RUNNING HEAD: MULTIDIMENSIONAL FAMILY THERAPY

Multidimensional Family Therapy:

A Therapeutic Strategy for Families with Adolescents Diagnosed with Internalizing or Externalizing Disorders

By

J. River Gaynor

A clinical project paper submitted in partial fulfillment of

the requirements for the degree of

MASTER OF NURSING

WASHINGTON STATE UNIVERSITY-VANCOUVER

Intercollegiate College of Nursing

Spring 2009

To the Faculty of Washington State University

To the member of the Committee appointed to examine the special project of J. RIVER GAYNOR find it satisfactory and recommend that it be accepted.

Chair: Sheela Choppala-Nestor, Ph.D., ARNP

Linda Eddy, Ph.D., ARNP

Melody Rasmor, MN, ARNP

Multidimensional Family Therapy:

A Therapeutic Strategy for Families with Adolescents Diagnosed with Internalizing or Externalizing Disorders

Abstract

By

J. River Gaynor, MA, BSN, RN

Washington State University

Spring, 2009

Chair: Sheela Choppala-Nestor,

Substance use and conduct problems that begin before the age of fifteen years result in a multitude of consequences involving the legal system and incarceration. Despite mounting evidence on the importance of the family role, as a whole, delivery of treatment focuses on the individual, with the family and other network members remaining in the periphery, if at all involved. Multidimensional Family Therapy (MDFT) is an evidence-based therapeutic strategy recognized and proven to reduce risk and promote protective factors in four domains of an adolescent's life. The benefits of MDFT are that it is more cost effective both as a community-based and inpatient treatment, targets a diverse population with co-morbid disorders, improves familial relations resulting in fewer delinquencies and out-of-home placements. This paper provides mental health practitioners with the information they need to make an informed choice about pursuing additional training and integrating MDFT into their clinical practice. Implementation would increase and promote change for families with adolescents seeking drug abuse treatment and resolution of related problems.

Table of Contents

List of Tables and Figures

Dedication

The interest to study this topic comes through clinical experiences with men and women inmates at two separate correctional facilities. Their life stories revealed patterns of parenting methods that correlate with deep-seated childhood pain, manifesting into criminal behavior, and a path of regret, sorrow and isolation. Their perseverance to heal and grow is inspiration towards developing a clinical practice to work with adolescents and their families in need of promoting protective factors and reducing risk.

Multidimensional Family Therapy: A Therapeutic Strategy for Families with Adolescents Diagnosed with Internalizing or Externalizing Disorders

The strongest and most consistent predictor of chronic legal offenses, educational problems, depression, unemployment, peer and family relational problems, and low self-esteem, begins with substance use and conduct problems before 15 years of age (Liddle, H.A., Rowe, C.L., Dakof, G.L., Henderson, C.E., & Greenbaum, P. E., 2009). Current national trends (Glick, R.L., Berlin, J.S., Fishkind, A.B., & Zeller, S.L., 2008) show growing mental health issues in children, increased pediatric-psychiatric emergency department visits, declining community-based family supports, increased child and adolescent drug use, closure of adolescent facilities, and more schools implementing zero tolerance behavioral policies. Despite these increasing problems, the practice of psychiatric nurse practitioners and mental health providers is too narrow to address this growing phenomenon in traditional care settings (Glick, R.L., et.al., 2008).

Childhood psychiatric disorders that do not resolve increase a child's risk for dropping out of school, and the problem persists into adulthood: 48 percent of children with behavior problems in kindergarten are enrolled in special education classes in the fourth grade; 74 percent of 21 year olds with mental health disorders had a childhood problem. Families have gone bankrupt trying to access the appropriate care for their child (U.S. Surgeon General, 2000). It is difficult for parents to find clinicians who practice from a biopsychosocial perspective, and may have to travel long distances to receive this type of care. The least desirable solution is to give up custody. According to the U. S. Surgeon General (2000), inpatient mental health treatment for children can have harmful consequences. The child and adolescent population is at increased risk, because mental health disorders left untreated results in disability, suicide, and distress for

their families and community. This ultimately affects our population's overall health, well-being and productivity.

