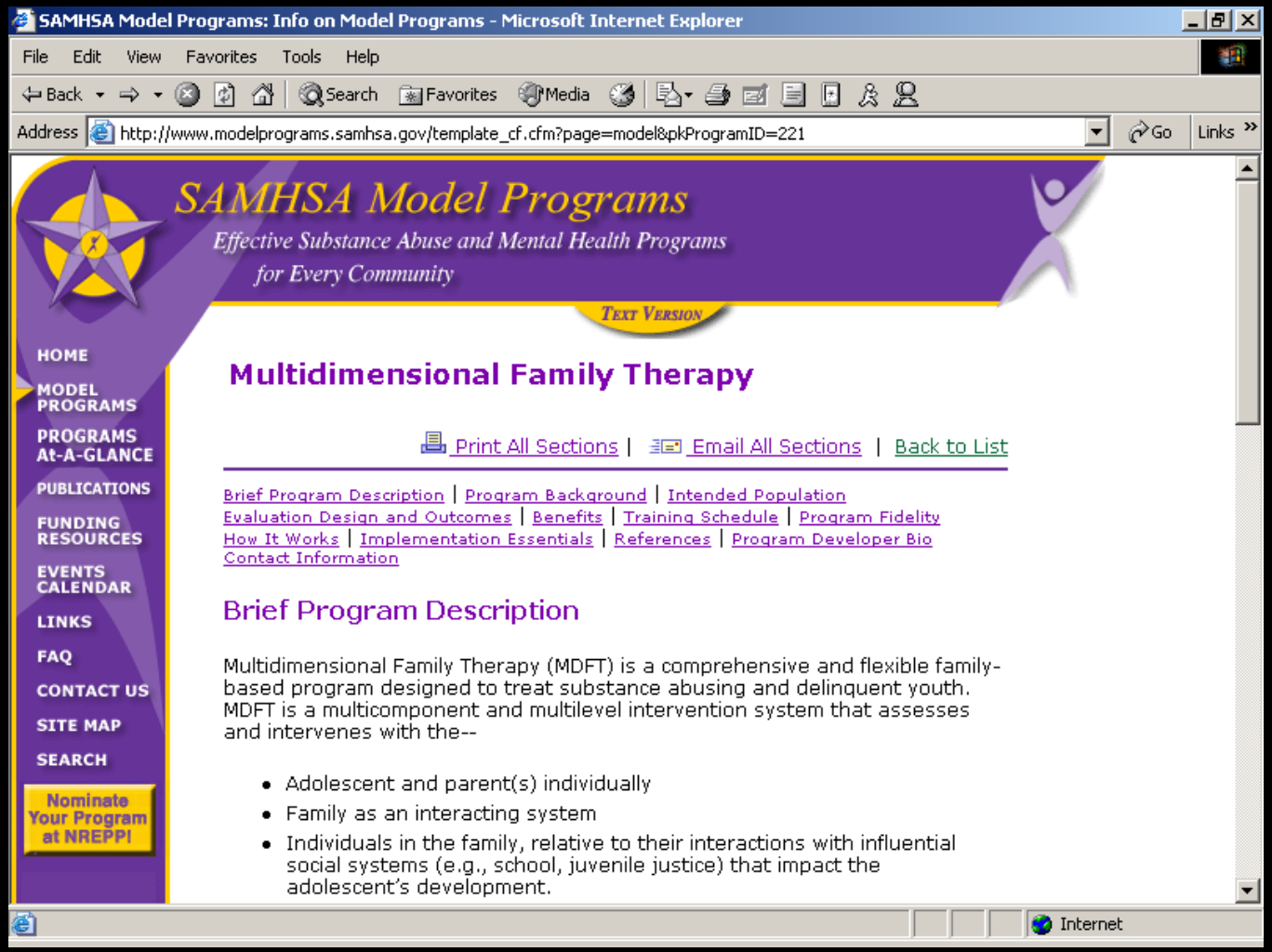
Multidimensional Family Therapy



Multidimensional Family Therapy



Multidimensional Family Therapy



Theoretical, Clinical, and Empirical Roots of MDFT

1. Adolescent Development
2. Parenting Practices and Family Functioning
3. Risk and Protective Factors for Adolescent Problems
4. Ecological Perspective (Bronfenbrenner)
5. Family Therapy: Structural (Minuchin) and Problem Solving (Haley) Therapies

Developmental Orientation

- "Suppose that a 6-year-old and a 16-year-old are referred for problematic levels of aggressive behavior. Although the presenting symptoms for the two children may be similar, it is unlikely that identical treatments could be provided with equivalent effectiveness to both children. Multiple developmental differences between children of different ages would likely necessitate the use of different assessment and treatment strategies. Even the degree to which such behaviors are viewed as problematic would vary as a function of age. Unfortunately, we know little about how or when a given treatment should be modified for use with children functioning at different developmental levels."
- "Although it appears that most treatments for children and adolescents are not developmentally oriented (because many of them are downward or upward extentions of treatments for individuals of ages other than the target population), there is a great potential for the integration of developmental research with clinical practice."
- "Knowledge of normative development can aid therapists in formulating appropriate treatment goals, provide a basis for designing alternate versions of the same treatment, and guide the stages of treatment."

Holmbeck et al in Weisz & Kazdin (2010)

Developmental Perspective in MDFT

- Substance abuse and delinquency as developmental disorders
- Provides a normative framework and particulars
- Assessment is developmental
- Interventions have a developmental frame and intention
- Knowledge guides content, framing and intervention, as well as evaluation
- ASUD and delinquency are developmental disorders (from Kandel to present)
- ASUD disrupts and makes achieving stage milestones and tasks more difficult, this has short term, and longer term, implications, it creates more risk and compromises to one's and one's family's future.

Beyond the basics: Overlapping developmental changes

- Development has been considered "inside" of a person
- Developmental tasks are milestones I accomplish or fail to accomplish in a particular order and according to a specific timetable… not exactly
- But development also has contextual and interpersonal aspects
- Coercive family process theory (Granic & Patterson, 2006)
- Parents' and children continually influence each others' behaviors
- When negative, this interaction amplifies the developmental trajectories of child misbehavior
- And, at the same time, these continuous interactions also worsen the quality of the parent-child/adolescent relationship
- Bidirectional dynamics between parent child relationships and substance abuse/offending results in correlated development, poorer quality relationships & higher levels of youth problems

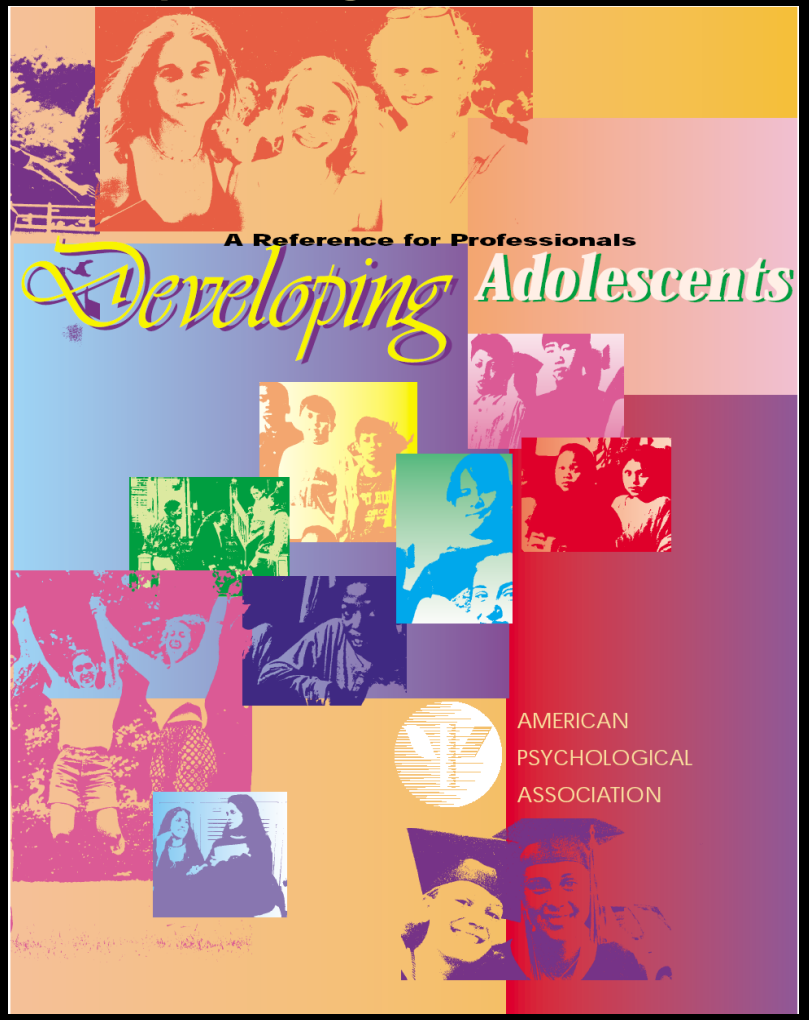
A clinical *North Star*:
Parent-youth relationship quality is instrumental to adolescent and parent (adult) development

Training Program Overview (6 months)

- Introductory Workshops To Introduce Basic Operating Principles, Interventions, Theory and Philosophy, Guidelines, Forms
- Select 1 Target Case For Ongoing Consultation and Supervision (2 weeks after initial training)
- Every Other Week Case Consultation On Phone
- Midterm Assessment: Written Exercise, Recorded Session Rated for Adherence
- 2 On-site clinic-based trainings (videotape review, live supervision)
- Certification: Written Exam, Recorded Session Rated for Adherence)

Developing Adolescents: A Reference for Professionals

American Psychological Association, 2002



Adolescent Cognitive Development

- Adolescents develop increasingly advanced reasoning skills
- Abstract thinking skills (e.g. beliefs, trust)
- Ability to think about how they feel and how others perceive them

Adolescent Brain Development

Teens brains are different from adult brains

- During puberty, the brain undergoes extensive changes
- Matures through age 24 – 25
- Teens respond differently to the world because of immature neural circuitry

Adolescent Brain Development: Brain Structures That Mature During Adolescence

- Directs how much effort person will expend to seek rewards (*nucleus accumbens)*
- Teens have preference for activities that require low effort yet produce high excitement:
  - Playing video-games, skate boarding, substance use, criminal activity

Adolescent Brain Development: Brain Structures That Mature During Adolescence

Integrates emotional reactions to pleasurable and aversive activities *(amygdala)*

Contributes to the tendency to:

a) React explosively to situations (angrily, aggressively)
b) Tendency for youth to mis-read neutral or inquisitive facial expressions of others as a sign of anger.

