A FAMILY-BASED, DEVELOPMENTAL-ECOLOGICAL PREVENTIVE INTERVENTION FOR HIGH-RISK ADOLESCENTS

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Family-based preventive intervention has emerged as a promising modality for preventing antisocial behavior problems in youth. This article introduces an intensive, family-based preventive intervention for high-risk adolescents: Multidimensional Family Prevention. Multidimensional Family Prevention combines the advantages of standard prevention models (curriculum based and protection focused) with those of psychosocial treatment models (assessment based and problem focused). The model's main features are described: theoretical foundations (risk and protection theory, developmental psychopathology, ecological theory), guidelines for constructing a multidomain prevention program (family and peer relationships, school and prosocial activities, drug use and health issues, cultural themes), and strategies for tailoring and implementing five flexible intervention modules (adolescent, parent, interactional, extended family, extrafamilial). Implemented in the family's home, the intervention works to create a resilient family environment that supports the basic adolescent developmental goals of renegotiated attachment bonds within the family and durable connections with prosocial institutions.

INTRODUCTION

Prevention has become a major programmatic and investigative force in the child and adolescent mental health specialty (Coie et al., 1993). Preventive interventions aim to prevent or delay psychosocial problems in youth by strengthening health and coping mechanisms and ameliorating early-onset symptoms before they mature into psychological disorders (Mrazek & Haggerty, 1994). Currently, antisocial behavior problems such as aggression, drug use, delinquency, and violence have received the majority of attention in the prevention field. National estimates indicate that adolescent drug use (Substance Abuse and Mental Health Services Administration ([SAMHSA] 1995) and delinquency and violence rates (Ossofsky, 1997) remain alarmingly high. These problems exact a great toll on the families and communities in which troubled youth reside, and the financial burden of interdiction and institutionalization for legal offenses associated with adolescent antisocial behavior is substantial. Also, once these problems develop in childhood and adolescence, they can be extremely resistant to remission and to treatment efforts (Reid, 1993). With such high stakes, the identification and dissemination of effective preventive interventions for antisocial behavior

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in early adolescence has become a top priority in the prevention field, indeed in our country (Elias, 1997).

Family-based prevention has emerged as a promising intervention modality for addressing the complex web of ecological influences that gives rise to the initiation of severe behavior problems (Hogue & Liddle, 1999). The impact of family-related factors on the development of antisocial behavior is now well documented. Disruptions in family management practices (Patterson, 1986), high rates of conflict and low rates of communication and involvement (Baumrind, 1991), and lack of parental investment in and attachment to their children (Brook, Nomura, & Cohen, 1989) all create vulnerability to various problems in youth. In contrast, positive parenting practices such as supportiveness and behavioral monitoring foster psychological well-being and insulate children against negative environmental influences (Steinberg, 1990). Family-based intervention models have considerable empirical support for treating existing childhood disruptive and antisocial behavior (Center for Substance Abuse Prevention [CSAP], 1996) and adolescent substance abuse (Liddle & Dakof, 1995), and preventive interventions have also demonstrated success in preventing adolescent drug use (Bry, Catalano, Kumpfer, Lochman, & Szapocznik, 1998) and violence (Borduin et al., 1995). For these reasons, interventions aimed at strengthening family coping mechanisms offer considerable promise for creating stable gains in therapy with problem youths (McMahon, Slough, & Conduct Problems Prevention Research Group, 1996).

This article introduces Multidimensional Family Prevention (MDFP), a family-based preventive intervention designed to prevent the onset of drug use and delinquency in high-risk adolescents. MDFP takes an ecological, counseling-based, and developmentally sensitive approach to prevention. In so doing, MDFP purposefully bridges the gap between prevention and treatment intervention. The theoretical premises, conceptual framework, and intervention principles of MDFP are derived from multidimensional family therapy (MDFT; Liddle, 2000), an empirically supported treatment for adolescent drug abusers. A summary of this research program appears elsewhere (Liddle & Hogue, in press). Multidimensional Family Prevention combines the curriculum-based and protection-focused methods of standard prevention with the assessment-based and symptom-focused methods of psychotherapy. In our view, this integrative approach to prevention offers the best hope for working effectively with adolescents and families in the highest-risk categories.

**INTERVENTION PRINCIPLES AND PARAMETERS**

*Guiding Frameworks of MDFP*

**Risk and protection theory.** Risk and protection theory has become the dominant theoretical framework in the prevention field (Jessor, Van Den Bos, Vanderryn, Costa, & Turbin, 1995). According to risk and protection theory, the onset of psychological symptoms is determined by the interaction between risk factors, which predispose an individual to the development of disorder, and protective factors, which predispose positive outcomes and buffer individuals against disorder. Complex behavioral problems such as drug use and conduct disorder do not stem from a single causal variable or a fixed set of specifiable precursors; instead, there are several pathways to the development of these disorders, and various contributing risk and protective influences can be identified in the psychological, biological, and environmental realms (Bukoski, 1991). Protective factors are thought to exert both a direct, positive influence on behavior and a moderating influence on the relation between risk factors and behavior (Jessor et al., 1995). Profiles of risk and protective factors are used to identify individuals considered to be at risk for behavioral problems so that appropriate preventive measures can be taken. Furthermore, the risk and protective factors themselves are frequently the targets of intervention (Hawkins, Catalano, & Miller, 1992).