The focus of this project is to raise practitioner awareness about the family context of child and adolescent difficulties. In addition, introduce multidimensional family therapy (MDFT) as a therapeutic intervention and treatment approach for families who have a child diagnosed with an internalizing or externalizing disorder. The aim of this paper is to introduce Multidimensional Family Therapy (MDFT) as a therapeutic intervention to nurse practitioners and mental health providers working with families and their children coping with internalizing and externalizing behaviors. Statistics related to the problems of children diagnosed with these disorders are reviewed. The types of populations served and outcomes of MDFT are discussed. Description and implementation of MDFT are presented with supporting tables on training, operating principles and stages of therapy. Discussion concludes with support of MDFT as an evidenced-based practice and therapeutic strategy that promotes protective factors in the family and reduces adolescent risk.

The Family Context of Psychopathology

According to Adlerian theory, personality development is significantly influenced by the family atmosphere and structure. The family system holds multiple subsystems that predispose a child to practicing methods that are a key influence on their relationships and behaviors for life (Corey, 2008). Subsystems include child-parent relationships, sibling relationships, and any extended relationships such as grandparents living in the home (Thorngren & Kleist, 2002).

Child behavior problems that are internalizing disorders include self-destructive behaviors such as substance abuse, suicidal ideation and attempts (Dodge & Polit, 2003), and anxiety and depression (Connell & Goodman, 2002; Rohde, Seeley, Kaufman, Clarke, & Stice,

2006). Child conduct problems that are externalizing behaviors include conduct disorder (CD) and oppositional defiant disorder (ODD) (Connell & Goodman, 2002). Externalizing disorders commonly begin with aggressive behavior and are exacerbated by the deficiencies a child experiences in his or her family, peer group, school program, or community. Disruptive behavior leads to a deficit in acquiring necessary skills and development, isolation, and rejection, ultimately escalating into more problematic behavior. The end result of this cycle is antisocial behavior (Miller & Prinz, 1990).

The government defines antisocial behavior as behaviors that have interpersonal targets: homicide, physical assault, sexual assault, robbery, verbal assault, vandalism, and relational aggression (Dodge & Petit, 2003). Adolescent antisocial behaviors make up the majority of outpatient juvenile mental health clinic referrals, and in schools account for the greatest enrollment in special education classes. Between the ages of 16 and 17, youth self-reports show the greatest number of violent acts, with more than 25 % of all male adolescence committing at least one serious violent crime (Dodge & Petit, 2003).

Many children who begin acting out aggressively at an early age continue to engage in antisocial behavior at each stage of their development. Adolescents who engage in risky behaviors are like magnets to other peers who do not have preexisting risk factors, and may predispose prosocial children to partake in risky behaviors (Connell, Dishion, Yasui & Kavanaugh, 2007; Winters, August & Leitten, 2003).

Externalizing behaviors produce conflict, rejection, isolation, poor skill acquisition, and learning problems, which result in failure experiences. These stressors increase risk for depression. Depression occurs at least once in 15-25% of children and adolescents, resulting in an increased risk for major depressive disorder (MDD) and other psychopathological symptoms.

Of children and adolescents who experience depression, 40-90% also have at least one comorbid disorder, usually anxiety, ODD or CD. Adolescence experiencing depression with a comorbid externalizing disorder generally have a life situation that elicits the external behavior first (Possel, Seemann, & Hautzinger, 2008).

Behavior problems can be related to parenting methods and psychopathology (Winters et. al., 2003). Studies show there is strong correlation between childhood externalizing disorders and a deficit in parental supervision and involvement in the child's activities, along with inconsistent discipline, and parental substance abuse (Connell & Goodman, 2002; Frick, et. al., 1992; Kilgore, Snyder & Lentz, 2000). Another study (Connell & Goodman, 2002) shows the relationship between childhood internalizing disorders and maternal depression, and externalizing disorders and maternal substance abuse and alcoholism. However, the difference between the results of maternal psychopathology versus paternal psychopathology correlating with behavioral problems in children is minimal (Connell & Goodman, 2002).

A child's age is also a factor related to risk for behavioral problems: maternal depression is more closely related to younger childhood disorders, and paternal alcoholism and depression with adolescent problems. Generally maternal and paternal disorders such as depression, anxiety, alcoholism, and anti-social personality disorder (ASPD) equally place children at risk for behavior problems. It is also important to consider that parent psychopathology and childhood behavioral problems can be bi-directional: A small study examined how 10-12 year old boys with challenging temperaments received harsher discipline by substance abusing fathers, revealing a correlation with increased child internalizing and externalizing behaviors (Connell & Goodman, 2002).