Adolescent Brain Development: Brain Structures That Mature During Adolescence

Complex processing of information, including making judgments, controlling impulses, foreseeing consequences, setting goals and plans *(prefrontal cortex)*

Immature prefrontal cortex explains why teens often show:

a) poor judgment and decision-making
b) poor impulse control
c) too often act before thinking

Adolescent Emotional Development

- Adolescents develop a sense of identity
  - "Who Am I"
- Consider how alike and different from others
  - Ethnicity
  - Gender
  - Sexual orientation
- Emotional Intelligence
  - Recognizing and managing emotions
  - Developing empathy
  - Learning to resolve conflict constructively
  - Developing a cooperative spirit

Social Development: Peer Relationships

Function of Peer Groups:

1. Reference point for identity development
   - Moral judgment & values
2. Source of information about family & environment
3. Powerful reinforcement
   - Popularity, status, acceptance

Social Development: Family Relationships

1. Regardless of family form, strong family bonding is related to:
   - Better school performance
   - Better emotional development
   - Less risk-taking behavior/drug use

2. Some parent-teen conflict is normal during this stage
   - Teens strive for independence
   - Optimal relationship is based on healthy interdependence
   - Teens seek new ways to relate to parents, and parents adjust as well

Parenting Adolescents:

5 Keys

1. Love and connect
2. Monitor and observe
3. Guide and limit
4. Model and consult
5. Provide and advocate

The Five Basics of Parenting Adolescents

1. Love and Connect

- Teens need parents to develop and maintain a supporting and accepting relationship

Strategies for Parents

Spend time just listening

Expect increased criticism

Treat each teen as unique

Provide meaningful roles

Appreciate and acknowledge teen's new interests

Parenting Basic #1: Love and Connect

- Spend time just listening
  - Helps you learn more about their relationships, school, interests, concerns
- Treat each teen as unique
  - Treat teens as distinct from siblings, stereotypes, his or her past, or your own past
- Provide meaningful roles
  - Provide roles that are useful and important to the family's well-being

Parenting Basic #1: Love and Connect

Expect increased criticism

→ Strengthen your skills for discussing ideas and disagreements in ways that respect both you and your teen

Appreciate and acknowledge teen's new interests

→ As well as new skills, strengths, aspects of adolescence in general (humor, intellect, etc.) and accomplishments

Key Message for Parents

Most things about the world are changing.

Don't let your love be one of them.

The Five Basics of Parenting Adolescents

2. Monitor and Observe

- Teens need parents to be aware of – and let teens know they are aware of their activities

Strategies for Parents

- Be involved in school events
- Watch for warning signs
- Track teen's whereabouts
- Seek Guidance if Concerned
- Keep in touch with other adults

Parenting Basic #2: Monitor and Observe

Be involved in school events

- Such as parent-teach conferences, back-to-school nights, and special needs planning meetings

Watch for warning signs

- Be watchful for poor physical or mental health, signs of abuse or neglect, drop in school performance, drug/alcohol use, promiscuity, withdrawal from friends and activity

Seek Guidance if Concerned

- Consult with teachers, counselors, religious leaders, physicians, parenting educators, family and tribal leaders, and others

Parenting Basic #2: Monitor and Observe

Track teen's whereabouts

Keep track of teens activities (directly or indirectly) by listening, observing, and networking with others who come in contact with your teen

Keep in touch with other adults

People who let you about the positive and negative trends of your teen (neighbors, family, religious and community leaders, teachers, and other parents)

Key Message for Parents

Monitor your teen's activities.

You still can, and it still counts.

The Five Basics of Parenting Adolescents

3. Guide and Limit

- Teens need parents to uphold evolving boundaries and important family rules and values

Strategies for Parents

Communicate expectations

Maintain family rules

Choose battles

Use discipline as a tool

Renegotiate responsibilities and privileges as teen matures

Parenting Basic #3: Guide and Limit

Communicate expectations

- Explain expectations that are high, but realistic

Maintain family rules

- or “house rules,” upholding some non-negotiable rules around issues like safety and central family values, while negotiating other rules (e.g. household tasks)

Use discipline as a tool

- Use discipline for teaching, not for venting or taking revenge

Parenting Basic #3: Guide and Limit

Choose battles

and ignore smaller issues in favor of more important ones, such as drugs, school performance, and sexually responsible behavior.

Renegotiate responsibilities and privileges as teen matures

in response to your teen's changing abilities, turning over some areas to the teen with appropriate monitoring.

Key Message for Parents

Loosen up, but don't let go.

The Five Basics of Parenting Adolescents

4. Model and Consult

- Teens need parents to teach them about how to interpret and navigate the larger world

Strategies for Parents

Answer teens' questions

Help teens get information

Express personal positions

Support teens' education

Set a good example (risk taking, health habits, emotional control)

Parenting Basic #4: Model and Consult

Answer teens' questions

Address teens' questions in ways that are truthful, while taking into account their level of maturity.

Help teens get information

Help your teen get information about future options and strategies for education, employment, and lifestyle choices.

Support teens' education and/or vocational training

Participate in household tasks, outside activities, and employment that develop their skills, interests, and sense of value to the family and community.

Parenting Basic #4: Model and Consult

Express personal positions

Inform your teen about your social, political, moral, and spiritual views, including issues of ethnicity and gender.

Set a good example (risk taking, health habits, emotional control)

Teens need parents to teach by example and ongoing dialogue.

Key Message for Parents

The teen years: Parents still matter; teens still care

The Five Basics of Parenting Adolescents

5. Provide and Advocate

Teens need parents to make available a supportive home environment and a network of caring adults

Strategies for Parents

Make informed decisions

Network within the Community

Arrange and advocate for preventive health care

Identify people and programs to support and inform you

Parenting Basic #5: Provide and Advocate

Make informed decisions

When choosing schools, find out about following:

- ✓ Safety, social climate, approach to diversity, community cohesion
- ✓ Opportunities for peer relationships and mentoring
- ✓ Match between school practices and your teen's learning style and needs.

Network within the Community

Identify resources that can provide positive adult and peer relationships, guidance, training, and activities for your teen (e.g., schools, family, religious organizations, and social services)

Parenting Basic #5: Provide and Advocate

Arrange and advocate for preventive health care

- Including necessary care for mental illness and substance abuse.

Identify people and programs to support and inform you

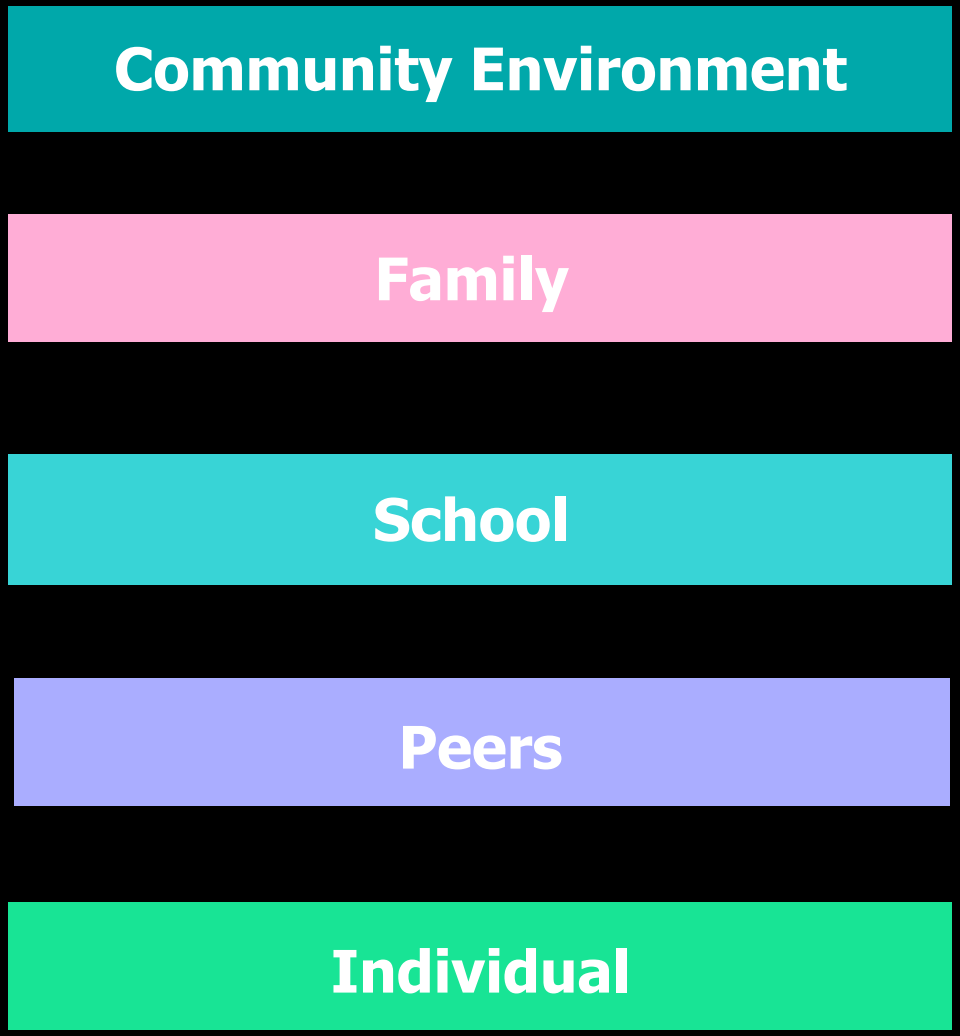
- You need support and information to help you manage parental responsibilities and in understanding the societal and personal challenges in raising teens.