**Developmental psychopathology.** The goal of developmental psychopathology is to examine the course of individual adaptation and dysfunction through the lens of normative development so that truly maladaptive behavior patterns can be distinguished from expectable variations within the normative range (Sroufe & Rutter, 1984). Developmental psychopathology is concerned not so much with specific symptoms in a given youth as with (1) the youth’s ability to cope with the developmental tasks at hand and (2) the implications of stressful experiences in one developmental period for (mal)adaptation in future periods. Moreover, because multiple pathways of adjustment and deviation may unfold from any given
point, emphasis is placed equally on understanding competence and resilience in the face of great risk (Garmezy, Masten, & Tellegen, 1984). The developmental psychopathology specialty has underscored the advantages of designing prevention programs for high-risk children before the onset of full-blown disorder so that the developmental trajectories of these individuals may be changed when more adaptive pathways are still available (Compas, 1995). Also, developmental psychopathology stresses the importance of understanding how key developmental markers affect symptoms and adaptation. For adolescents, prevention models must consider how to account for—and how to help participants negotiate—developmental challenges such as self-regulation and exploratory behavior (Hill & Holmbeck, 1986), increased autonomy and egalitarian interactions within the family (Steinberg, 1990), and increased involvement in the peer group (Brown, 1990).

Ecological theory. Ecological theory is concerned with understanding the web of social influences that form the context of human development (Bronfenbrenner, 1986; Brook et al., 1989). Ecological theory regards the family as the principal context in which human development takes place, and it takes a keen interest in how intrafamilial processes are affected by extrafamilial systems. In keeping with ecological theory, ecological models of prevention and treatment frequently adopt a family-based approach to intervention (Henggeler, Borduin, & Mann, 1993) and intervene simultaneously in multiple social systems (Borduin, 1994). Thus, social spheres outside the individual and family (e.g., neighborhood, school, peer) are routinely subject to assessment and intervention. Note that ecological intervention models do not ask practitioners to change schools or neighborhoods per se. Instead, interventions aim to influence how family members relate to (i.e., think about and interact with) these systems (Liddle, 1995).

Fundamental Prevention Goals

Risk and protection theory, developmental psychopathology, and ecological theory teach one common lesson: Problem behavior develops from a complex interaction between personal, developmental, familial, and environmental factors over time and across social contexts. Furthermore, a large body of empirical research on risk and protection consistently highlights two factors—bonding to family and bonding to prosocial resources—as being pivotal for protecting youth from antisocial outcomes (Hawkins et al., 1992). To address these issues with high-risk youth, MDFP implements a multidimensional philosophy of assessment and intervention in the service of achieving two fundamental prevention goals for every family: (1) helping the adolescent achieve a redefined, interdependent attachment bond to parents and the family and (2) helping the adolescent forge durable connections with prosocial institutions such as school, recreational programs, and religious institutions.

Regarding bonding to the family, MDFP helps families negotiate the changing but continuing attachment bond that exists between adolescents and parents. As adolescents mature, their relationships with parents should graduate from strong emotional dependence to an increasing emotional interdependence that respects both the autonomy and connectedness needs of adolescents (Silverberg & Gondoli, 1996). This transformation unfolds in conjunction with adolescents’ striving for increased responsibility and self-determination, which naturally gives rise to increases in parent-adolescent bickering and minor conflict (Steinberg, 1990). However, emotional detachment from parents is not a developmentally sound condition for adolescents, even within highly conflicted families. On the contrary, strong parent-adolescent attachment bonds are known to provide a secure base from which adolescents can build psychosocial competency and self-reliance in novel behavioral and emotional environments (Silverberg & Steinberg, 1987). Evidence clearly indicates that close family relationships are associated with numerous indicators of adolescent well-being and competence (Resnick et al., 1998).

Regarding adolescent bonding to prosocial institutions, it is well documented that having weak ties to positive influences outside the family is associated with deviant outcomes in adolescence. For example, lack of commitment to school and poor school achievement have been consistently linked to truancy, drug use, and general delinquency (Steinberg, Fletcher, & Darling, 1994). Social alienation is a signature personality characteristic in youth who use drugs (Brook, Whiteman, Cohen, Shapiro, & Balka, 1995), and frequent school transitions and limited access to meaningful roles in the community also places adolescents at risk for substance use (Steinberg, 1991). Finally, association with antisocial peers is the single most powerful
precursor of drug use and other behavioral problems (Donaldson, 1995). In contrast, strong connections to prosocial institutions are a critical factor in positive adjustment. Academic success and investment in school (Steinberg, Elmen, & Mounts, 1989), involvement in recreational activities (Mahoney & Cairns, 1997), and association with prosocial peers (Parker, Rubin, Price, & DeRosier, 1995) all insulate adolescents against behavioral problems.