Sometimes children have risky behaviors even without parent psychopathology. It is natural for a child to want to discover their uniqueness (Connell & Goodman, 2002). Their innate searching combined with other social, familial and peer pressures can elicit anything from a manageable disruption to cataclysmic events involving their family members, primarily the parents. A child's search for their autonomy can lead to criminal behavior, substance use and abuse, and other activities that warrant the juvenile justice system to be involved. Whether or not child problem behaviors have a correlation to parent psycbopathology, across the life span behavior problems can result in unstable employment, addiction, homelessness, traumas, unstable relationships, domestic violence, child abuse, and legal involvement (Connell & Goodman, 2002). As an opportunity for growth and change, and preventing a child from being imprisoned, the justice system may mandate family therapy (Thorngren & Kleist, 2002).

Multidimensional Family Therapy

Beginning interventions in a child's life at the first onset of behavior problems is the best method for preventing future behaviors that lead to the cycle of antisocial behaviors (Kilgore, et. al., 2000; Miller & Prinz, 1990; Winters, et. al., 2003). However, typically, disorders that result in mandated therapy occur during the adolescent years. Clinically the challenge for treatment providers is to abate or cease early problem behaviors before they become patterns of destructive behavior that are extremely resistant to change. For example, children who begin substance use before 15 years old take 29 years to achieve one year of substance abstinence. When treatment is started within 10 years of initial drug use onset, recovery time is reduced to 14.5 years. For this reason, policy makers, treatment researchers and clinicians concur that early adolescence is the decisive stage for therapeutic treatment interventions to diminish early-stage internalizing and externalizing behaviors that lead to delinquency. Multi-system and family oriented interventions

are extensively researched and show the greatest potential for treating internalizing and externalizing behaviors (Liddle, H.A., et.al, 2009).

Although the child's behavior may be the initial reason for therapy, there is a strong possibility that the etiology of a child's behavior are parents struggling with their own issues that may benefit from therapy as well. Even if the parents are not personally dealing with their own issues, an adolescent about 13 to 14 years of age goes through a normal process of being more involved with their peers, and begins to pull away from their parents' engagement and supervision, the process of premature autonomy. MDFT therapy is appropriate for this population in order to prevent and intervene in the causal factors of problem behaviors that result in family discord, legal involvement, cost to society and complications over the life span (Connell et. al., 2007; Miller, & Prinz, 1990; Liddle, H.A., et. al., 2009).

Background

MDFT is a family-based treatment strategy for adolescents with internalizing and externalizing disorders. Clinical and theoretical aspects of developmental psychology and psychopathology are integrated with an ecological perspective. The developer of MDFT, Dr. Howard Liddle, is a professor in the departments of Epidemiology and Public Health, Psychology, and Counseling and Psychology. He is also Director, Center for Treatment Research on Adolescent Drug Abuse at the University of Miami School of Medicine. Over the past 20 years MDFT has been cultivated as a treatment strategy for adolescents and their families dealing with substance abuse and delinquency (Liddle, H.A., Rodriguez, R.A., Dakof, G.A., Kanzki, E., & Marvel, F.A., 2005). This strategy has been recognized among the most reliable interventions for treating adolescent drug abuse and related problems. MDFT is certified as a Substance Abuse and Mental Health Services Administration (SAMHSA) Model Program, and as an Effective

Program by the National Center for the Advancement of Prevention for inclusion in the National Registry of Effective Prevention Programs (NREPP) (CTRADA, 2006).

Evidence of Effectiveness

In a 12-month follow-up, MDFT showed a significant intervention outcome related to abstinence and decrease in frequency of substance use. Self-report and court records indicated that adolescents in MDFT therapy had fewer arrests or placed on probation. Youth also exhibited a moderate decrease on the General Mental Distress Index. Secondary outcomes related to family functioning, peer delinquency and school functioning include: improved family interactions during treatment with simultaneous reduced negative family interactions; a moderate effect in decreased peer delinquent associations during treatment and maintained during follow-up; academic and conduct grades of participants receiving MDFT improved significantly (Liddle, H.A., et. al., 2009).

In controlled clinical studies MDFT had consistent results compared with other treatments. Substance use decreased, abstinence increased, emotional and behavioral problems improved, school functioning dramatically improved with students receiving higher, passing grades, and family functioning improved. Delinquencies such as arrests, convictions, probations, and out home placements also decreased (CTRADA, 2006).