Key Message for Parents

You can't control their world,

but you can add to and subtract from it

Risk and Protective Framework



Risk and Protective Factors for Adolescent Substance Abuse

Community Environment

Risk

- Community norms that promote or permit substance use
- Living in impoverished
- Neighborhoods characterized by high crime rates and alienation
- High rates of transition/mobility
- Cultural disenfranchisement

Protection

- Caring and supportive community
- High expectations of youth
- Religious based activities
- Community sponsored activities

Risk and Protective Factors for Adolescent Substance Abuse

Community Environment

Family

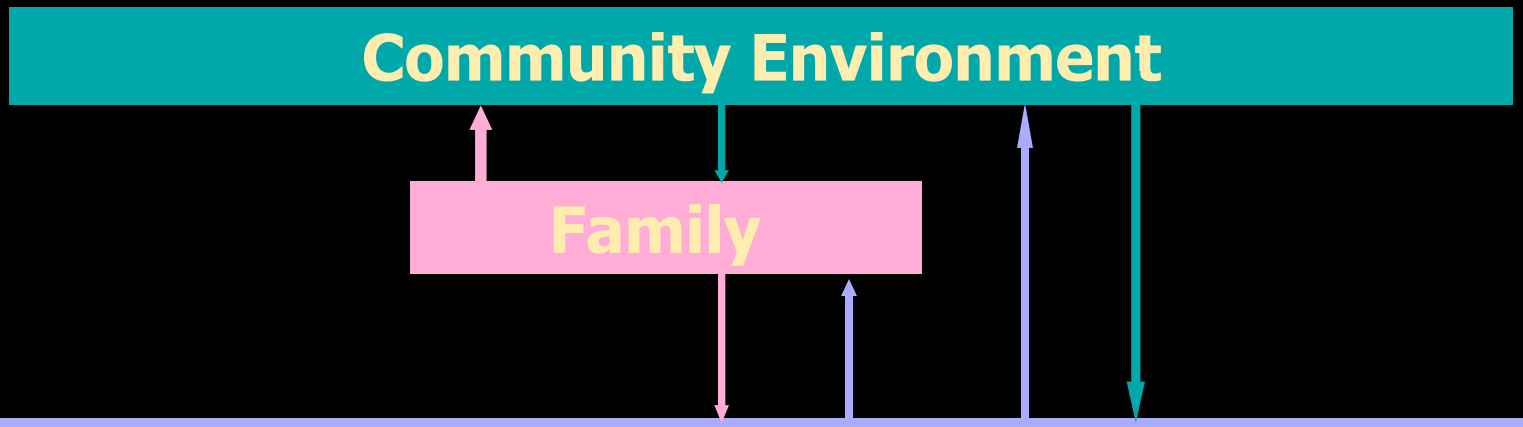
Risk

- Parental abuse of alcohol, drugs, criminality
- An abusive or conflict ridden family
- Low parental support
- Low parental monitoring
- Poor family management, discipline, and problem solving
- Favorable attitudes toward teen alcohol, drug use
- Parents' mental illness
- Ineffective parenting skills

Protection

- Emotional support
- A sense of basic trust
- High parental expectations
- Clear rules and expectations
- Parental monitoring
- Positive bonding

Risk and Protective Factors for Adolescent Substance Abuse



Peers/Partners

Risk

- Involvement with peers who use and have favorable attitudes towards alcohol, drugs, delinquency, etc
- Involvement with peers who engage in problem behaviors
- Peer rejections
- Poor social skills

Protection

- Involvement with positive peer group activities and norms
- Social competencies such as decision making skills assertiveness, and interpersonal communication

MDFT Theory of Adolescent Problem Behavior

1. Adolescent substance abuse is multi-faceted
2. Risk factors are mutually influencing; protective factors buffer against deviance
3. Adolescent problems are defined in a social context
4. Adolescent substance abuse and co-occurring disorders are a systemic problem that derails development
5. The family is the primary context of healthy development
6. Peers and other influences operate in relation to the buffering effects of families

MDFT Theory of Change

- Adolescents need to develop a positive, supportive relationship with parents
- Symptom reduction and enhancement of prosocial and normative developmental functions occurs by:
  - Targeting the family
  - Facilitating curative processes across life domains (teen, parent, family, extrafamilial)

MDFT Theory of Change (cont.)

- MDFT interventions target interpersonal and intrapersonal processes in each domain
- Intervention targets are understood temporally – as "pathways to change"
- MDFT helps stop the cascading momentum established by the interacting risk and development-derailing process

MDFT Theory of Change (cont.)

- Problem behavior can desist when meaningful, concrete alternatives are created, accepted, attempted and adopted
- If it has been multiple risk factors and a network of influences that have created and maintained adolescents' co-occurring problems, then the same complex of interrelated influences must be systematically targeted for change

Therapist Behavior is Fundamental for Success

MDFT Therapists are…

1. Believers in change: Optimistic
2. Seekers of strength: Respect and admire the parent and teen – we see them better than they see themselves
3. Comfortable working in close emotional proximity
4. Driven by a "do what it takes" attitude and follow through
5. Non-punitive and non-judgmental
6. Always seeking to improve skills/outcomes

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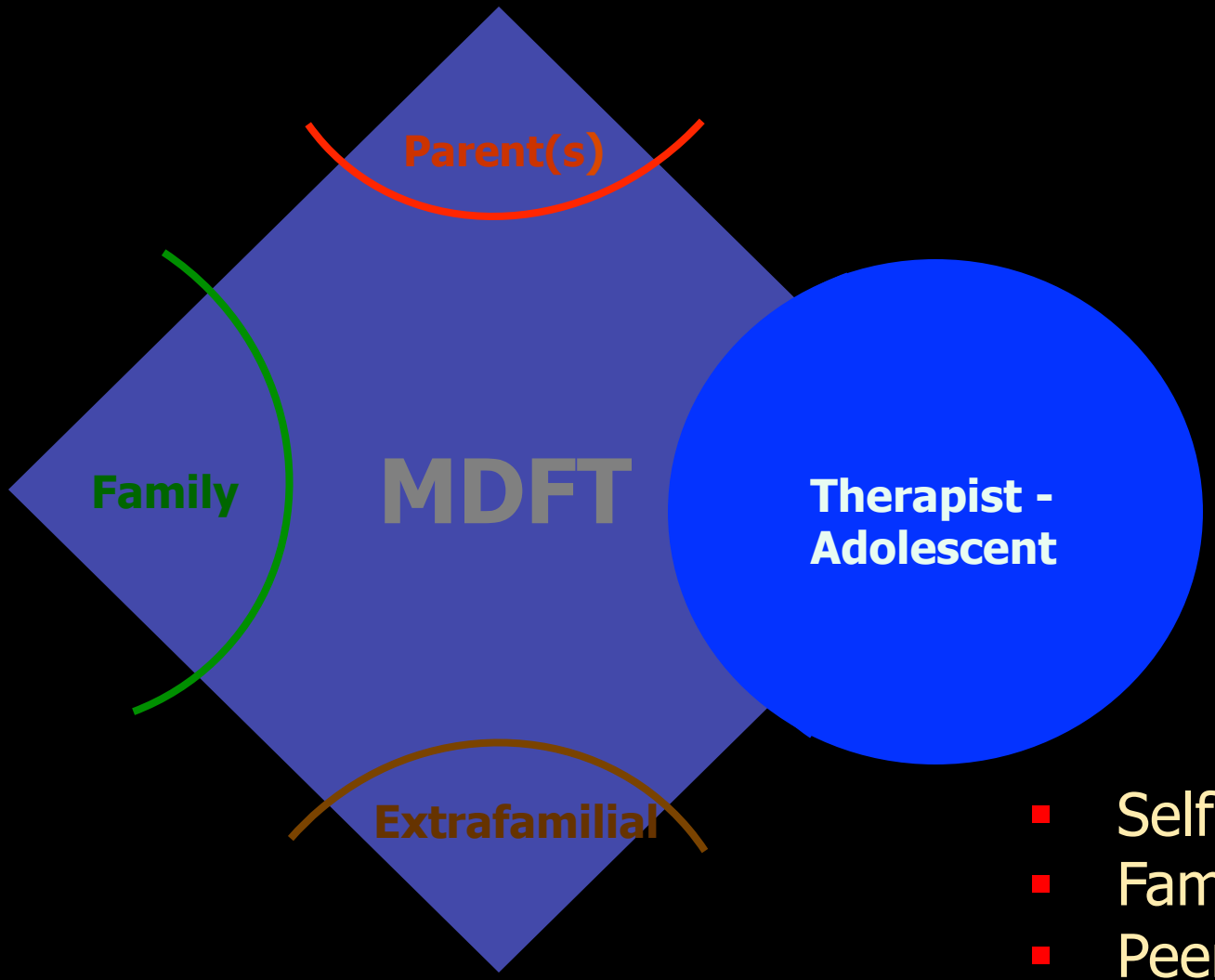
Four Intervention Targets in MDFT