**MDFP Intervention Parameters: Emphasis on Development and Ecology**

Preventive interventions need to assess target populations for their risk status so that suitable prevention strategies can be selected for specific populations (Offord, 1996). Multidimensional Family Prevention is an indicated preventive intervention. Indicated prevention are provided to individuals who are identified as high risk based on direct assessment of that person’s risk profile (Mrazek & Haggerty, 1994). Indicated populations typically exhibit prediagnostic but detectable levels of behavioral symptoms that foreshadow future disorders; moreover, youths with the most severe risk profiles tend to exhibit behavioral problems in several social contexts (Reid, 1993). To intervene effectively with these youths, it is necessary to seek change not only at the individual and family levels but also at the level of behavioral transactions between the family and relevant extrafamilial systems.

In keeping with this ecological focus, MDFP is both a home-based and a community-based intervention. MDFP counseling sessions occur primarily in the home of the family. Home-based delivery offers several potential advantages to institution- or office-based models (Spoth & Redmond, 1996). Transportation to clinic sites is a notable barrier to participation for many families, particularly those who are economically disadvantaged, that is alleviated by home-based work. The convenience and flexibility afforded to families and practitioners in scheduling sessions can enhance recruitment and participation rates. Home-based delivery also allows the practitioner to make use of all available resources in the home and community, including family members not predisposed to clinic visits. Sessions take place in the everyday environment of the family, which supports the acceptability and generalizability of interventions. Counselors also function as de facto case managers who make visits to schools, churches, and other neighborhood institutions to broker services for the family. The overarching goal of case-management activity is to facilitate the family’s increased involvement with local agencies and increased competence in acquiring supportive services of all kinds. The need for and intensity of this community-based work is determined individually for each family in the course of assessing the family and setting the counseling agenda (as described below).

Sessions always occur with single families, never in group format. Decisions about session composition are made at the discretion of the counselor on a case-by-case and session-by-session basis. Both individual and conjoint sessions are regularly used, and it is common for a single session to contain a mixture of individual and conjoint minisessions. Families receive services for 3–6 months, and counselors make an average of three substantive contacts per week for every case. During this time each family receives a total of 10–25 sessions, which take place either in person or (occasionally) by phone and last 30–90 min. Counselors make 5–10 in-person additional contacts with community agencies on behalf of the family. Depending upon the exigencies of the case, the intensity of program delivery varies on a case-by-case basis. Families that present relatively few distressing issues may be scheduled for only one session per week, whereas those who have greater needs or experience crises during counseling may receive two in-person sessions and several phone contacts per week.

The prevention model’s commitment to home-based, intensive intervention is extended to its program recruitment procedures. Engaging families in prevention services is one of the most difficult challenges faced in our field (Resnik & Wojcicki, 1991), and enthusiasm for including parents in prevention efforts has been considerably dampened by the numerous obstacles and modest success reported by most programs (Durlak, 1997). Multidimensional Family Prevention recruitment procedures are extensive, and a full description is provided elsewhere (Hogue, Johnson-Leckrone, & Liddle, 1999). Recruitment is conducted by the prevention counselors themselves, rather than by adjunct staff, so that sophisticated clinical skills are (necessarily) brought to bear on the manifold challenges that arise during recruitment. Counselors recruit families using intensive, systemic engagement techniques that include phone contact(s) with functional
parents followed by an in-home recruitment visit. The recruitment process is marked by counselor flexibility and persistence, sensitivity to the unique circumstances presented by each family, and readiness to allocate substantial program resources to enlist families.

For complex and intensive interventions such as MDFP, great attention must be devoted to counselor training and supervision. Multidimensional Family Prevention counselors are required to have at least a master's degree and 2 years of post-master's experience in family-based intervention. Training in MDFP includes approximately 100 hr of model-related literature review, didactic seminars and review of videotapes with an MDFP supervisor and previously trained therapists, and completion of at least two pilot cases during which every session is supervised live or by videotape. Following training, counselors receive 4 hr of face-to-face supervision per week that include a review of developments and case conceptualization for every case, videotape review of sessions, and live supervision of sessions in progress.

One final, critical parameter to be considered is program cost. Ecologically based intervention models such as MDFP require that significant effort be devoted to every family, including multiple contacts each week, sessions offered over several months, and case-management services as needed. Moreover, in order to offset the considerable degree of emotional stress and fatigue experienced by counselors working with multiproblem adolescents and families (Bank, Marlowe, Reid, Patterson, & Weinrott, 1991), programs must hire well-trained counselors, cap caseloads at 10-12 or fewer families, and provide ample staff support and supervision. This kind of programmatic and administrative intensity is necessary for intervening successfully with high-risk adolescents and families (Borduin et al., 1995). However, supporting this level of intensity is an expensive venture, and cost issues are of paramount importance to prevention programs operating in fee-for-service and health-maintenance-organization environments (Rotheram-Borus, 1997). Thus, MDFP should be used only with those adolescents exhibiting the highest risk profiles (e.g., subdisorder delinquency, incipient drug use, serious risk factors in multiple domains), such that potential rewards to participants and their communities justify the substantial costs-per-family involved.