Components and Structure of the Program

MDFT consists of components aimed at decreasing a child's symptoms, and promoting developmental performance by mediating behavioral changes in several areas. The principles of this therapy center on the adolescent as an individual, and their problems, strengths, and goals, as well as the parents' issues, parenting methods, family relationships and extrafamilial influences. In order to address specific issues that need focus in each family, and track their progress over

time a multisource clinical assessment is used. Four separate modules focus on various aspects of adolescent and family functioning, and are empirically established domains of risk and protective factors for both children and families. Each module is vital to promoting change, and is concomitantly worked through by the therapist. (Hogue, Dauber, Samoulis, & Liddle, 2006 a; Hogue et. al., 2006 b; Liddle, H.A., et. al., 2009).

Each of the four modules has a different focus. The MDFT adolescent module entails developing a therapeutic alliance with the adolescent client and alternative behaviors to externalizing behaviors, and promoting problem solving skills and prosocial behaviors. The primary adolescent risk factors are assessed: isolation, school failure, relations with delinquent peers, diminished participation with prosocial organizations, and delinquent behaviors. Adolescent interventions include: mediating academic objectives and goals with educational resources, anger management skills, drug refusal skills, impulse control, and defining positive friendships (Hogue et. al., 2006 a; Hogue et. al., 2006 b; Liddle, H.A., et. al., 2009).

The adolescent group therapy is manual-guided, based on social learning principles, and uses empirically established cognitive-behavioral therapy for adolescence. One therapist leads the session; an average of 4-6 male and female adolescents may attend. The group is open so new members begin as previous members complete treatment. This approach allows members the continuity to begin a new treatment module, and complete all 6 modules (each 2 weeks long) in 12-16 weeks without too much content repetition (Liddle, H.A., et. al., 2009).

A risk and protective factor framework is used, focusing on behaviors related to low self-esteem, school problems, and strained social performance. Principles related to self-efficacy, self-management, and coping skills for everyday life stressors are integrated into the six

modules: drug education, self-esteem, values and identity, decision making, personal control and interpersonal communication (Liddle, H.A., et. al., 2009).

The MDFT family focused module also builds a therapeutic alliance with the parent, as well as develops the parents' involvement with the child, and enhances positive parenting skills. The primary parental risk factors are assessed: disengagement, substance abuse, parenting methods, stress, isolation, family support and communication. The interactional module works with the parent and child together so the therapist can observe the interactions, and then facilitate changes to enhance emotional connection and communication skills. The extrafamilial module focuses on family competency by connecting parents with support groups, drug counseling and community resources. In addition it strengthens all the social relationships the child is involved with such as school, peers, extracurricular activities, and the juvenile justice system (Hogue et. al., 2006 a; Hogue et. al., 2006 b; Liddle, H.A., et. al., 2009).

The most significant feature of the MDFT model is the integration of therapy aimed towards the individual adolescent, the individual parent, the family, and extrafamilial influences. Simultaneously focusing interventions on all four domains has a marked impact on the outcomes. Family therapy models that are solely strategy-based result in only low levels of change while the integration of individual therapy and family therapy increases the potential for higher levels of change in addition to improved family organization and adaptation (Hogue et. al., 2006 a; Melito, 2006).

Roles and Relationships in MDFT

In addition to integrating therapies as a method for improving treatment outcomes, therapist alliance is crucial. In MDFT research shows that therapists developing a strong parent alliance early in the treatment process predicted positive outcomes more than adolescent alliance.

However, early weak adolescent alliance that grew throughout therapy resulted in more positive treatment outcomes for externalizing behaviors; whereas adolescent alliance that diminished over the course of therapy resulted in increased symptoms (Hogue et. al., 2006 a).

In MDFT the therapist-parent and therapist-child alliances have interchangeable effects. When the child's level of focus and alliance are higher than the parents, the results are improved family cohesion, and reduced family conflict and parental stress. When the parental level of focus and alliance is greater than the child's alliance the results are improved treatment completion, and reduced child behavioral problems. A specific issue is parent motivation to keep supervising and staying engaged with their children who are exhibiting detrimental behaviors.

Interventions can be offered to parents based on assessment of the issues and problems the family is experiencing, but a parent is only motivated to practice the interventions to the extent that they perceive the need for intervention (Connell et. al., 2007). When parents and therapist are aligned in therapeutic goals, parents tend to be more involved emotionally in the child's daily functioning, an outcome that is associated with family therapy (Frick, et. al, 1992; Shelef, et. al., 2005).