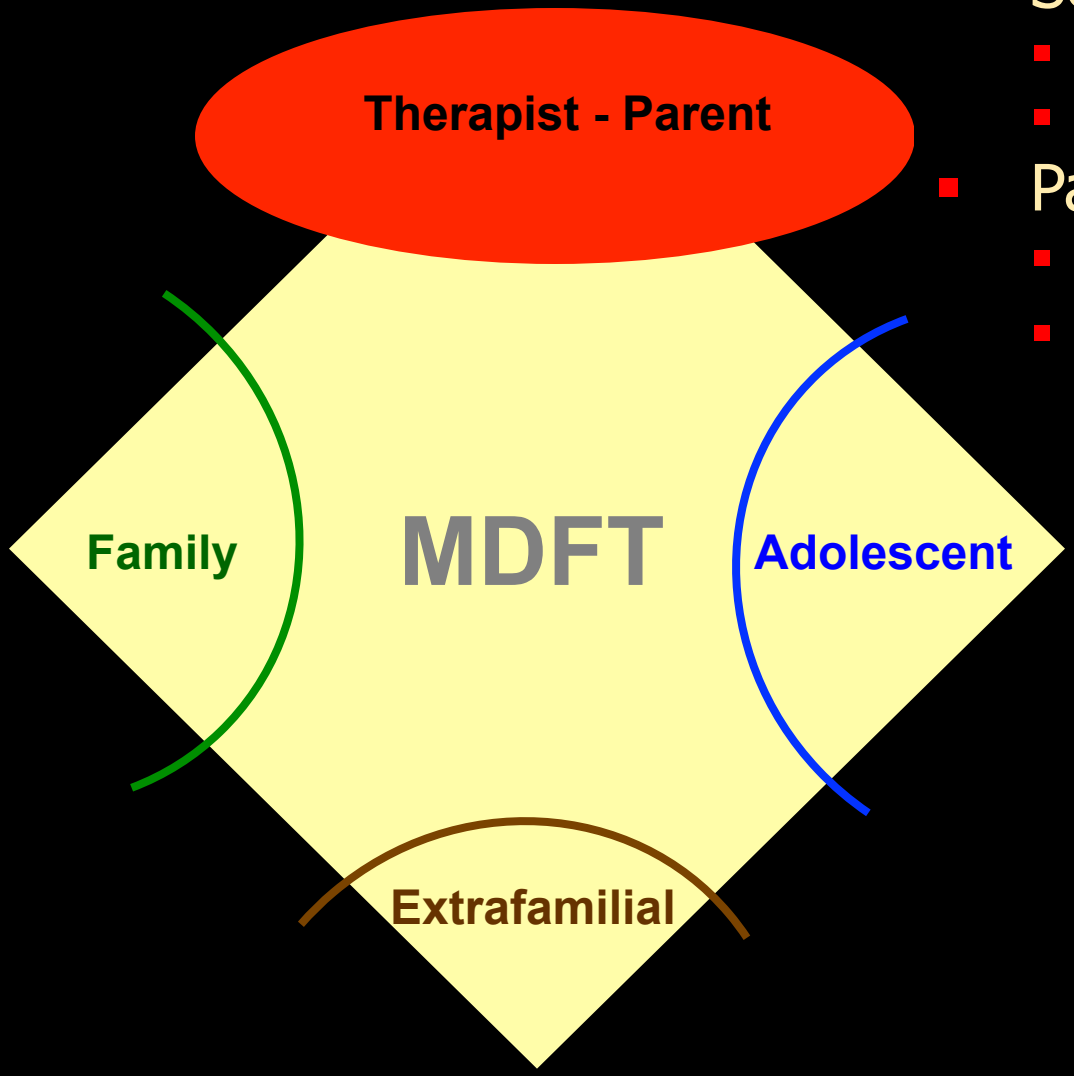
1. Adolescent: Self, son/daughter, peers
2. Parent: Self and parenting
3. Family Interaction and Family Relationships:
4. Extrafamilial: Individuals and families exist in context; extrafamilial focus eliminates barriers to treatment participation and success, and sharpens skills in negotiating with other systems