INTERVENTION STRATEGIES AND TECHNIQUES

Multidimensional Family Prevention is a clinically flexible, highly individualized prevention model, and its fundamental principles and intervention techniques are applied according to counselor judgment about the status and needs of a given family (Jacobson et al., 1989). Multidimensional Family Prevention Model centralizes the unique history, values, identified problems, interactional patterns, and goals of the family and its members within the assessment and intervention process. In addition, generic prevention themes (e.g., connection to the family, involvement in prosocial activities) and structured, skills-oriented training are incorporated into the intervention agenda as indicated. This section offers guidelines for constructing and implementing an individualized prevention agenda with each family that incorporates both risk and protection themes.

Assessing Risk and Protection Domains and Setting an Individualized Prevention Agenda

Multidimensional Family Prevention utilizes a multidomain, multisystems assessment strategy for evaluating various dimensions of the adolescent’s and family’s psychosocial functioning. It focuses on seven domains of functioning that are linked to the development of risk and protective mechanisms in adolescent populations and that represent critical foci of concern for families with high-risk youth, who typically demonstrate elevated risk levels in more than one domain (Jessor, 1993; Petraitis, Flay, & Miller, 1995). Multidimensional Family Prevention counselors assess each domain of functioning in order to identify major problem areas and protective supports in the life of the adolescent and to map out the nature and extent of family involvement in each context. These domains make up the intervention curriculum of the model, insofar as they are systematically assessed with every family and become the key components of the preventive intervention.

Family relationships. This domain pertains to the history and patterns of positive and negative interactions within the family, strength of positive and negative bonds between family members, role that extended or estranged family members play in family life, child caretaking and monitoring arrangements,
family communication and coping style, family responsiveness to the emotional or behavioral problems of one member, and so forth.

School involvement. This domain pertains to any aspect of the adolescent’s school experience, including school grades and conduct, educational goals, homework habits, presence of learning disabilities, school-based extracurricular activities, relationships with teachers or school-based mentors, and parental knowledge about and involvement in school issues.

Prosocial activities. This domain pertains to adolescent and parent involvement in youth activities and social institutions other than school, including sporting and social clubs, tutoring and academic enrichment programs, leadership and vocational programs, religious institutions, and youth-monitoring agencies such as juvenile justice and probationary programs.

Peer relationships. This domain pertains to the adolescent’s friendships and other peer-related issues, such as attitudes and experiences about friendships, identification with the values of the particular peer culture, behavioral activities favored by close friends and larger peer groups, attitudes and expectations regarding interactions with older peers or nonaffiliated peer groups, parental contact with friends and the parents of friends, parental knowledge and judgment about peer-related behaviors and values, and so forth.

Drug issues. This domain pertains to adolescent and parental attitudes about and involvement in drug use, including parental history of substance use and drug treatment, adolescent history of substance use, drug involvement by other family members, drug use and drug attitudes held by the adolescent’s proximal peer network, drug-related activity at school and in local neighborhoods, and so forth.

Cultural themes. This domain pertains to salient aspects of the adolescent’s particular sociocultural background, including family knowledge and attitudes about racial/ethnic history, parental teaching about culture-specific values, culturally based family rituals or religious practices, emergence of the adolescent’s cultural identity, personal experiences of prejudice on the part of the adolescent or parent, socioeconomic hardships and barriers related to race and ethnic background, personal and family mechanisms for coping with ethnic bias, and so forth.

Adolescent health and sexuality. This domain pertains to a broad range of adolescent physical and mental health concerns, including existing or emerging physical problems (e.g., diabetes, weight problems), psychological or behavioral problems (e.g., depression, anxiety, aggression, impulsivity), issues related to self-concept and self-care, adolescent and family expectations regarding dating and sexual relationships with the opposite sex, issues related to sex and sexuality, and knowledge about sexually transmitted diseases.

An informal assessment of the family’s risk and protective factors within each of these domains occurs in the program’s initial sessions. The domains are not assessed in a predetermined, programmatic fashion. Instead, the idiosyncratic characteristics of the family determine the priority, timing, and depth with which each domain is explored. As the assessment progresses, some domains may loom large in the family landscape and hence become a focal area of work, while other domains with lesser relevance may recede into the background. In assessing each domain, the counselor pursues three avenues of inquiry simultaneously: history and perspective of the adolescent, history and perspective of the functional parent(s), and history and status of the relationship between the adolescent and parent(s). The assessment is managed so that sensitive issues can be addressed in a respectful manner; careful consideration is given to when topics should be raised with individuals alone, raised with all members present, or raised first in private and then again (with permission and preparation) in a conjoint setting. In all situations, the counselor is interested in identifying risk and protective factors that bear directly on the adolescent’s key developmental challenges.

