Multidimensional Family Therapy: A Science-Based Treatment System

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Yes, I have heard about family psychotherapy — but opinions are no substitute for data. (Garfield, 1982)

MDFT is a family-based intervention for adolescent substance abuse and associated mental health and behavioural problems (Liddle, 2010). Integrative in several ways, MDFT uses an ecological or contextual conceptual framework to understand the developmental tasks of teens and their families. Research-derived knowledge about risk and protective factors, and proximal causes, correlates and contributors to adolescent drug and related problems inform clinical thinking and interventions with every case. A multisystems approach, MDFT assesses and intervenes in four areas: (1) the adolescent as an individual and a member of a family and peer network; (2) the parent(s), both as individual adults and in his or her role as mother, father or caregiver; (3) the family environment and family relationships, as manifested in day-to-day family transactional patterns; and (4) extrafamilial sources of influence such as peers, school and juvenile justice. Interventions are made within and coordinated across domains. Progress in one area or with one person has implications for and use in others. Individual meetings with parent(s) and teen set the stage for family sessions, and family meetings may offer content and new outcomes that need to be brought to extrafamily meetings with juvenile justice or school personnel. MDFT was developed and tested as a treatment system rather than a one-size-fits-all approach. A treatment system offers different versions of a clinical model that vary according to factors such as clinical sample characteristics (older versus younger adolescents, juvenile justice involved versus no involvement in juvenile justice systems), and treatment parameters (type of clinical setting and treatment dose).
Four types of MDFT studies have been conducted: (1) efficacy/effectiveness controlled trials, (2) process studies that identify ingredients and therapeutic processes related to clinical progress and outcomes, (3) economic analyses, and (4) implementation studies testing the model's transfer to community settings. Independent reviews support the quality of MDFT’s scientific evidence (Austin, Macgowan, & Wagner, 2005; Becker & Curry, 2008; Vaughn & Howard, 2004; Waldron & Turner, 2008) and identify it as a model program and evidence-based practice (Drug Strategies, 2003, 2005; NIDA, 1999; NREPP, 2009).

**Adolescent Substance Abuse**

We know a great deal about the ingredients, sequence, and interactions that predict drug involvement. Adolescent substance abuse can progress along various, frequently intersecting developmental pathways, hence its designation as a multidimensional and multidetermined phenomenon requiring a multiple systems strategy with interventions that target several different contexts and domains of functioning.

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

**Ten Principles Organise the Approach**

1. **Adolescent drug abuse is a multidimensional phenomenon.** Individual biological, social, cognitive, personality, interpersonal, familial, developmental, and social ecological aspects can all contribute to the development, continuation, worsening and chronicity of drug problems.

2. **Family functioning is instrumental in creating new, developmentally healthy lifestyle alternatives for adolescents.** The teen’s relationships with parents, siblings and other family members are a fundamental area of assessment and change. The adolescent’s day-to-day family environment offers numerous and essential opportunities to re-track the developmental problems of youth.

3. **Problem situations provide information and opportunity.** Symptoms, problem situations, provide assessment information as well as essential intervention opportunities.

4. **Change is multifaceted, multidetermined and stage-oriented.** Behavioural change emerges from interaction among systems and levels of systems, people, domains of functioning, and intrapersonal and interpersonal processes. A multivariate conception of change commits the clinician to a coordinated, sequential use of multiple change methods and working multiple change pathways.
5. **Motivation is not assumed but it is malleable.** Motivation to enter treatment or to change will not always be present with adolescents or their parents. Treatment receptivity and motivation vary in individual family members and relevant extrafamilial others. Treatment reluctance is not pathologised. Motivating teens and family members about treatment participation and change is a fundamental therapeutic task.

6. **Multiple therapeutic alliances are required, and they create a foundation for change.** Therapists create individual working relationships with the adolescent, the subsystem of individual parent(s) or caregiver(s), and individuals outside of the family who are or should be involved with the youth.