Operating Principles

MDFT (Liddle, H.A., Rodriguez, R.A., Dakof, G.A., Kanzki, E., & Marvel, F.A., 2005). provides a framework of ten operating principles for guiding the do's and don'ts of therapy:

1. Adolescent problems are a multidimensional phenomenon, defined interpersonally, intrapersonally, in terms of interactions of a multiple system, and levels of influence.
2. Problems are an opportunity to provide critical assessment information and important interventions.
3. Clinicians coordinate multiple change pathways and methods via a multivariate conception of change.
4. Motivation is malleable. Resistance points to important processes in need of therapeutic focus.
5. Working relationships are critical. Therapy comes by supportive, but outcome focused

working relationships with families and extrafamilial supports.
6. Interventions are individualized and customized to each member, family and environmental circumstance. Interventions target risk factors and promote protective processes.
7. Therapy entails planning and flexibility. Through collaboration, therapists evaluate each intervention outcome, and alters the plan accordingly.
8. Treatment and its multiple components are phasic. Theme development, intervention plans, implementation, and the overall therapy process are organized and delivered in stages.
9. Therapists take responsibility for the promotion of participation and motivation of all individuals involved, providing treatment consistency, evaluating intervention success.
10. Therapist attitude and behavior are fundamental to success. They advocate for both adolescents and parents, and are careful not to take extreme positions.

Wide Applicability

MDFT has been proven to help adolescents in outpatient treatment who are in early stages of substance, dealing with substance use problems and frequency, delinquency, and internalized stress ((Hogue, Dauber, Stambaugh, Cecero, & Liddle, 2006 b; Liddle, H.A., et. al., 2009). Studies (CTRADA, 2006) of teens, referred by juvenile court services, with severe drug abuse that heavily use marijuana, cocaine, alcohol and other drugs show successful treatment. MDFT has been proven effective as a community-based prevention program treating younger adolescents initiating drug use. Diverse populations, both male and female, have received the benefits of MDFT: inner-city minority, including African-American and Hispanic youth and their families, urban and rural Caucasian adolescents and families, young adolescents at high risk for substance abuse, and adolescents with co-morbid psychiatric diagnoses (CTRADA, 2006).

Practical Implementation of MDFT: A Guideline for Mental Health Practitioners

Pre-Implementation Considerations-Frequency, Setting and Experience

MDFT has been successfully transported into pre-existing treatment programs. A unique aspect about MDFT is its flexibility and adaptability towards provider needs, client needs, and

characteristics of the treatment setting. Through a collaborative adaptive process, developers have tested a treatment system to overcome barriers to implementation in order to address the needs of all stakeholders involved. (CTRADA, 2006; Liddle, H.A., et. al., 2009).

Depending on the severity of the problem, setting, and family functioning, MDFT sessions can occur one to three times per week over 3-6 months. MDFT parameters that predict a high level of treatment fidelity include therapeutic contacts: an average of 30% contacts alone with adolescents, 20% alone contacts with parents, 33% with the family, and 17% with extrafamilial agencies such as school or court. (Liddle, H.A., 2009).

Several versions of the approach have been developed, tested and used: office-based, in-home, brief, intensive outpatient, day treatment, residential treatment. Therapists can work simultaneously in the four interdependent treatment domains based on the adolescent's and family's specific risk and protective factors. However, in MDFT studies (Liddle, H.A., et. al., 2009) clinicians conducted therapy only in the modality they were trained, and had a minimum of a master's degree in counseling, social work, family therapy or a related field. In addition, they had prior experience of two years in their field and complete 30 hours of initial training. Important therapist attributes in delivering treatment fidelity and technical quality are skillfully delivering interventions in a timely and appropriate manner (Hogue, A., Dauber, S., Barajas, P.C., Fried, A., Henderson, C.E., & Liddle, H.A., 2008).