Interrelated Aspects of MDFT Approach



- Self
- Family
- Peers

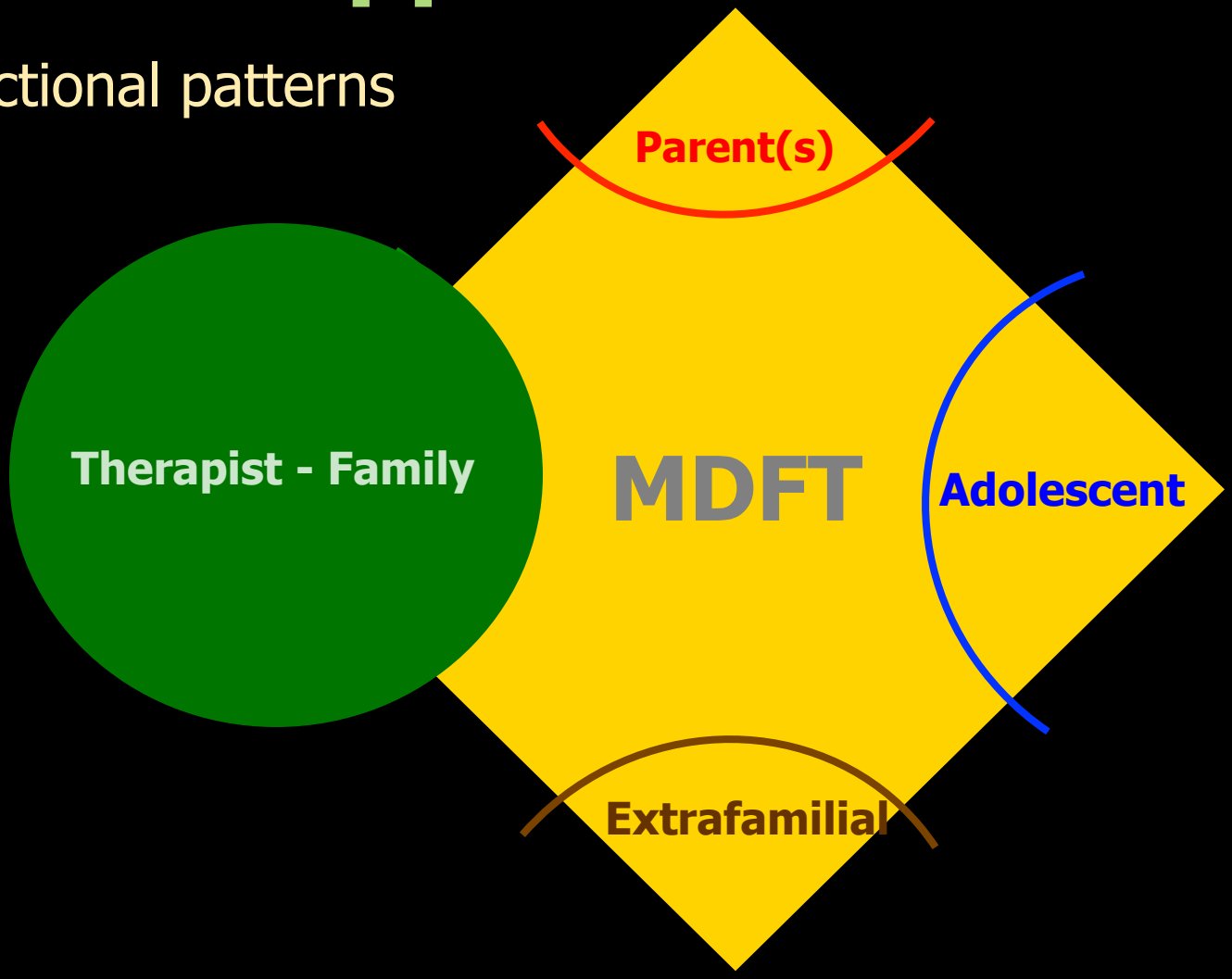
Interrelated Aspects of MDFT Approach



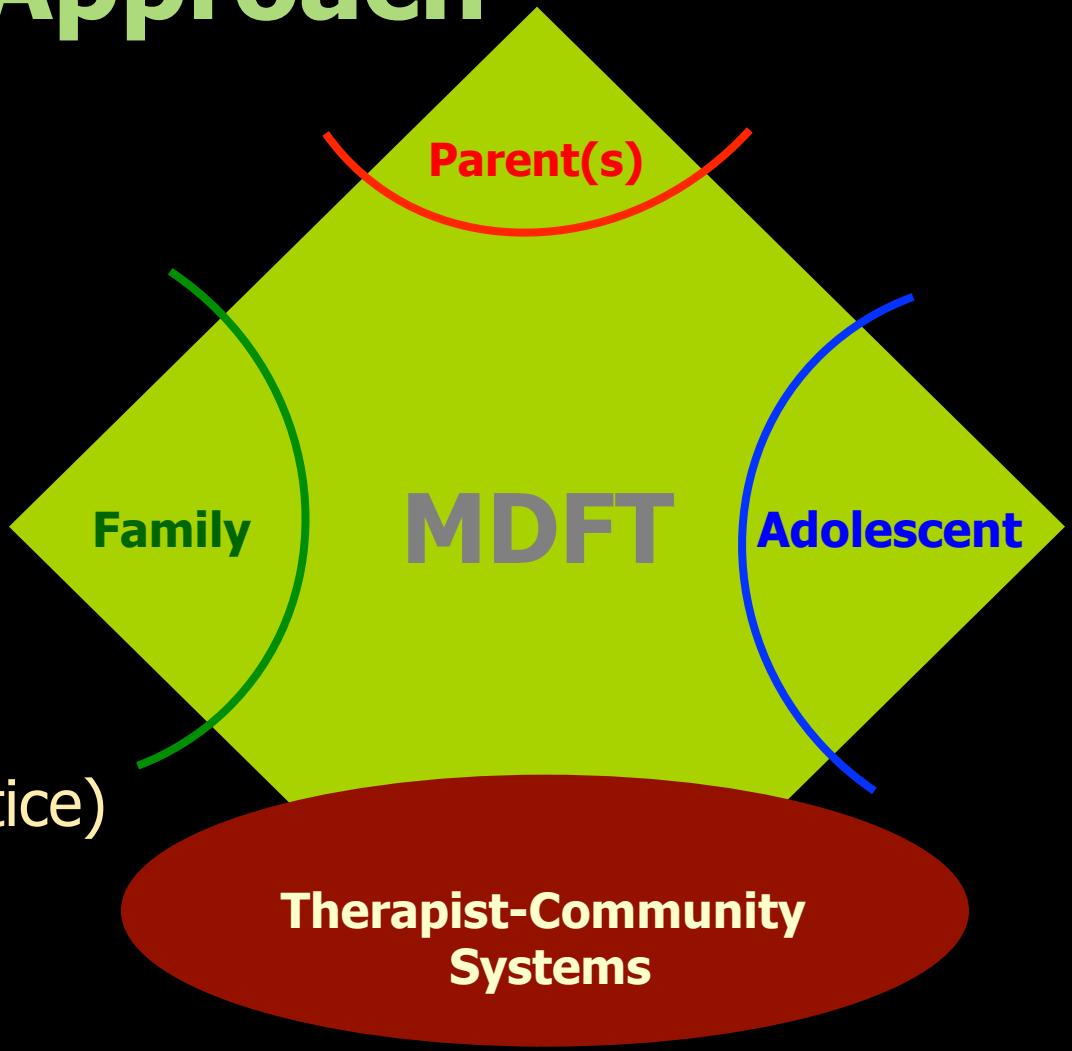
- Self
  - Overall functioning
  - Stress and burden
- Parent
  - Love and commitment
  - Guidance and limit setting

Interrelated Aspects of MDFT Approach

- Transactional patterns



Interrelated Aspects of MDFT Approach



- School
- Neighborhood
- Legal (Juvenile Justice)
- Social
- Medical

Key Interventions Actions in MDFT (across domains and stages)

- Develop and Maintain Multiple Therapeutic Alliances (Youth, Parent, Extrafamilial)
- Enhance Motivation To Change: Create Positive Expectations/Develop Sense of Crisis and Urgency with Parents
- Develop Collaborative Respectful Relationships with Youth and Parents

Key Interventions Actions cont.

- Multiple Change Targets (Youth, Parents, Family Relationships, Social Systems)
- Identify and Enlarge upon Strengths & Competencies—We are Not "Psychopathological Sleuths."
- Celebrate Small Successes

Key Interventions Actions cont.

- Facilitate Meaningful Discussions Between Youth and Parents: Heart-to-Heart, Emotional, Serious, Real, Enhance Mutual Understanding and Conflict Resolution
- Find Workable Answers To Current Problems: Parenting Practices, House Rules, Conflict Resolution, School, Court
- Failure and Crises are Intervention Opportunities

Three Stages of Treatment

Stage 1: Build the Foundation:
Develop Alliance and Motivation

Stage 2: Work the Themes /Request Change

Stage 3: Seal the Changes and Exit

MDFT in Action: Orchestrating Work Across Domains and Over Time

Play DVD: Case Illustration: Girl with Sunglasses and Black Gloves

Stage 1. Setting the Foundation for Change:

Alliance and Motivation

A. Motivate Parents and Youth to Participate in Therapy and to Change

B. Begin Developing Multiple Therapeutic Alliances: Tasks, Bonds, Goals

Stage 1: Alliance & Motivation

Alliance Facilitates Motivation

Stage 1: Alliance and Motivation

- Approximately 4 Sessions
  - Session 1: Multipart Family
  - Session 2: Multipart Family
  - Session 3: Adolescent Alone
  - Session 4: Parents Alone
- Stage 1 Goals Are Launched Within the First Couple of Weeks But Developed Further in Stage 2

Motivation

Distress & Hope

Motivate Parents & Youth: Focus on the *Four Ds* – Distress, Despair, Dissatisfaction and Discrepancy

Use current crisis or circumstances to focus and mobilize parents & youth

- Elaborate on the consequences (developmental and extrafamilial)
- Develop a sense of urgency
- Draw a portrait of current unhappiness

Motivate Parents and Youth- Hope: Create Positive Expectations

- Portray confidence in the program and in the ability of the youth and parent to solve their problems and have a better life
- Lend them your optimism/your portrait of the future
- Produce an early success in the area that is most accessible

Alliance Building: Youth and Parent

1. Empirically based predictor of success
   - 3 kinds of alliances: Parent, teen, and extrafamilial (persons of influence)
2. Complement, agree, empower, listen and respect
3. Encourage a collaborative process
   - “Let’s work together to figure out how to make this better for all of you”

Stage 1: Adolescent Domain

Be positive and encouraging

- Compliment and support the teen
- Identify and amplify strengths
- Inquire, discuss, facilitate and encourage expression of hopes and dreams
- Be collaborative – you aren't the expert on the teen's life, but you can advocate to help make things better

Stage 1: Adolescent Domain

Show interest in the teen and get to know the details of his/her life:

- Adopt a curious, open and respectful stance: Get to know youth
- Allow youth to voice concerns and complaints/ specifics of what wants changes in family, self, life generally

Stage 1: Adolescent Domain

"There is something in this for you."

- Distress: *What do you want changed in this family, in your situation, life? You don't seem happy about how things are going and how things are in this family.*
- Hope: *We can make something happen here. I believe you can change your life.*

Stage 1: Adolescent Domain

Seek commitment from youth (even an initial readiness to try something new):

1. Are you willing to give this therapy a try?
2. Will you work with me?
3. Do you think maybe this program can help you get some of what you want? Can we work together to help make things better for you?

Stage 1: Parent Domain

Just as you develop an alliance and seek to foster motivation with the teen, it is equally important to engage parents in the process of therapy and change

- Compliment and support them as adults with their own lives and concerns, as well as parents
- Seek and enlarge strengths – the good efforts they have made in parenting and their commitment
- Inquire, discuss, facilitate and encourage expression of their own hopes and dreams
- Be collaborative – you are part of the parenting team or system for the time they are in therapy
- Main objective is to engage them in the process of change by reconnecting them with the teen and instilling hope that their efforts will pay off

Stage 1: Parent Domain

Assess and validate parenting efforts

- Encourage parents to talk about past and current efforts to help youth
- Seek out competencies and strengths in parenting
- Establish a developmental perspective on teens and families
- Explore parents' childhood/family of origin: how did their own ideas about parenting develop? How were they parented?

Stage 1: Parent Domain

- Communicate to parents that this program is for them too
- Elicit and empathize with current/past stresses and burdens (not just parenting)
- Portray yourself as an ally and advocate for parent to relieve stress and burden – you are part of the parenting team

Stage 1: Parent Domain

- Enhance and strengthen feelings of love and commitment
- Parental Reconnection Interventions (PRI)
  - Help them remember when they felt more loving toward their adolescent - when things were better between them. Go back in time to positive, loving moments and help resuscitate those feelings.

Stage 1: Parent Domain

- You Are The Medicine: Nobody else can save your child

- No Regrets: You want to look back and know you did everything possible to save your child

Stage 1: Parent Domain

Seek a Commitment:

1. I will do whatever it takes!

2. We will work together as a team to save our child (even if divorced, separated, in turmoil).

Stage 1: Parenting Interventions

- Parenting interventions in help move parents to a more accepting/receptive position with the teen
- Increasing the parent's commitment and love for the teen are essential in order for them to consider a new kind of relationship with the adolescent
- This new relational experience creates the necessary foundation to request changes in parenting attitudes, beliefs, and behaviors

Stage 1: Family Domain

- Assess Family
- Ask:
  - How did they get to this point?
  - Ask each family member his/her view of the situation (problem). Ideas about the cause
  - What are the disagreements in the family?
  - How have they tried to make it better?
- Observe:
  - How they talk to one another
  - How they express love
  - Overall emotional tone
  - How they deal with disagreements, conflict

Stage 1: Family Domain

- Assess family history
  - Look for themes of strength as well as past betrayals, neglect, abuse that will need to be talked about in Stage 2.
- Focus on the affective component of their relationship
  - Move to a level of love, commitment, connectedness, relationship and compassion.