7. **Individualised interventions foster developmental competencies.** Interventions have generic or universal aspects. For instance one always wants to create opportunities to build teen and parental competence during and between sessions. But all interventions must be personalised — tailored or individualised to each person and situation. The family’s background, history, interactional style, culture, language and experiences are dimensions on which interventions are customised. Structure and flexibility are two sides of the same therapeutic coin.

8. **Treatment occurs in stages; continuity is stressed.** Particular standard operations (e.g., adolescent or parent treatment engagement and theme formation), parts of a session, whole sessions, stages of therapy, and therapy overall are conceived and organised in stages. Continuity — linking pieces of therapeutic work together — is critical. Each session is one piece that is woven together into a seamless whole. Similarly, the parts of treatment are woven together in an active attempt by the therapist to maintain continuity and build linkages between sessions.

9. **Therapist responsibility is emphasised.** Therapists are responsible for (a) promoting participation and enhancing motivation of all relevant persons, (b) creating a workable agenda and clinical focus, (c) providing thematic focus and consistency throughout treatment, (d) prompting behaviour change, (e) evaluating, with the family and extrafamilial others, the ongoing success of interventions, and (f) revising interventions as necessary.

10. **Therapist attitude is fundamental to success.** Therapists advocate for adolescents and parents. They are neither ‘child savers’ nor unidimensional ‘tough love’ proponents. Therapists are optimistic but not naive or Pollyannaish about change. Their sensitivity to environmental or societal influences stimulates ideas about interventions rather than reasons for how problems began or excuses for why change is not occurring. As instruments of change their personal functioning facilitates or handicaps their work.

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**The Interdependence of Intervention and Assessment**

**Multidimensional Assessment**

A comprehensive, multidimensional assessment process identifies risk and protective factors in relevant areas. Information about functioning in each target area comes through individual and family interviews, observations of both spontaneous and
directed family interactions, and observation of family member interactions with influential people outside of the family. The approach has four intervention targets: (1) adolescent, (2) parent, (3) family interaction, and (4) extrafamilial social systems. In exploring the target areas, clinicians explore life details and current functioning based on research-derived knowledge about the multifaceted development of adolescent substance abuse and related problems. Attending to deficits and hidden areas of strength, we obtain a clinical view of the unique combination of assets and weaknesses in the adolescent, family, and social context. This includes a formulation of how the current situation and behaviours are understandable, given the adolescent’s and family’s developmental history and current risk and protection profile. Interventions aim to decrease risk processes known to be related to dysfunction development or progression, and enhance protection, first within what the therapist finds to be the most accessible and malleable domains. Assessment is an ongoing process. It continues throughout therapy as new information emerges. Therapeutic plans are revised according to feedback from the interventions that we make.

Family Assessment

The assessment process typically begins with a meeting that includes the entire family. Therapists observe family interaction and note how individuals contribute differentially to the adolescent’s life and current circumstances. Family interaction assessment occurs with direct therapist inquiries and observations of enactments during family sessions, as well as individual meetings with family members. We meet individually with the adolescent, the parent(s), and other members of the family within the first session or two. Individual meetings clarify the unique perspective of each family member, their individual view of relationships and the current problems, how things have gone wrong (e.g., juvenile justice involvement, legal and drug problems, neighborhood and peer influences, school and family relationship difficulties), what they have done to address the problems, and what they believe needs to see change with the youth and family.