When staff were trained and incorporated MDFT, client outcomes improved by 50 %. Training procedures to ensure therapist fidelity entailed weekly supervision with model experts by live individual supervision, video feedback, and group supervision. Sessions were weekly and office-based, occurring over 16-24 weeks. Important therapist attributes in delivering treatment fidelity and technical quality are skillfully delivering interventions in a timely and appropriate

manner (Hogue, A., et.al., 2008). Two types of training are available through The University of Miami Leonard M. Miller School of Medicine. The first type offers full training in MDFT leading to certification. Please refer to the following table for details (CTRADA, 2006):

	Multidimensional Family Therapy (MDFT) Certification
Startup Costs	2 full-time master's level therapists. 1 full-time case manager (bachelor's level or paraprofessional). Cellular phones for therapists and case manager. Urine test kits for weekly drug testing. Ground transportation costs for conducting in-home sessions. Audiovisual equipment for recording and reviewing sessions (video camera, tripod, digital video tapes, and digital audio recorder).
Administrative Costs	Training for the 6-month certification is between $25,000-$30,000 per team. This includes all training costs.
Training Infrastructure	3 on-site visits including 5 day introductory workshop. 2 site visits which include presentation, videotape, and live supervision. Bi-weekly phone call case consultations, access to MDFT Online Learning Program, review of tapes therapy sessions, and 2 examinations. There is face-to-face onsite at the trainee site, and additional training/support using our MDFT technology training tools (PDA, MDFT Online Learning Program, web-conferencing, and listserv).
Materials	All written and online materials are provided by trainers.
Time (To Implementation)	Begin seeing training cases within 2 weeks from the Introductory Week training so implementation begins immediately. Time to full implementation is 6 months.
Training Requirements	Trainees must start will a small caseload, and have time available to participate fully in all the training activities which includes one (1) time with the University of Miami trainers and two (2) times for self study using the MDFT Online Learning Program.
Fidelity	Certification is based on fidelity and competence.
Contact Information: Person, Phone, and Email	Gayle Dakof, Ph.D. (305) 243-3656 gdakof@med.miami.edu

The second type of training is less intensive, comprehensive, and expensive. This training costs $7,500 (includes travel, materials, and fee). A MDFT trainer comes to the clinical site for three days of introductory training. In this type of training, staff will be introduced to the MDFT intervention system. At the end of this training, clinicians should be able to improve their clinical work by incorporating MDFT principles into their practice; however they will not be certified in MDFT (CTRADA, 2006).

Delivery of the Program

The individual CBT treatment (Hogue, A., et. al., 2008) contains five modules: Establishing a working relationship, Drug Use Monitoring and Harm Reduction (integrates exemplary techniques regarding assessment of drug use behavior, refusal skils, and limiting use), Behavioral Skills Training (anger management, problem solving, role playing, relaxation techniques, communication skills and decision making), Cognitive Therapy Techniques (coping with thoughts about drug use, and strategies for cognitive monitoring and change), and Increasing Prosocial Behavior.

MDFT is delivered in three stages (Liddle, H.A., et.al., 2005):

Stage 1: Comprehensive assessment of the problem and underutilized strengths. Therapeutic alliances developed with all participating members. Themes, focus area, and therapeutic goals established.
Stage 2: Change is made across the interwoven subsystems (individual, peers, family, school) through the working process, based on the initial assessment.
Stage 3: Finalizing the changes, preparing members for the next stage of development, using their newfound knowledge and skills from therapy.

Barriers to Address

Barriers to implementing evidenced-based treatments related to adolescent community-based settings are well documented. Integration of empirically-based interventions for adolescents into non-research clinical settings is minimal despite the growing research demonstrating intervention efficacy. Factors necessary for facilitating the instruction in MDFT include direct personal contact between clinicians and MDFT developer-researchers. Basic beliefs around the principles of change and valuing integration of a new model into an existing program must be shared by stakeholders. The edification of MDFT is a process that promotes enhanced treatment towards positive client outcomes. Research-developers must assess clinicians' readiness for change (Liddle, H.A., et.al., 2002).

Community clinics generally are characterized by large case loads where therapists do not undergo regular clinical supervision to increase their clinical skills. Clinicians must find the new model interesting and credible. Despite a clinician's interest in growing their professional development, working in an overburdened system can deter their time and resources for undertaking more skills training. Community based treatment programs lack the resources to reimburse and provide incentives for clinicians to take further training (Liddle, H.A., Rowe, C.L., Gonzalez, A., Henderson, C.E., Dakof, G.A., & Greenbaum, P.E., 2006).

Conclusion

Implementing evidenced based practices is necessary in professional clinical work. Evidenced based practices afford a therapist who is providing treatment for families and children with the techniques required for outcomes that not only prevent childhood behaviors that lead to

involvement with the juvenile justice system, but leave individuals and families at a higher level of functioning. The specialty of adolescent therapy has become a critical, empirically-based area. Through research and clinical advances, family-based interventions have warranted implications in adolescent therapeutic strategies (Liddle, H.A., 2004).