Stage 1: Family Domain

- Learning Through Experience is the primary theory of change and intervention in MDFT
- Enactment is a method to facilitate experiential change
- An MDFT therapist helps the family have a new experience of each other – goes beyond "better communication," "insight," or "understanding"
- Therapist facilitates *experience* of new realities or possibilities in session, which are then practiced/ adopted outside

Stage 1: Building the foundation - Extrafamilial Domain

Assess:

1. Barriers to participation
2. Parents' skill in advocating for youth/accessing services
3. Needs in all social service domains:
    a. Financial assistance (DCF)
    b. Immigration
    c. Housing
    d. Food
    e. Health Care
    f. Mental Health Care (psychiatric or more intensive services for any family member.)
    g. Disability
    h. Social support for family

Stage 1: Building the Foundation: Extrafamilial Domain

Tasks: School

1. Obtain adolescent's school records (report cards, behavioral records, psychological assessments, etc.)
2. Meet the adolescent's school counselor and teachers. Establish a collaborative relationship.
3. Monitor daily school attendance

Stage 1: Building the Foundation: Extrafamilial Domain

Tasks: Juvenile Justice

1. Meet with juvenile justice officials involved in the adolescent's case (Probation Officers, Case Managers)
2. Obtain adolescent's face sheet (list of all his/her charges and terms of the probation agreement)

Stage 1: Building the Foundation: Extrafamilial Domain

Tasks: Prosocial Activities

1. Identify suitable activities (tutoring, vocational, recreational, community service)
2. Discuss information with youth/family and the importance of the adolescent being involved in prosocial activities.

Stage 2: Facilitate Change Adolescent Domain

A. Facilitate self examination: Who you were, who you are, who you want to be
   - Address the truth about drug use, delinquency, high risk sex, school problems, and how these problems relate
     a) Use the drug screen
     b) Explore consequences/risks
     c) Develop discrepancies between dreams and current lifestyle choiceS
   - Explore ambivalence about change/Examine barriers to change

Stage 2: Address Co-Morbidity Adolescent Domain

- Assess for co-morbidity (depressions, anxiety)
- Refer to psychiatrists for evaluation and medications if necessary
- Work collaboratively with psychiatrist and family to facilitate medication compliance

Stage 2: Facilitate Change Adolescent Domain

MDFT framework on drugs and alcohol use:

- NOT a moral issue (good/bad) or disease
- Pattern of choices that over time become a habit (eventually addiction) that is extremely hard to break
- Drugs worry us most because they make teens unavailable to themselves – incapable of thinking about their lives
- Develop discrepancies between the choices they' re currently making and their hopes/dreams for themselves

Stage 2: Facilitate Change Adolescent Domain

B. Move To Action
   1. Have collaborative discussions with adolescent about how to get to where they want to be
   2. Make concrete plans
   3. Make steps to realize the plan, evaluate outcomes, and adjust plan as necessary

This is a very problem-focused, behavioral intervention.

Stage 2: Facilitate Change Adolescent Domain

C. Prepare adolescent to express concerns, opinions, thoughts, feelings to parents
   1. Help adolescent identify key issues and themes to address with parents
   2. Help adolescent to effectively communicate key issues
   3. Help them decide what they want to say to their parents
   4. Give them lines and rehearse
   5. Give confidence (advocate, support)

Stage 2: Facilitate Change Adolescent Domain

D. If depressed, work with psychiatrist if on meds. Regardless of medication, launch depression module.
   a. Education to parent and teen about depression and its symptoms/effects
   b. Have youth keep daily activity log and review in therapy sessions.
   c. Have youth keep automatic thought log and review in therapy sessions.
   d. Regular consultation with psychiatrist if youth is on meds - collaboration is key

Core MDFT Session:
Joining Together Two (or more) Pieces of Work –

Linking an Individual Session to a Family Session:

Russ and his Parents

What These Sessions Illustrate

Two subsystem sessions (both with teen)

- First: whole family, then teen alone
- Whole-part dynamic
  - "Whole" - Focus on self of teen, how he feels, what's going on with him
    - Also, setting the foundation
  - "Part" – Focus on communicating how he feels to his parents
- Staging different pieces of work
- Orchestration of different therapeutic scenes or events
- Therapist facilitates with good focus and persistence and clear and direct communication about important events and circumstances in the life of the family

Remember….

1. MDFT stresses organization and a therapist's conceptualization
   - of the case
   - of the therapeutic process
2. Flexibility exists within structure
   - Plenty of room for judgment and creativity
3. Therapist behavior is vital to success
   - Getting the ball rolling with standard areas of work
   - Reading feedback and adjusting on the basis of mini-outcomes
   - Perceptual and implementation skills account for therapeutic success

"Baseline" Segment: Background and Pre Therapy Assessment (DVD chapter 1)

1. A whopper – adolescent violent at home and in school (hit a teacher, fights with parents)
2. This was the second try at assessment – both ended the same way
3. Youth was on probation, being considered for residential, getting into fights regularly, using alcohol and marijuana a few times a week
4. Referral source: "Here's a case for you" (but… "He's not a good therapy candidate")

Therapist and Adolescent Alone – End of First Session (DVD chapter 5)

1. Create expectations
2. Therapist defines the program
3. Establishes: “What can be in this for you?”
4. To create a therapeutic focus:
   - Finds and amplifies area of distress and dissatisfaction
5. Attends to motivation behind that focal area
   - Uses what he knows - “You didn’t look so happy” – “… new way of dealing with your anger”

Therapist and Russ alone – End of first session – family session

1. Logic model of interdependence
   - Establish and support a certain premise
   - "What is happening with them, and the ways in which they have treated you affects you" – and "that's something we can address here"
2. Be specific about how you work and why you work the way you do
   - Here's what's involved in this program – "we'll do these things…"
3. Therapist sets the stage
   - Is a bit long winded but the point is made
4. Apparently mixed results – Russ' arms folded, forced ending handshake

Session 2- Two parts: First Teen alone, and then, Teen plus parents (DVD chapter 6)

1. Continues work with Russ
2. Define and focus on distress and how that felt distress could be addressed/changed
3. Provide an opportunity to begin that change process
4. Address problems directly (Let's try to address things and change them now vs. vs. "tell me about the problem")
5. Enactment is a technique and mechanism of change
6. Helps teen become motivated (by focusing on hurt and despair and defining the issues that need to be brought to the parents) for this area of change
7. Sets up the next part of the session

Session 2, Part 2, Russ and Parents

1. Therapist frames the discussion, keeps it going
2. "Brings" Russ from the individual session to the family session
3. Pose question, hold the issue still - "Why does Russ get so angry?"
4. Let Russ say what he has to say, he's ready per the individual sessions with therapist
5. Mind set
   - Start a process between family members
   - Help them experience new realities
   - Try to achieve small but steady outcomes (good listening, acceptance of others, empathy)
6. Address what needs to be addressed to move toward change
7. Successive approximation approach to change

- Teen's behavior prompts good behavior from mom
- Teen's behavior and mom's response are examples of small steps toward change

Summing Up (1 of 2)

1. Focus is very important to overall and in-session outcome
2. Knowing what to focus on is critical
3. And, knowing how to work that focus is more important
4. Remember the therapist's intentions and what he elicited and prompted in the sessions
5. In-session outcome is important; it can be shaped
6. Segments show different and standard pieces of work
7. Shows orchestration execution

Summing Up (2 of 2)

8. Subsystem thinking yields subsystem sessions
9. Enactment set up and skill in execution
10. Working for small changes in the session
11. Teens can reflect, talk and express themselves just fine
12. And, parents can respond
13. Bottom line:
    - Therapists, by what they focus on, and how they focus on it, facilitate change directly by the actions they ask family members to take in sessions

Stage 2: Facilitate Change in the Parent Domain

Rationale for MDFT Parenting Interventions

1. Parents' functioning and their parenting practices predict teens' problems as well as positive outcomes
2. Changes in parenting correlate with changes in the teen, even after problems have begun
3. Establishing strong alliance and motivation are primary interventions before requesting that parents change
4. Therapists gain an understanding of the parent's experience/distress about their current circumstances and ideas about what ought to be different

Parenting Practices – 10 Basic Principles of Good Parenting

#1 Remember, parents matter

- Make a difference in the life of teens by providing guidance and support. At times, it may seem like the teen does not want parents around. However, teens really do need their parents and needs to know they care.

"What you do makes a difference. Your kids are watching you. Don't just react on the spur of the moment. Ask yourself, 'What do I want to accomplish, and is this likely to produce that result? ‘”

Parenting Practices – 10 Basic Principles of Good Parenting

#2 Stay warm and close

- It's impossible for parents to love their teen too much. Encourage parents to spoil their teen with love and support every day. Spend time together at meals, and remember to say, "I love you."

"What we often think of as the product of spoiling a child is never the result of showing a child too much love. It is usually the consequence of giving a child things in place of love – things like leniency, lowered expectations, or material possessions."

Parenting Practices – 10 Basic Principles of Good Parenting

#3 Stay involved with teen's life

- Encourage parents to ask questions about schoolwork and friends, and attend teen's extracurricular activities. Teens need to know parents are interested in them.

"Being an involved parent takes time and is hard work, and it often means rethinking and rearranging your priorities. It frequently means sacrificing what you want to do for what your child needs to do. Be there mentally as well as physically."

Parenting Practices – 10 Basic Principles of Good Parenting

#4 Set limits and provide structure

- Encourage parents to clearly communicate expectations to their teen. Rules and expectations should change throughout the child's life, but children of all ages need clear rules.

"Any time of the day or night, you should always be able to answer these three questions: Where is my child? Who is with my child? What is my child doing? The rules your child has learned from you are going to shape the rules he applies to himself."

"But you can't micromanage your child. Once they're in middle school, you need let the child do their own homework, make their own choices, and not intervene."

Parenting Practices – 10 Basic Principles of Good Parenting

#5 Enforce rules and consequences

- Encourage parents to let their teen know what the consequences of breaking rules will be ahead of time. Follow through on enforcing punishments.

"Setting limits helps your child develop a sense of self-control. Encouraging independence helps her develop a sense of self-direction. To be successful in life, she's going to need both. Accepting that it is normal for children to push for autonomy is absolutely key to effective parenting. Many parents mistakenly equate their child's independence with rebelliousness or disobedience. Children push for independence because it is part of human nature to want to feel in control rather than to feel controlled by someone else."