Adolescent Assessment

Therapists elicit the teen’s life story, an important assessment and engagement intervention strategy, during early individual sessions. Sharing their life experiences contributes to the teen’s engagement. It provides a detailed picture of the severity and nature of the teen’s drug use (teens in the MDFT projects have used a wide variety of drugs; but generally, cannabis and alcohol, along with tobacco, are the most common drugs of abuse) and circumstances and trajectory of drug use over time, family history, peer relationships, school and legal problems, and important life events. One useful technique involves asking the adolescent to draw an eco-map that represents his or her current life space. This would include the neighbourhood, indicating where the teen hangs or goes to buy and use drugs, where friends live, the location of school or work, and, in general, where the action is in his or her environment. Therapists inquire about the adolescent’s health and lifestyle issues, including sexual behaviour (Marvel, Rowe, Colon, DiClemente, & Liddle, 2009). The presence and severity of comorbid mental health problems is determined through the review of previous records and reports, the clinical interview process, and psychiatric evaluations.
Parent(s) Assessment

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

Relevant Social System Assessment

Finally, assessment of extrafamilial influences involves gathering information from all relevant sources. This information is combined with the adolescent’s and family’s reports in order to compile the fullest possible picture of each individual’s and the family’s functioning relative to external systems and current circumstances. With funding from a local foundation, our Miami-based treatment program now provides on site educational academic tutoring that is part of the core MDFT work. The adolescent’s educational/vocational placement is assessed thoroughly. Alternatives are generated in order to create workable alternatives to drug use and to build bridges to a productive lifestyle. Therapists build relationships and work closely and collaboratively with the juvenile court and probation officers in relation to the youth’s legal charges and probation requirements. They focus the parents on the potential harm of continued negative or deepening legal outcomes, and using a nonpunitive tone, they strive to help teens face and deal with their legal situation. Assessment of peer networks involves encouraging the adolescent to talk about peers, school, and neighborhood contexts in an honest and detailed manner, and this is used to craft focal treatment areas. The creation of concrete alternatives that provide prosocial, developmentally enhancing day to day activities using family, community or other resources is a driving force the extrafamilial domain, and of course, of MDFT generally.

Interlinked Multidimensional Interventions Facilitate Adolescent, Parent, and Family Development

We target behaviours, emotions, and thinking patterns implicated in substance use and abuse, as well as the complementary aspects of behaviours, emotions, and thought patterns associated with development-enhancing intrapersonal and familial
functioning. Intervention targets always connect to assessment. Multifaceted, interventions have intrapersonal (i.e., feeling and thinking processes) and interpersonal and contextual aspects (i.e., transactional patterns between family members or between family member and extrafamilial persons). Strategy and a logic model of what change is and how it occurs are important in multisystems clinical work.

Change targets are prioritised. The focus for change begins in certain areas first, and then changes in these areas are used as departure points for the next, usually more difficult, working areas for change. All roads must lead to changing drug use and abuse and related problem areas. When development-enhancing interventions are effective, they create everyday outcomes that are incompatible with previous drug using behaviours and ways of moving through life. New developmental competencies emerge, sponsoring progress toward completing previously compromised developmental tasks. New behaviours crowd out the drug-using lifestyle and replace it with a new, more adaptive way of growing up and relating to one's adolescent. We assess and intervene in four interdependent and mutually influencing subsystems with each case. The multi-person focus is theory based and practical. While other family-based interventions might address parenting practices by working alone with the parent for much of the therapy, MDFT not only works with the parents individually but also focuses significantly on the teen alone, apart from the parent sessions, and apart from the family sessions. These individual sessions have enormous strategic, substantive and relationship building value. They provide vital point of view information and reveal feeling states and historical events that are not always forthcoming in family sessions. Family-based treatment means establishing multiple therapeutic relationships rather than single therapeutic alliances as is the case in individual treatment. If individual therapeutic alliances are basic to individual therapy's success, multiple therapeutic alliances, and success in those relationships, are equally fundamental to success in our version of family based therapy. They actualise the kinds of therapeutic processes from which positive clinical outcomes emerge. A therapist's relationships with different people in the mosaic that forms the teen's and family's lives are the starting place for inviting and instigating change attempts. The strategic aspects of these actions are probably obvious by now. There is a leveraging, a shuttle diplomacy that occurs in the individual sessions as they are worked to create content, motivation, and readiness to address other family members in joint sessions.