Reports from influential policy-makers and accepted research literature on family-based treatment for adolescent disorders conclude that families and parents need to be involved (Liddle, H.A., 2004). The conceptual framework for family-based therapy recognizes the contribution of a dysfunctional family environment to adolescent risk. The systemic view of MDFT also acknowledges the opposing reality that adolescent problems disrupt family functioning and relationships.

MDFT is formatted for flexibility related to intensity of treatments, number of sessions, and service delivery locale (e.g. sessions in homes, inpatient hospitals, schools, clinics, juvenile court, correctional facilities). MDFT is also tested and appropriate for adolescents diagnosed with co-morbid substance abuse and psychiatric disorders. Parents receiving MDFT report significant improvement from pre-treatment to 12 month post-treatment in both adolescent internalizing symptoms and externalizing behaviors. As a result of participating in MDFT, adolescents show improved school functioning, decreased substance use and abstinence, which in turn enhances family functioning (Liddle, H.A., 2004).

In transporting MDFT technology to mental health staff members, therapists' strategies notably improved. Therapist adherence to the training resulted in more comprehensive practices. Clinicians' expanded their methods to include strategies focused on family and parenting practices, and school and juvenile justice interventions that enhance youth outcomes. These

outcomes are a result of improved staff problem solving related to youth diagnosed with internalizing and externalizing behaviors (Liddle, H.A., et. al., 2006).

Psychiatric-mental health nurse practitioners (PMHNP) play a crucial role in implementing change for families and children coping with internalizing and externalizing behaviors. As key players in the mental health delivery system, PMHNP's can further promote child and family protective factors by advancing their therapeutic skills and strategies through MDFT training and implementation into their scope of practice and clinical settings. In addition to individual children and families benefiting, globally the community would benefit by a reduction in pediatric-psychiatric emergency visits, police involvement, and burdens on the legal system.

References

Center for Treatment Research on Adolescent Drug Abuse (CTRADA) (2006) *Multidimensional family therapy.* Miller school of medicine university of miami, retrieved from http://med.miami.edu/ctrada/x14.xml, on February 26, 2009.

Connell, A.M., Dishion, T.J., Yasui, M. & Kavanaugh, K. (2007). An adaptive approach to family intervention: Linking engagement in family-centered intervention to reductions in adolescent problem behavior. *Journal of consulting and clinical psychology,* 75 (4), 568-579.

Connell, A.M. & Goodman, S.H. (2002). The association in psychopathology in fathers versus mothers and children's internalizing and externalizing behavior problems: A meta-analysis. *Psychological bulletin,* 128 (5), 746-773.

Corey, G. (2008). *Theory and practice of group counseling.* Belmont, CA: Thomson Brook/Cole.

Cummings, C.M., & Fristad, M.A. (2007). Medications prescribed for children with mood disorders: Effects of a family based psychoeducation. *Experimental and clinical psychopharmacology,* 15 (6), 555-562.

Delate, T., Gelenberg, A.J., Simmons, V.A., Motheral, M.S., & Motheral, B.R. (2004). Trends in the use of anti-depressants in a national sample of commercially insured pediatric patients, 1998-2002. *Psychiatric services,* 55, 387-391.

Dodge, K. A. & Petit, G. S. (2003). A biopsychosocial model of the development of chronic conduct problems in adolescence. *Developmental psychology,* 39 (2), 349-371.

Frick, P.J., Lahey, B.B., Loeber, R., Stouthamer-Loeber, M., Christ, M.G. & Hanson, K. (1992). Familial risk factors to oppositional defiant disorder and conduct disorder: Parental

psychopathology and maternal parenting. *Journal of consulting and clinical psychology,* 60 (1), 49-55.

Glick, R.L., Berlin, J.S., Fishkind, A.B., & Zeller, S.L. (2008). *Emergency psychiatry:Principles and practice.* Philadelphia, PA: Lippincott Williams & Wilkins.

Hogue, A., Dauber, S., Samoulis, J., & Liddle, H.A. (2006 a). Treatment techniques and outcomes in multidimensional family therapy for adolescent behavior problems. *Journal of family psychology,* 20 (4), 535-543.