Consider the drug issues domain. The counselor may ask the adolescent whether she has personally used drugs, has friends who use drugs, has peers who encourage or discourage drug use, and/or knows any adolescents who have profited or suffered by using or selling them. The counselor may also solicit the teen’s thoughts and feelings regarding drug use in her family and the direct or indirect messages that she receives from her family about drug use. Similarly, the counselor is interested in the parents’ thoughts and attitudes about drug use, ideas they may harbor about the pressures and temptations to which the teen is exposed, and their expectations regarding the teen’s values and behavior. For cases in which the parent has a current or former substance use problem, the counselor may inquire about the parent’s history of drug use, how this use has negatively affected his or her life in general and his or her ability to parent the teen, and the messages
he or she would like to pass on to his or her child(ren). Finally, the counselor attempts to facilitate conversations between the adolescent and parent(s) about drug use in order to assess how the family talks about these issues. Of interest is both the content and process of this conversation: the kinds of information and sentiments that are (and are not) expressed, the degree of openness and respectfulness displayed by each person, how members present and receive strongly held opinions, the parent’s ability to solicit the personal viewpoint of the adolescent, and so forth.

The main goal of assessing risk and protection domains during the first few sessions is to crystallize family specific issues that will become the focus of the counseling. To accomplish the task of setting the prevention agenda, MDFP follows several procedural guidelines. First, the counselor makes it clear to the parent(s) that they are fundamental to the program’s process. Attention is paid to dispensing any preconceptions that the program is meant to “straighten out” the adolescent, and the importance of continued parental influence and parent-adolescent communication for adolescent development is underscored. Also, connections between parental well-being, parenting competence, and adolescent adjustment are discussed. The counselor seeks to establish him- or herself as a resource for parents with regard to both parenting matters and personal matters that affect the parenting process.

Second, counselors use a story-telling, oral-history format, rather than a structured interview format, to assess risk and protection. That is, the counselor asks questions that access narrative detail and cannot be answered with a simple “yes/no” response. Such questions tend to elicit cognitive, behavioral, and emotional content (often simultaneously), and they give rise to autobiographical accounts of historical connections between family members rather than to bland generalizations or litanies of complaint. An oral-history assessment poses questions such as “When you first held your son in arms, what dreams did you have for him as an adolescent? As an adult?”; “Describe some of the happiest times you have had together as a family. Describe some of the hardest?”; “How do your parents let you know when they are proud of you? When they are disappointed?”; and “What childhood experiences most shaped your ideas about how to be a good parent? How has parenthood been different than expected?” Questions such as these allow the counselor to explore how family members think about themselves in relation to their family as well as how they relate to one another on a behavioral and emotional level.

Third, at every juncture the counselor assesses the knowledge that parents possess about their teenager’s life outside the family. Remaining appropriately influential in the adolescent’s life is related to becoming (or remaining) knowledgeable about their adolescent’s extrafamilial life. Thus, the assessment attempts to map out the various ecological contexts of the adolescent, from the point of view of both adolescent and parent: Who are her best friends, and what do they do together? What is happening in school and in after-school settings on a day-to-day basis? Who are the most important extrafamilial adults in her life, and how often does contact occur? Parents with a deep knowledge of these issues can effectively extend the protective influence of the family to other ecological contexts in a way that promotes healthy development. As such, the counselor is interested in what adolescents share with their parents about these contexts, how motivated the parents are to know details, and how they go about asking the adolescent to share this information.

Especially within high-risk populations, assessment of risk and protection domains will often uncover one or more risk factors that exert a significant press upon the family. For example, the adolescent may be failing classes or initiating fights at school; the adolescent may be upset that his opinions are ridiculed or dismissed by his parents, while the parents lament that the adolescent has grown sullen or emotionally detached; the parents may express harsh criticism that the adolescent is associating with antisocial peers or experimenting with sex, while the adolescent steadily grows angry and withdraws in response. Problems such as these tend to be perceived by families as highly stressful, resistant to change, and warranting immediate intervention. In short, high-risk prevention populations often present with difficulties in adaptation that command a treatment-like urgency (Tolan, 1996). It is therefore imperative that preventionists who work with high-risk populations have sufficient training and skills, sanction from the family, flexibility within the model in choosing and adapting interventions, and supervisory support from the program for addressing these difficulties in a competent manner.

What if the assessment reveals that a family has few problems or concerns of alarming magnitude?
Even within high-risk populations, many adolescents and families present with relatively mild risk factors and reasonably solid coping mechanisms in some or most domains. For such cases, protection-oriented themes will receive the bulk of attention in counseling. Protection-oriented themes are generated from the counselor's expertise in general risk and protective mechanisms and normative family psychology coupled with knowledge of the particular family gained from the assessment process. Protection-oriented themes take the form of “What every family should know and do in order to manage normative adolescent transitions,” and they assume the functions of (1) curbing mild symptoms or nascent problems and (2) building individual and family coping skills as an inoculation against future risk. For example, a parent may be coached to meet with a teacher to plan a more structured homework regimen for the adolescent; a parent and adolescent may be guided to articulate specific preferences, expectations, and rules regarding dating practices; families may be asked to consider revitalizing ties with a biological parent who has become estranged from the adolescent. Such interventions do not necessarily remedy immediate distress so much as they foster a more protective family context in which developmental needs are recognized and integrated within the governing family system. Note that protection-oriented themes are pursued with all families, even those with relatively few coping skills and a multitude of daily stressors. Prevention themes related to developmental trajectories, changes in the parent-adolescent relationship, and appropriate parental involvement in the adolescent's life are explored even with highly stressed families.