Parenting Practices – 10 Basic Principles of Good Parenting

#6 Be consistent

- Help parents learn how to discuss and agree on basic parenting principles for guiding their children. Then, be consistent each day and in every situation. Mixed messages from parents can lead to frustration for both parents and children. Children need consistency to help them structure their lives.

"If your rules vary from day to day in an unpredictable fashion or if you enforce them only intermittently, your child's misbehavior is your fault, not his. Your most important disciplinary tool is consistency. Identify your non-negotiables. The more your authority is based on wisdom and not on power, the less your child will challenge it."

Parenting Practices – 10 Basic Principles of Good Parenting

#7 Engage teen in decisions and conversations

- Help parents learn how to discuss the reasons for rules and consequences. This does not mean that the rules or consequences will change, but it will help the teen understand parents reasons and respect you. Teens don't respect authority when it seems arbitrary.

"Generally, parents overexplain to young children and underexplain to adolescents. What is obvious to you may not be evident to a 12-year-old. He doesn't have the priorities, judgment or experience that you have."

Parenting Practices – 10 Basic Principles of Good Parenting

#8 Don't use harsh discipline

- Harsh discipline, like yelling or slapping, is not an effective long-term approach to discipline. Help parents learn to not discipline when they are angry. Instead, make arrangements to talk to the teen at a later time when wisdom and good judgment, not anger, will guide parental discipline choices.

"Children who are spanked, hit, or slapped are more prone to fighting with other children. They are more likely to be bullies and more likely to use aggression to solve disputes with others."

Parenting Practices – 10 Basic Principles of Good Parenting

#9 Treat teen with respect

- Teens are growing up. Help parents acknowledge teen's increasing independence and ability to make decisions. Guide teen in making positive choices, but realize that he or she will make mistakes.

"The best way to get respectful treatment from your child is to treat him respectfully. You should give your child the same courtesies you would give to anyone else. Speak to him politely. Respect his opinion. Pay attention when he is speaking to you. Treat him kindly. Try to please him when you can. Children treat others the way their parents treat them. Your relationship with your child is the foundation for her relationships with others."

Parenting Practices – 10 Basic Principles of Good Parenting

#10 Understand adolescence is a period of change – for parents and children

- Help parents gain knowledge about adolescent development. Teens are changing physically, emotionally, and cognitively. Help parents look for resources to help them understand the changes their teen is going through. Remember, parents' relationship with their teen is changing, not ending.

"Make sure your parenting keeps pace with your child's development. You may wish you could slow down or freeze-frame your child's life, but this is the last thing he wants. You may be fighting getting older, but all he wants is to grow up."

Stage 2: Facilitate Change Parent Domain

A. Support Parents as Human Beings
   - Help parent look at their own life and what they want for themselves. (Assess level of support, need for services, make appropriate referral and follow up)
   - Emphasize self-love, self care. “You need to take care of yourself. You can’t be a good parent if you don’t take care of yourself.” Focus on parent’s needs: who they are and who they want to be.

Stage 2: Facilitate Change Parent Domain

B. Prepare Parents For Action

- Help parents identify what they want for their teen/family (choose battles—what is really important to parent)
- Focus on relationship and emotions
- Examine barriers to and ambivalence about change
- Assist in establishing support that will help them be successful with parenting
- Educate about parenting and development
- Empower parents (information, confidence)

Stage 2: Core Parent Session: Resuscitating Hope/Prompting Action

Background and Goals of Session:

- Therapist had been working with family for several months, with good success
- Recently adolescent relapsed heavily: using, not going to school, not following family rules, not caring about drug court.
- Drug court is ready to commit him. Mom is ready to give up and stop treatment.
- The main goal was for the mother to not give up and to make a commitment to continue to work in therapy and outside of therapy to help her son.

MDFT-Working with the Parent

Given this situation, what is the therapeutic goal for the next session?

Therapeutic Goal

Prevent mother from giving up on her son:

- Recognize that her son is not hopeless
- Recognize that she is the only one who can save her son.
- Feel confident in her ability to help her son (empowerment)
- Say she will not give up on her son, and will do whatever it takes

How Does an MDFT Therapist Reach The Stated Therapeutic Goals?

- Brings into relief, in a way that elicits emotion from the parents, the seriousness of teen's situation
- Highlights teen's strengths, achievements, and competencies
- Empowers parent so she feels competent, and has confidence in her ability to help teen
- Focuses on parent's relationship with her boyfriend because this influences mother's ability to feel competent
- Expresses compassion, understanding and total support of parents
- Is respectful toward and collaborative with parent

The Therapist Does Not:

- Lose focus on stated therapeutic goals and interventions to achieve goals
- Encourage problem solving

Pay Attention To:

1. Mom's drift away from involvement and agency
2. Therapist's focus on current situation, teen's needs, mom's circumstances and decision(s), and the possibility of taking action, again
3. Listen for mom's primary position, as well as for openings
4. Watch therapist's relationship building, empathy and acceptance, exploration of other aspects of mom's life, and insertion of generic themes such as parental connection, and unique role of parents, and the potential for mom to act

Play DVD

MDFT-Working with the Parent

- What is the goal of the next session?
- Who will come to that session?
- How will the therapist set up/start the session?

Stage 2: Facilitate Change Parent Domain

C. Strengthen Parenting Team Work

- Address inter-parent conflict – Inspirational
  - They must put aside their differences; come together for the child
- Address inter-parent conflict – Behavioral
  - Help parents work out a plan for how they will work as a team to parent child. Offer a trial and error framework.

Play DVD- Gayle & Divorced Parents

Stage 2: Facilitate Change Parent Domain

D. Help Parents Communicate in a New Way

- Prepare parent to hear son/daughter voice (complaints, concerns, past and current hurts, etc). "If you want to have influence on your adolescent you have to know him/her. You may hear some things that are difficult and that you may not like. It is very important that you are able to hear about his/her world."

Stage 2: Facilitate Change Parent Domain

E. Address Parents' Beliefs/Attitudes about Alcohol and Drug Use

- Help parents examine their own behaviors, including drug use or other high risk behaviors. Encourage change in relevant areas as they affect the child.
- Encourage strong anti-drug stance and strong pro-school stance (Even if parent uses themselves, their stance to the adolescent is crucial).

Stage 2: Facilitate Change Parent Domain

F. Enhance age appropriate parenting skills:
   - Monitoring
   - Limit setting/House Rules
   - Consequences (positive and negative)
   - Follow through

Stage 2 Core Parenting Sessions: William and his Two Moms

1. 15-16 years old
2. Juvenile justice involved
3. Significant and long-term deviant peer affiliation
4. Using cannabis several times a week
5. Mom (Maritza) and partner (Miriam) – stable relationship but struggling with two oldest kids, William and older brother

Tape illustrates important aspects of MDFT

1. Important content and how to focus this content in session
2. Continuity of therapy, referring and using themes and content from other sessions, bringing them forward to re-work and renew attention to important matters (parental teamwork and actions re curfew, and role of tracker) and using out of session events to bring them back into the session
3. Making it real: Using enactment in session
4. Relying on standard and core areas of work to bring out and address idiosyncratic aspects of this family (teamwork, self of the teen – good side/bad side [risk – deviant peers and protection – strong family, changed self])

Summary of important content focused on in the session

1. Parental subsystem focus and techniques to improve functioning of the team – curfew, supporting "maturity demands" of the parental subsystem
2. Using the move of brother to Orlando to foster sensitivity and caring of Wm for mom – what she was going through
3. Using a standard *convention* – the different aspects of self, good side and bad side , and bringing this into session in a dramatic, physicalistic and symbolic way – to play out the forces of family vs. street influences

Summary of core therapeutic skills

1. Keeping a solid and therapeutic focus
2. Using one's time in a session well
3. "Quality time" – think "quality sessions"
4. Bring out of session activities and events into sessions
5. Use in session events to give homework for out of session activities
6. Link previous work to current session's focus
7. Enactment as a way of promoting beginnings of change

Stage 2: Facilitate Change Family Domain

Enactment: Primary Change Mechanism

Experiential versus Talking About It

"Create Alternative Realities"

- Different ways of talking to each other
- Different experiences of being with each other and relating together
- Different ways of thinking about each other

Stage 2: Facilitate Change Family Domain

A. Facilitate Parent – Youth Discussions

- Bring conflict out in the open. Put it on the table so family can deal with it
- Help adolescent and parent dialogue:
  a) Youth expresses opinions, complaints, concerns, desires to parents
  b) Parents listen and restrain inclination to interrupt, disagree, judge
  c) Parents respond in constructive ways, acknowledging youth's view

Stage 2: Facilitate Change Family Domain

B. Facilitate Age Appropriate Problem Solving and Negotiation:

- Help establish effective ways to problem solve. Improve conflict resolution skills. Express views without fighting and blaming.
- Encourage age appropriate negotiation. Work together to set certain limits and consequences.

Stage 2: Facilitate Change Family Domain

C. Address Alcohol and Drug Use Directly and Productively in Family Sessions

- Drug screen results are used in family sessions to focus the family on the seriousness of the problem (also to show good progress).
- The teen is not blamed/criticized, but instead the family is mobilized around the ongoing puzzle of "what are we not doing here?" "what' s not in place to help Michael stay clean?"

Stage 2: Core Family Session: Using Drug Screens in Session

Carlos and Carlos

Stage 2: Facilitate Change Family Domain

D. Facilitate expression of love/concern behind limit setting and disciplining

T: Tell him why you are doing this.