Interventions With the Adolescent

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

**Interventions With the Parent**

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

**Interventions to Change the Parent–Adolescent Interaction**

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

Interventions With Social Systems External to the Family
MDFT also facilitates changes in the ways that the family and adolescent interact with systems outside the family. Substance-abusing youth and their families are involved in multiple social systems. Success or failure in negotiating these systems has considerable impact on the teen’s and parent’s life course. Close collaboration with the school, legal, employment, mental health and health systems influencing the youth’s life is critical for initial and durable change. For an overwhelmed parent, help in dealing with complex bureaucracies or in obtaining needed adjunctive services not only increases engagement, but also improves his or her ability to parent effectively by reducing stress and burden. Therapists help to set up meetings at school or with juvenile probation officers. They regularly prepare the family for, and attend the youth’s juvenile justice disposition hearings, understanding that successful compliance with the juvenile justice supervision requirements is a core therapeutic focus and task. School or job placements are also basic aspects of the therapeutic program since they represent real world settings in which they youth can develop competence, succeed and build a pathway away from deviant peers, drugs and antisocial behaviour. In some cases, medical or immigration issues, or financial problems may be obvious and urgent areas of need and stress. Our approach understands the interconnection of all of these life circumstances to the improvement of family life, parenting, and a teen’s reclaiming of his or her life from the perils of the streets. Not all multisystem problems can be solved, but in every case, our rule of thumb is to assess all of them, make priorities, and as much as possible, work actively and directly to help the family achieve better day to day outcomes relative to the most consequential and malleable areas.

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

If decisions about session composition flow from therapeutic goals, it should be emphasised that not all goals are set a priori. For instance, some goals are at smaller operational levels than an objective such as increase of parental competence. Some therapeutic goals are set and existing goals are adjusted on the basis of feedback that one reads from the family and extrafamilial others. Therapeutic feedback from any and all parts of the therapeutic system and environment is sought and used constantly to answer the following core questions: How is this therapy going? What have I accomplished in terms of addressing and successfully attending to MDFT’s core areas of work — the four domains of focus? (For example, do I know the teen’s hopes and dreams? Do I know the parents’ burdens? What am I working on extrafamilially — in the natural environment of the teen and family?) What are we working on and is this content and focus meaningful? Are we getting results, progressing reasonably?

Thus, while core pieces of work in MDFT, such as engagement of the teen and working on parent issues (e.g., parenting practices, the shaping of the parent-teen relationship through the interpersonally and behaviourally oriented technique of enactment) may dictate session composition and participation because of the obvious nature of their work; other aspects of therapy, such as working a given therapy theme, for example, may require feedback to be read before session composition can be determined or decided. Having a clear sense about the core aspects of what one has to focus on in MDFT, working in the four domains of adolescent, parent, the teen-parent relationship, and the extrafamilial, largely, but not completely, indicates who should be present in a given session. A therapist’s realisation that his relationship with the adolescent is slipping after a rough session or
negative outside-of-therapy event (e.g., a tense court hearing where a decision went against the adolescent), must be used quickly (i.e., reading of feedback) to right the therapeutic course. An individual meeting, in the clinic, in the home, at school, or at a fast food restaurant is needed, and it is in the therapist's best interest to act quickly in relation to feedback of this type. Decisions about session composition are vital and they can be confusing. However, once one readjusts the decision making lens to put therapeutic goals first, and to determine those goals on the basis of the core aspects of the approach, in conjunction with a close reading of feedback, session composition decision making becomes easier. The therapist's ongoing and naturally occurring assessments of multiple domains of functioning always provide a trustworthy answer to where he or she needs to go and what needs to be focused on. From these questions derive operational and more simple questions — who do I work with next, and when.

Research Evidence

MDFT has been developed and tested primarily in NIDA and other federally funded research projects since 1985. The studies have been conducted at sites across the United States, among diverse samples of adolescents (African American, Hispanic/Latino, and White youth between the ages of 11 and 18) of varying socioeconomic backgrounds. Internationally, a five country multisite trial of MDFT, funded by the Health Ministries of Germany, France, Switzerland, Belgium and The Netherlands is nearly complete. Participants in MDFT studies meet diagnostic criteria for adolescent substance abuse disorder. Most samples had significant co-occurring problems as well, most commonly, delinquency, and secondarily, depression and anxiety.