MDFP Intervention Modules

Multidimensional Family Prevention features five integrated modules of intervention, each associated with a core roster of intervention goals and techniques. Multidimensional Family Prevention counselors rely on training, experience, and accumulating knowledge of the family to coordinate intervention efforts within and among the five modules. Depending on the nature of the family's risk and protection profile, more time may be devoted to some modules than others. Modules are not meant to be implemented in a sequential or prearranged fashion, nor is it usually feasible to complete work in one module prior to focusing on others. Instead, progress in one module tends to potentiate work in others, and critical themes are cycled throughout different modules, and sometimes recycled within a given module, throughout a family's participation in the program.

Adolescent module. This module focuses on the role of the individual adolescent within the family system as well as his or her membership within other social systems, principally school and peer groups. Normative developmental issues such as school achievement, family support and stress, emotional and physical maturation, romantic interests, prosocial and antisocial influences within the peer group and neighborhood, and the consequences of engaging in antisocial behavior are discussed for their personal relevance and for their suitability as focal topics with parents. Also, the counselor tries to elicit detail about the adolescent's day-to-day life, fears and worries, and hopes and dreams.

It is crucial for several reasons that the counselor work to understand the extended social systems in which the adolescent operates. In attempting to make an initial connection with the adolescent, the counselor may open up content areas related to extended systems that are comfortable and meaningful for teens (e.g., social or sporting activities, what friends are like, how the teen spends time in the neighborhood), thereby reducing anxiety and tension while increasing motivation to participate. The counselor helps the adolescent to paint a detailed picture of how she makes decisions in her life, how stable and supportive her peer network is, and how she is adjusting to achievement and maturity demands. In this way the counselor gains better access to the everyday world of the adolescent and the risk and protective factors found there, and this information becomes the basis for designing practical and relevant prevention strategies.

Details about activities in extended social systems are also natural building blocks for constructing goals in counseling that have personal meaning for the adolescent. It is important to both the engagement process and to the ultimate success of counseling that the adolescent endorse an individualized rationale for counseling (Liddle et al., 1992). The creation of a personally meaningful agenda is a key element in establishing a strong working alliance with the teenager (Diamond, Liddle, Hogue, & Dakof, 1999); strength of the working alliance has proven to be a robust predictor of intervention outcome, at least with
adults (Horvath & Luborsky, 1993). Adolescents should be convinced that prevention counseling can be worthwhile, a vehicle for thinking about their unique issues and working on self-defined goals that may be quite different from those of parents and other adults. The counselor proceeds in building this agenda by taking a posture of respect and support for the adolescent’s personal experience, both inside and outside the family. The counselor acknowledges that the adolescent has her own story to tell and suggests that this story will be heard in counseling. In so doing, a fruitful working alliance can be developed based on mutual trust and on the teen’s commitment to working toward concrete and meaningful goals.

**Parent module.** The parent module uses individual sessions with the parent(s) to establish a counselor-parent working alliance, review their history of perceived successes and failures as parents, and present a developmentally informed perspective on adolescent risk and adaptive functioning. Also, intrapersonal and interpersonal experiences apart from the parenting realm are explored so that personal resources are cultivated and impediments to effective parenting are addressed. When indicated, parenting skills are enhanced in the areas of monitoring, discipline and limit setting, fostering a supportive emotional climate, and modeling coping strategies.

An ecological view of parenting is essential for developing sensitivity to the life circumstances of parents (Luster & Okagaki, 1993). Parents of high-risk adolescents are often under considerable stress from a variety of sources. Many are single parents with other children, some struggle with considerable relationship problems or economic hardships, and some exhibit depression or other forms of psychopathology, all of which precipitate symptoms in the adolescent and thereby constitute part of the adolescent’s risk profile (Robinson & Garber, 1995). In such cases, a significant portion of the parental focus may be devoted to (1) identifying how these stressors affect the parenting environment, (2) determining how the adolescent (and other children) can be better shielded from their effects, and (3) helping parents to access various social (and, if needed, psychiatric) resources for themselves and their families. Counselors should also acknowledge the history of the parents’ efforts to raise the adolescent. Parents of adolescents with incipient behavior problems have typically tried many things over many years to curb these behaviors, often stringing together a succession of defeated attempts to enact more effective parenting practices (Patterson, Reid, & Dishion, 1992). At the same time, parents may express strong negative feelings about the parenting that they received in their own family of origin, and these historical issues often need to be addressed prior to, or concurrently with, helping them transform the current parenting environment.