P: I'm doing this because I love you, and I want the best for you. I don't want you to go to jail. I want you to be safe. I want you to have every advantage in life…

T: So Gina, why is your mom changing how she sets and follows through with rules?

Y: Because she loves me – I see that.

Stage 2: Facilitate Change Family Domain

E. Enhance Love

- Focus on affective component of relationships
- Support and enhance family communication of warmth and love
- Help family members to recognize how important they are to each other
- Facilitate expressions of love

Stage 2: Facilitate Change Family Domain

F. Facilitate Healing/Development of Trust

- Help parents to address trust as a core issue with youth and how trust can be regained (not an overnight process)

- Help youth address trust issues with parents and understand what is needed to rebuild trust on both sides

Stage 2: Core Family Session: Healing Hurts and Reconnecting

Milton and Milton

Background about Milton

1. Milton felt abandoned by his father
2. He had been using and also selling drugs to help mother support household
3. His mother had severe mental health issues (schizophrenic) that could not be consistently reduced through medication – she was not a functional parent
4. Milton was failing in school
5. He had been arrested several times for drug-related charges and was pending “direct file” to the adult system because of the serious nature of his crimes

Enactment between father and son

1. Helped father listen to son with an open, interested and attentive stance
2. Son told father about his feelings – and how it was for him to miss him so much
3. Father expressed regret for not being there, and related his own experiences
4. They were able to talk to each other in a new way, revealing feelings they had never expressed and a level of understanding that had not been possible before – achieved a new experience
5. Ended with hope that things could be better for them and that they could have a new start

Stage 2: Facilitate Change Extrafamilial Domain

Help parents become increasingly more independent and skillful in their attempts to advocate for their child and manage the family's extrafamilial needs

Stage 2: Facilitate Change Extrafamilial Domain

1. Continue to teach and guide parents about ongoing extrafamilial tasks.
2. Be available for trouble shooting if the parents encounter any problems.
3. Be prepared to carry out more intensive teaching if new or unexpected extrafamilial needs come up.

Stage 2: Facilitate Change Extrafamilial Domain

4. Check in with parents about how they are doing with the extrafamilial tasks:
   - Discuss problems encountered
   - Follow-up with parents after meetings, court appearances, appointments, etc.
   - Provide parents with encouragement and the necessary guidance to be increasingly more effective and confident

Case Managers

- Knowledge of community resources (i.e. legal system, DCF, immigration, etc.)
- Willingness to do home-based and community-based work
- Passion for working with families in need
- Commitment to outcome and a clear understanding why this work is important

Case Management Aspects

- Assertive in interactions with other agencies; not only persistent, but also able to be creative and find multiple pathways to obtain desired outcome
- Good social, verbal and written skills (i.e. negotiate effectively in the community and legal system)
- Ability to work closely within a team of multiple therapists and manage and prioritize many specific tasks

- Flexibility in terms of work hours: TAs arrange their work schedules according to what is needed for the families; sometimes this necessitates working nights and/or weekends
- Willingness to work within a team and understand the importance of collaboration and cooperation

Extrafamilial Assessment

What are the kinds of extrafamilial needs families may have?

- Basic needs: Housing, financial, food
- Psychiatric/Medical Referrals
- Legal (Delinquency and/or Dependency/ Family Court)
- School
- Immigration
- Connections to Prosocial Activities

Basic Needs: Housing, Financial, Food

Rationale: Facilitate engagement and meet basic needs; families have a difficult time establishing a clinical focus if they do not have a place to live, food, etc.

1. Are you behind on your rent?
2. Are you in danger of being evicted?
3. Are you able to make ends meet?

Basic Needs: Housing, Financial, Food

1. Are you receiving any economic assistance (Food stamps, AFDC, WIC, Social Security benefits, child support, help from other family members, emergency food)?
2. Would you like help to obtain economic assistance?

Psychiatric and Medical Referrals

Rationale: Severe psychiatric/medical illness in the family system inhibits communication and behavior change. For parents, this may mean a physical inability to parent, which affects their ability to provide basic needs for their kids (lack of adequate monitoring, inability to be present at school, legal meetings). This needs to be assessed to determine if the parent can be helped with these skills or if someone else can be involved in the treatment.

Psychiatric and Medical Referrals

1. Do you or any one in your family suffer from mental health problems? If family is Hispanic: Do you or any one in your family suffer from “los nervios”?
2. Are you seeing a psychiatrist?
3. Are you taking any medication? If yes, what medication are you taking? Are you seeing a doctor to monitor meds?
4. Have you ever been hospitalized? If yes, when and why?

Psychiatric and Medical Referrals

5. Have you ever thought of hurting or killing yourself?
6. Do you have a hard time getting out of bed?
7. Do any members of the family have a substance abuse problem? If yes, are they currently using? In treatment?
8. Do you or any one in your family suffer from any medical illness? If yes, are you/they under medical care at this time? Are you their primary caretaker?

Legal (DJJ)

Rationale: Collaboration with the court is critical for successful attainment of treatment goals, including getting out of the DJJ system. We can lose a case quickly if contact is not made with the appropriate court officials. Having a collaborative relationship with these individuals can provide leverage with families and facilitate progress in tx.

Legal (DJJ)

1. Has the client ever been arrested? If yes, does the client have any open charges? What are the client's charges? Who is the client's DJJ worker or PO?
2. Has DCF ever been involved with the family? If yes, why? Does the family have a DCF caseworker at this time?
3. Does the client have a civil court case open at this time? Court order for tx?
4. Does the client have any court appearances upcoming? When?
5. Is the client involved in Drug Court?

School

Rationale: School is a major part of the adolescent's life and thus a very important focus in MDFT. We need to know the severity of school problems (academic and behavioral) in order to assess client's needs and formulate a treatment plan. The school system is very complex and it takes time to get things done. If the adolescent is not in the appropriate school setting or program, success in school is unlikely.

School

1. Nature of school problems (academic and/or behavioral)?
2. Has the teen ever been suspended? If yes, how many times and why? Has client been referred to alternative school? Is s/he currently in danger of being expelled?
3. Has client ever been evaluated for special education services?
4. Is client receiving special services at school or outside of school?

School (cont.):

- Prepare and enable parents to facilitate school interventions on their own prior to termination
- Maintain active contact with schools, alternative education programs, etc.
- Monitor contact and progress with tutoring programs

Immigration

Rationale: Families in fear of deportation may not attend extrafamilial appointments, e.g., court or school meetings. Engagement with families can be jeopardized because they may fear the therapist as part of the system.

- Do they have residency?
- Do they have a work visa?
- Are they legal in the USA?
- Are they USA citizens?

Recreational and Vocational Services:

- Make referrals to appropriate agencies
- Help prepare applications and organize for interviews
- Take client (parent or adolescent) to appointments at job agencies, vocational rehabilitation, or interviews

Recreational and Vocational Services (cont.):

- Monitor attendance at all prosocial activities (e.g., sports)
- Take clients to 12-step meetings
- Facilitate parental access to support groups and/or 12-step meetings as necessary

Recreational and Vocational Services (cont.):

- Evaluate appropriateness of recreational activities in terms of content, staff competence, and rapport
- Determine cost, hours, attendance requirements
- Facilitate mentor contact and monitor contact

Health Services:

- Maintain updated contacts with providers
- Facilitate health care service access
- Make referrals/appointments to appropriate agencies
- Take family members to appointments with health care providers as necessary
- Obtain results from providers
- Visit family members at inpatient facilities when appropriate as requested by therapist

Legal Services:

- Maintain contact with juvenile probation officer
- Attend court hearings as needed
- Visit clients in detention as requested by therapist
- Take family members to Immigration and Naturalization appointments as necessary

A Week in the Life of an MDFT Therapist

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
9:00 AM	Phone calls/texts to confirm sessions & plans for the week	School Visit Court or Consults with JPO's	Case A Session #2		Study Time, Paperwork, Consults with JPO's, Court, Return Phone Calls	Make up Sessions for Parents who work	
9:30 AM							
10:00 AM	Complete TA Task List by 12 noon	Individual Supervision	School Visits, Court or consults w/ JPO's	Make up Parent Session or Session with Adolescent out of School			
10:30 AM							
11:00 AM	Complete Weeklies & Case Conceptualizations		Case B Session #2			Monthly MDFT HIV Workshops	
11:30 AM	Drive Time		Study Time	Assignments from Supervisors			
12:00 PM	Phone Calls	Therapist-TA Meeting					
12:30 PM	Study Time						
1:00 PM		Staff Meeting	Drive Time	Drive Time			
1:30 PM							
2:00 PM			Case D Session #1	Case D Session #2	Drive Time		
2:30 PM							
3:00 PM	Drive Time				Phone Calls	Drive Time	
3:30 PM	Case A Session #1	Clinic Night		Drive Time	Case F Session #2		
4:00 PM			Drive Time	Case G Session #1		Make up Sessions	
4:30 PM					Drive Time		
5:00 PM	Drive Time Phone Calls		Case E Session #1				
5:30 PM	Case B Session #1			Drive Time	Phone Calls		
6:00 PM			Drive Time	Case C Session #2	Case E Session #2		
6:30 PM			Phone Calls				
7:00 PM	Drive Time	Drive Time	Case F Session #1				
7:30 PM	Case C Session #1	Occassional Emergency Session/Phone Calls					
8:00 PM							

Assumes 7 cases

MDFT DVDs

http://www.hazelden.org/OA_HTML/ibeCCtpItmDspRte.jsp?item=14298&sitex=10020:22372:US

http://www.apa.org/VIDEOS/4310853.html

Thank you!