Randomised Controlled Trials

Ten completed randomised controlled trials have tested MDFT against a variety of comparison adolescent drug abuse therapies. MDFT has demonstrated superior outcomes to several other state-of-the-art, active treatments, including a psychoeducational multi family group intervention, peer group treatment, individual cognitive–behavioural therapy (CBT), and residential treatment (Liddle, Dakof, Parker, Diamond, Barrett, & Tejada, 2001; Liddle & Dakof, 2002; Liddle, Rowe, Dakof, Ungaro, & Henderson, 2004; Liddle, Dakof, Turner, Henderson, & Greenbaum, 2008; Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009; Liddle, Dakof, Henderson, & Rowe, in press). These studies have included samples of teens with serious drug abuse (i.e., heavy marijuana users, with alcohol, cocaine, and other drug use) and antisocial behaviours. The following section summarises key clinical trial findings. An independent government review of the scientific evidence for MDFT found positive outcomes across 9 treatment outcome domains (NREPP, 2009).

Treatment Engagement and Retention

In a recent study with a juvenile offender sample who began MDFT while in detention and continued MDFT with an outpatient MDFT regimen, MDFT cases retained 87% of its participants, compared to 13% in the services as usual condition for at least 3 months of post-detention treatment. This engagement and reten-
tion rate is consistent with previous MDFT studies. In another MDFT trial with clinically referred young (11–15 years) adolescents in which youth received services once or twice a week over 4 months, MDFT retained 96% of its participants (Liddle et al., 2004, 2008). In another study testing MDFT as an outpatient alternative to residential treatment (i.e., justice-involved, multiply-impaired teens with largely co-morbid diagnoses), 87% of MDFT participants were retained for three or more months of treatment, compared to 59% retained in the comparison intervention–residential treatment (Liddle, 2002).

**Substance Abuse**

MDFT participants’ substance use is reduced significantly. Using an example from one study, MDFT youths reduced drug use between 41% and 66% from baseline to treatment completion. These outcomes remained consistent at one year follow-up (Liddle et al., 2001; Liddle et al., 2004; Liddle et al., 2008; Liddle et al., 2009). MDFT youths also have demonstrated abstinence from illicit drugs after treatment significantly more than teens in comparison treatments (Liddle & Dakof, 2002; Liddle et al., 2001; Liddle et al., 2008; Liddle et al., 2009). For instance, in a recent study (at post-treatment and at one year follow-up) MDFT participants had 64% drug abstinence rates compared to 44% for CBT (Liddle et al., 2008); in another study, MDFT achieved a 93% abstinence outcome compared to 67% for group treatment (Liddle et al., 2009). MDFT has been effective as a community-based drug prevention program as well; and using a brief 12-session (over 3 months), in-clinic (community treatment setting) weekly protocol, MDFT has successfully treated clinically referred younger adolescents who recently initiated drug use (Liddle et al., 2009).

**Substance Abuse Related Problems**

Substance abuse related problems (e.g., antisocial, delinquent, externalizing behaviours) were reduced significantly in MDFT vs. comparison interventions including manual-guided active treatments. Ninety-three per cent of MDFT youth report no substance related problems at one year follow-up (Liddle et al., 2009).

**School Functioning**

School functioning improves more dramatically in MDFT than comparison treatments. MDFT clients have been shown to return to school and receive passing grades at higher rates (Liddle et al., 2001; Liddle et al., 2009), and also show significantly greater increases in conduct grades than a comparison peer group treatment (Liddle et al., 2009).