The rationale that underlies parenting attributions and behaviors is discussed in detail with the parent alone prior to attempting coached interactions with the adolescent. The parent module focuses specifically on parenting practices related to how parents monitor the adolescent’s behavior, set and enforce rules in the home, and provide an atmosphere of supportive guidance. We translate established principles of effective parenting into practical strategies that mesh with the ecological niche and everyday parenting routine of the family (Liddle, Rowe, Dakof, & Lyke, 1998). The main goal of this work is to clarify how parents can, and cannot, affect the adolescent’s behavior. Parents need to receive accurate information about how much influence they actually wield on adolescent behavior and about the most efficient means for using this influence. In MDFP, this information is presented in a way that is interactive (vs. didactic) and fitted to the family’s historical and immediate context (vs. generic) so that parents perceive the relevance and feasibility of altering parenting practices to match developmental demands.

**Interactional module.** The interactional module facilitates change in family relationship patterns by providing an interactional context wherein families develop the motivation, skills, and experience to modify interpersonal bonds and interact in more adaptive ways. Family members are helped to understand and validate the values and perspectives of other members. Adolescents and parents are asked to evaluate their attachment bonds and the balance they have achieved between autonomy and connectedness. Also, counselors arrange, coach, and review in-session interactions among family members in an effort to decrease conflict, increase communication effectiveness, and promote improved problem-solving skills (Diamond & Liddle, 1996).

Family relationships and interactional patterns are main foci of assessment and intervention in MDFP, with greatest emphasis placed on the parent-adolescent relationship. A basic goal of the interactional module
is fostering and/or maintaining an emotional interdependence in the relationship between the adolescent and the parents. This is carried out primarily through the focusing of in-session conversations between parents and adolescents on family-specific core themes. Counselors seek to understand and ultimately modify the current context of the parent-adolescent relationship by evaluating and coaching their unrehearsed interactions in session (Minuchin & Fishman, 1981). Conversations are sometimes prompted by the counselor in direct attempts to change interactional patterns and, thus, change the relationship; at other times, the conversations occur spontaneously. The counselor watches how the parent and adolescent communicate, how they solve or fail to solve problems, and how the viewpoint of each is validated or thwarted. The counselor then looks to shape interactions in an attempt to provide new experiences of existing relationships or to break new relationship ground, thereby instilling more adaptive and protective relationship habits. This may involve the counselor translating or extrapolating a communication from one person to another, interpreting new meaning to an interaction as it unfolds, or pushing the content or intensity of dialogue into new areas. The opportunity for families to practice new relationship patterns, and to do so in a context in which new behaviors are supported and refined, would seem to be critical for their acceptability and long-term durability. Moreover, as families practice adaptive relationship behaviors in session, they become more able to recognize what good conversations sound and feel like, which promotes the generalizability of these behaviors to novel situations.

It is unwise to underestimate the difficulty that may be posed by asking a parent and adolescent to engage in unrehearsed conversation in session. Parents and adolescents generally spend a comparatively small amount of daily time together in conversation (Larson & Richards, 1994), and the task of conversing “naturally” about emotional or conflictual topics in the alien environment of a counseling session can be formidable (Diamond & Liddle, 1996). Especially in high-risk families with a history of negative or impoverished communication, teenagers and parents may need considerable coaching from the counselor before they can begin productive in-session conversations. This coaching is carried out in one-to-one sessions dedicated to preparing participants individually for later, mutually planned interactions in session. The overall objectives of preparatory individual coaching include helping each participant to formulate the content and style of what is to be said, prepare for potential reactions by other participants, and solidify a minicontract that enables the counselor to challenge the participant to follow through as planned once the interaction begins. Preparatory coaching with high-risk families will often center on encouraging participants to express less extreme, emotionally hardened positions. By preprocessing intensely experienced feelings or entrenched opinions in this manner, family members can take a needed first step toward defusing habitual problems in communication.

*Extended-family module.* Individual and interactional work with the adolescent and functional parent(s) are core to MDFP. At the same time, it is important to recognize that other family members are often instrumental in fostering adaptive, or maladaptive, socialization. Siblings, family members not presently living in the home, and extended-family members are included in assessment, agenda formulation, and counseling interventions. Family members other than parents who play a key role in the adolescent’s life are invited to participate in family sessions, and individual sessions are sometimes held with these members on an as-indicated (i.e., counselor-defined) basis. For example, it is common for MDFP counselors to ask older siblings to share their histories of successes, failures, and lessons learned with target adolescents. Also, with the cooperation of the functional parent(s), counselors look to reinvigorate relationships between adolescents and estranged parents or adult relatives, when such relationships hold the promise of reliable guidance and support for the youth in the future.