Hogue, A., Dauber, S., Stambaugh, L.F., Cecero, J.J. & Liddle, H.A. (2006 b). Early therapeutic alliance and treatment outcome in individual and family therapy for adolescent behavior problems. *Journal of consulting and clinical psychology,* 74 (1), 121-129.

Hogue, A., Dauber, S., Barajas, P.C., Fried, A., Henderson, C.E., & Liddle, H.A. (2008). Treatment adherence, competence, and outcome in individual and family therapy for adolescent behavior problems. *Journal of consulting and clinical psychology,* 76 (4), 544-555.

Kilgore, K., Snyder, J. & Lentz, C. (2000). The contribution of parental discipline, parental monitoring, and school risk to early-onset conduct problems in african american boys and girls. *Developmental psychology,* 36 (6), 835-845.

Liddle, H.A. (2004). Family based therapies for adolescent alcohol and drug use: research contributions and future research needs. *Society for the study of addiction,* 99 (2), 76-92.

Liddle, H.A., Rodriguez, R.A., Dakof, G.A., Kanzki, E., & Marvel, F.A. (2005). Multidimensional family therapy: a science-based treatment for adolescent drug abuse. In

J. Lebow (Ed.), *Handbook of clinical family therapy,* New York: John Wiley and Sons, pp. 128-163.

Liddle, H.A., Rowe, C.L., Dakof, G.L., Henderson, C.E., & Greenbaum, P. E. (2009). Multidimensional family therapy for young adolescent substance abuse: Twelve month outcomes of a randomized controlled trial. *Journal of consulting and clinical psychology,* 77 (1), 12-25.

Liddle, H.A., Rowe, C.L., Gonzalez, A., Henderson, C.E., Dakof, G.A., & Greenbaum, P.E. (2006). Changing provider practices, program environment, and improving outcomes by transporting multidimensional family therapy to an adolescent drug treatment setting. *The American journal of addictions,* 15, 102-112.

Liddle, H.A., Rowe, C.L., Quille, T.J., Dakof, G.A., Mills, D.S., Sakran, E., & Biaggi, H. (2002). Transporting a research-based adolescent drug treatment into practice. *Journal of substance abuse treatment,* 22, pp. 231-243.

Melito, R. (2006). Integrating individual and family therapies: A structural-developmental approach. *Journal of psychotherapy integration,* 16 (3), 346-381.

Miller, G.E. & Prinz, R. J. (1990). Enhancement of social learning family interventions for childhood conduct disorder. *Psychological bulletin,* 108 (2), 291-307.

Pfeffer, C.R. (2007). The FDA pediatric advisories and change in diagnosis and treatment of pediatric depression. *American journal of psychiatry,* 164, 843-846.

Possel, P., Seemann, S. & Hautzinger, M. (2008). Impact of comorbidity in prevention of adolescent depressive symptoms. *Journal of counseling psychology,* 55 (1), 106-117.

Rohde, P., Seeley, J.R., Kaufman, N.K., Clarke, G.N. & Stice, E. (2006). Predicting time to

recovery among depressed adolescents treated in two psychosocial group interventions. *Journal of consulting and clinical psychology,* 74 (1), 80-88.

Shelef, K., Diamond, G.M., Diamond, G.S., & Liddle, H.A. (2005). Adolescent and parent alliance and treatment outcome in multidimensional family therapy. *Journal of consulting and clinical psychology,* 73 (4), 689-698.

Sills, M. R., & Bland, S.D. (2002) Summary statistics for pediatric psychiatric visits to US emergency departments, 1993-1999, Pediatrics, 110 (4), 40.

Thomas, C.P., Conrad, P., Casler, R., & Goodman, E. (2006) Trends in the use of psychotropic medications among adolescents, 1994-2001. Psychiatric services: Psychiatryonline.org, 57 (1).

Thorngren, J. M., & Kleist, D. M. (2002). Multiple family group therapy: An interpersonal/postmodern approach. In L. Gebo (Ed.), *Groups: Process and practice* (pp. 339-344). Belmont, CA: Thomson Brook/Cole.

U.S. Public Health Service (2000). *Report of the surgeon general's conference on children's mental health: A national action agenda.* Washington D.C., Department of Health and Human Services.

Winters, K.C., August, G, and Leitten, W. (2003). *Preventive interventions for externalizing disorders in adolescents.* In D. Romer (Ed.). Reducing adolescent risk: Toward and integrated approach. Thousand Oaks, CA: Sage Publications, Inc.