**Psychiatric Symptoms**

Psychiatric symptoms show greater reductions during treatment in MDFT than comparison treatments (30% to 85% within-treatment reductions in behaviour problems, including delinquent acts and mental health problems such as anxiety and depression) (Liddle et al., 2006; Liddle et al., 2009). Compared with individual CBT, MDFT had better drug abuse outcomes for teens with co-occurring problems, and decreased externalising and internalising symptoms, thus demonstrating
superior and stable outcomes (one year) with the more severely impaired adolescents (Liddle et al., 2008).

**Delinquent Behaviour and Association With Delinquent Peers**

MDFT-treated youths have shown decreased delinquent behaviour and associations with delinquent peers, whereas peer group treatment comparisons reported increases in delinquency and affiliation with delinquent peers. These outcomes maintain at 1-year follow-up (Liddle et al., 2004; Liddle et al., 2009; Liddle et al., in press). Department of Juvenile Justice records indicate that compared to teens in usual services, MDFT participants are less likely to be arrested or placed on probation, and had fewer findings of wrongdoing during the study period. MDFT-treated youth have also required fewer out-of-home placements than comparison teens (Liddle et al., 2006). Importantly, parents, teens, and collaborating professionals have found the approach acceptable and feasible to administer and participate in (Liddle et al., in press).

**Theory-Related Changes: Family Functioning**

MDFT youth report improvements in relationships with their parents (Henderson, Rowe, Dakof, Hawes, & Liddle, 2009; Liddle et al., 2009). On behavioural ratings, parenting practices (Schmidt, Liddle, & Dakof, 1996) and family functioning improves (e.g., reductions in family conflict, increases in family cohesion) to a greater extent in MDFT than family group therapy or peer group therapy (observational measures), and these gains are seen at 1-year follow-up (Liddle et al., 2001). Furthermore MDFT-treated youths report gains in individual and developmental functioning on self-esteem and social skill measures (Liddle, et al., 2006; Liddle et al., 2009).

**Studies on the Therapeutic Process and Change Mechanisms**

MDFT studies have demonstrated how to improve family functioning by targeting in-session family interaction (Diamond & Liddle, 1996) and how therapists build successful therapeutic alliances with teens and parents (Diamond et al., 1999). Adolescents are more likely to complete treatment and decrease their drug taking when therapists have effective therapeutic relationships with their parents (Hogue, Liddle, Singer, & Leckrone, 2005) and with the teens as well (Robbins et al., 2006). Strong therapeutic alliances with adolescents predict greater decreases in their drug use (Shelef, Diamond, Diamond, & Liddle, 2005). Another process study found a linear adherence-outcome relation for drug use and externalising symptoms (Hogue et al., 2005). Relatedly, MDFT seems to have superior performance compared to comparison treatments with more difficult cases, those having higher severity of drug abuse (Henderson et al., 2009). MDFT process studies found that parents’ skills improve during therapy, and critically, these changes predict teen symptom reduction (Henderson et al., 2009; Schmidt et al., 1996). Culturally responsive protocols have demonstrated increases in adolescent treatment participation (Jackson-Gilfort, Liddle, Tejeda, & Dakof, 2001). We are beginning to understand the relationship of particular kinds of interventions and key target outcomes. In one example, interventions focusing on in-session family change produced differences in drug use and emotional and behavioural problems (Hogue, Liddle, Dauber, & Samuolis, 2004).
Economic Analyses
The average weekly costs of treatment are significantly less for MDFT ($164) than standard treatment ($365). An intensive version of MDFT has been designed as an alternative to residential treatment and provides superior clinical outcomes at significantly less cost (average weekly costs of $384 versus $1,068 [French et al., 2003; Zavala et al., 2005]).