*Extrafamilial module.* The extrafamilial module is the vehicle through which the counselor seeks to develop a high level of collaboration between the family and all other ecological systems to which the adolescent is connected—school, peer, recreational, and so forth. Interventions typically assume one of two basic forms: (1) discussions about the parents’ participation in, contacts with, and knowledge of the adolescent’s life outside the family, with emphasis on the protective benefits of parents remaining personally involved in those systems, and (2) helping parents appreciate the importance of remaining fluent in the adolescent’s subjective experience of those systems. Multidimensional Family Prevention counselors work to promote parental involvement by encouraging parents to attend school conferences, arrange independent
meetings with teachers, visit the sites of extracurricular activities, meet best friends, and meet the parents of best friends. For parents who are already active in the adolescent’s school and peer networks, counselors discuss strategies for remaining engaged in these systems even as new demands for independence and responsibility emerge in later adolescent years. Parents are also asked to consider how much they know about how their teen selects friends and recreational activities, as well as how much they are consulted or informed about these decisions. This module also includes interventions designed to help forge extended systems of support for the adolescent and family. Counselors routinely accompany family members in meeting with adults invested in the adolescent (e.g., teachers, program directors, social workers) and investigate various community resources available to both adolescents and parents. In this way, the counselor acts as a direct support for the family and helps parents become more competent advocates on behalf of the teenager. Also, counselors look to engage all adults who can act as sources of nurturance and guidance for the teen. This process invariably extends beyond the family to include mentoring adults such as close neighbors, teachers, coaches, and personnel from community agencies.

CONCLUSION

Multidimensional Family Prevention is a multimodule, intervention-flexible, family-based preventive intervention for preventing antisocial behavior in high-risk adolescents. It combines the advantages of standard prevention models, which take a curriculum-based and protection-focused intervention approach, with the advantages of psychosocial treatment models, developed with clinical samples, which take an assessment-based and problem-focused intervention approach. This dual focus is needed for working effectively with adolescents who are at greatest risk for developing drug use, delinquency, and violent behaviors. Such adolescents require intensive prevention services that address both risk and protective factors, devote considerable energy to the family environment, and coordinate efforts across multiple social contexts influencing the lives of adolescents.

At the crux of the distinction between MDFP and standard family prevention is individualized assessment and development of a customized intervention plan for each family. Certainly, these two MDFP elements are also prominent features of most psychotherapy models. The question then arises: How is MDFP different from family-based treatment approaches, such as systemic family therapy (e.g., Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998) or behavioral family intervention (Taylor & Biglan, 1998)? This question is more complex than it might appear at first. For example, some argue that prevention should concern itself primarily with large-scale or population-based intervention (Albee & Gullotta, 1997), while others recognize the legitimacy of small-scale and even case-by-case prevention strategies (SAMHSA, 1998). Such issues are at the heart of recent efforts to formalize the continuum of intervention services spanning preintervention, prevention, treatment, and maintenance (NAMHC, 1998), and the issues are too complex to permit full exposition here.

At the least, MDFP can be distinguished from family therapy at three levels. First, there is a population distinction. Preventive interventions target universal, selective, and indicated populations. These populations, on average, exhibit less severe and less entrenched behavioral symptoms, if any, than treatment referrals, which typically have a diagnosable disorder. Second, there is an intentional distinction. The ultimate aim of prevention is to lessen the likelihood of possible or anticipated symptoms, and intervention goals are expressed in terms of outcome probabilities (Mrazek & Haggerty, 1994). The ultimate aim of treatment is to reduce symptoms and alleviate disorder immediately, and therapeutic progress can be determined in large measure at termination. Third, there are numerous formal distinctions, that is, differences in the intervention components that characterize prevention versus treatment approaches. For example, MDFP typically offers a home-based delivery system and includes case-management services; these features are absent from most family therapy models.

Multidimensional Family Prevention most closely resembles home-based family preservation (Haapala, 1996; Schoenwald & Henggeler, 1997). Home-based family preservation is aimed at preventing out-of-home placement of children in high-risk families. Like MDFP, family preservation attempts to facilitate healthier interactions among family members, strengthen family connections with community
resources, balance clinical intervention with case management, and hold sessions at home as well as at community locations. However, family preservation targets families that have a documented history of toxic parenting (e.g., parents with histories of child abuse or neglect) or that have a child member with diagnosable symptomatology (e.g., conduct-disordered youth). As a result, it is significantly more intensive than MDFP: Services are provided on demand around the clock, counselors work in teams and maintain almost daily contact with families, caseloads are usually capped at two to six families per counselor, and concrete goods (e.g., food, financial support) are often provided directly.

At this time little is known about how population, intentional, and formal differences between prevention and treatment ultimately translate into functional differences in the conceptualization and implementation of family interventions. For example, what adjustments are required to transport behavioral-family-skills-training curricula from treatment to prevention settings? What are the implications for administering interventions in group settings, traditionally preferred by preventionists, versus individual settings, often favored by therapists? How can family therapy models be transformed to serve as true prevention approaches with less severe populations who are not symptomatic (preclinical populations)?

To our knowledge there are no studies comparing family-based prevention versus treatment approaches for disorders within similar populations. Also, to date there is a virtual absence of research on prevention-services implementation and delivery (NAMHC, 1998). Investigating the relative merits of family prevention versus therapy for given disorders and establishing adherence benchmarks for models within each specialty are top priorities for creating empirically based guidelines to help practitioners select and implement the right intervention for the right client.

REFERENCES


Steinberg, L. (1990). Autonomy, conflict, and harmony in the family relationship. In S. Feldman & G. Elliot (Eds.), *At the