Implementation Research
MDFT integrated successfully into a representative day treatment program for adolescent drug abusers (Liddle et al., 2002; Liddle et al., 2006). There were several noteworthy findings: following training, therapists delivered MDFT with superb fidelity (e.g., broadened treatment focus post-training, addressed more approach-specific content themes, focused more on adolescents’ thoughts and feelings about themselves and extrafamilial systems), with model adherence at 1-year follow-up; clients’ outcomes were significantly better, and these outcomes maintained at follow-up as well; association with delinquent peers decreased more rapidly after therapists received MDFT training (Liddle et al., 2006), drug use was decreased by 25% before and 50% after a MDFT training and organisational intervention (and the probability of out-of-home placements for non MDFT youth was significantly greater before MDFT was used in the program); program or system-level factors improved dramatically as well, according to, for example, adolescents’ perceptions of a program’s increased organisation and clarity of expectations (Liddle et al., 2004).

Conclusions
MDFT is one of the most extensively researched therapies for adolescent substance abuse and delinquency. Several aspects of the approach can be highlighted at this stage of its 25-year history. MDFT is a flexible treatment system. Different versions of the approach have been implemented successfully in diverse community settings by agency clinicians, with both male and female adolescents from varied ethnic, minority, and racial groups. Study participants were not narrowly defined, rarefied research samples; participants were drug using, and generally showed psychiatric comorbidity, delinquency and juvenile justice involvement. Assessments included state of the science measures, theory-related dimensions, and measures of clinical and practical knowledge, important to the everyday functioning of target youth and families. MDFT has been tested against active treatments, including individual CBT and high-quality peer group and multifamily approaches, as well as services as usual. It has been varied on dimensions such as treatment intensity and demonstrated favourable outcomes in its different forms. An intensive version of MDFT was found to be a clinically effective alternative to residential treatment. On the other end of the spectrum, MDFT has been effective as a prevention program with at-risk, nonclinically referred youths, and as an effective intervention for clinically referred young adolescents early on in drug and criminal justice involvement. The research program has used the most rigorous designs in conducting efficacy/effectiveness trials, followed CONSORT guidelines, used intent to treat analyses, and participated in multisite RCTs. We developed psychometrically sound adherence measures (Hogue et al., 1998), and we have successfully trained therapists, supervisors, and trainers in drug abuse and criminal justice settings nationally and
internationally. MDFT process studies have illuminated the model’s internal workings, and confirmed some of our hypotheses about the model’s mechanisms of action. Cost analyses indicate MDFT is an affordable alternative compared to standard outpatient or inpatient treatment costs. Although often thought of as a drug abuse treatment only, MDFT also has generated evidence in multiple trials demonstrating a range of favourable outcomes far beyond drug taking and drug abuse (NREPP, 2009). Delinquency, externalising, and internalising symptoms have improved significantly in MDFT trials. HIV- and STD-risks have decreased in our newest work (developing a family-based HIV prevention module). We have also demonstrated the capacity to target and change key components of the outcome equation (affiliation with drug using peers, family and school functioning, as examples). Our RCTs routinely track outcomes with one year follow-ups, and the outcomes retain at this assessment. Newer studies include four years’ post intake assessments.

MDFT offers a unique clinical focus in how it establishes individual relationships with parent and teen, works with each alone in individual sessions, targets family interactional changes, and also works with individuals and parents vis-á-vis the teen’s and family’s social context. MDFT’s treatment development tradition is strong, given its process studies and use of behavioural ratings of videotapes in these studies. The approach’s revisions and extensions now include manual-guided modules that begin MDFT with youths in juvenile detention, and continue after release, as part of the regular MDFT outpatient phase (3–4 months) (Liddle et al., in press), and an integrated parent-involved, youth HIV/STD prevention intervention (Marvel et al., 2009). Training and supervision and quality assurance protocols are well developed, and our online training course includes the model’s core sessions and clinician microskills via streaming video segments.

Impressive advances have been made in development and testing evidence based treatments for adolescents, as this special issue testifies. At the same time, the pace of adopting these interventions into regular community settings of mental health and addictions clinics, schools, and juvenile justice, as examples, remains painfully slow. Although treatment developers and researchers have responded admirably to critiques offered in previous developmental eras that questioned the relevance of their treatments and research, much more needs to be done to create effective therapies for non-research contexts.

References


