Manual for Multiple Family Group Intervention: An Affect Regulation and Attachment Treatment

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Multiple Family Group Intervention

Introduction

The primary features of the Multiple Family Group Intervention are multiple pathways to change (e.g., emotion and arousal re-regulation, conflict resolution, re-attachment) within different contexts (e.g., individual, family, and peer). Research has shown that externalizing and internalizing behaviors such as substance use, aggression, depression, or sexual acting out are primary ways in which individuals manage their emotions and their ability to interact with others. If they have many ways of managing arousal and the attendant interactions, these behaviors use may not escalate to problem levels; but if these externalizing/internalizing behaviors are the primary affect (emotion) regulation and relationship practices, diagnosable disorders often develop.

Common problem situations in adolescence frequently result in difficulties with emotion (affect) regulation and attachment negotiation with parents. As a result, in some families conflictual and coercive cycles of fighting and avoiding among family members become common interactional patterns. These patterns are associated with high levels of negative affect and arousal that disrupt family members' attachment bonds (Cooper, Shaver, & Collins, 1998; Ducharme, Doyle, & Markiewicz, 2002), impair cognitive functioning (Gottman, 1994), and foster chronic physiological arousal (El-Sheikh, 2001; Gottman & Katz, 2002) which is frequently mitigated and alleviated by substance use, sexual behavior, aggression, or other externalizing/internalizing behaviors. The result is that adolescents become disconnected from their families, unable to cope well with conflict and negative affect, and more likely to associate with deviant peers who are already involved in these problematic behaviors. Adolescents who are attached securely to their caregivers and able to regulate their affect and arousal functionally are more successful in negotiating paths to adulthood than are those who are not (Cummings & Davies, 1996; Gottman, 1994; Moore, Moretti, & Holland, 1998). If the parents of

adolescents have not been able to learn effective ways of managing their own emotion and arousal, they are not likely to be able to help their children through this adolescent transition without leaving them at risk for externalizing/internalizing difficulties. In fact, many caregivers of adolescents who become involved in substance use, aggression, and sexual acting out have their own difficulties with these behaviors.

The focus of this affect/arousal regulation and attachment Multiple-Family Group Intervention is on helping adolescents and parents connect on an emotional level in order to encourage understanding and empathy between them and ultimately reduce problem behaviors (Liddle, Rowe, Dakof & Lyke, 1998). Adolescents and parents are given opportunities to access their negative emotions, such as anger, resentment, and bitterness, in a safe environment and acknowledge and manage the more vulnerable feelings, such as fear and sadness, associated with them. These more vulnerable feelings allow adolescents and parents to retrieve the positive emotions and feelings and their desires for connectedness that have been hidden beneath the negative affect and conflict that has arisen during adolescence. The primary goals of the Multiple Family Group Intervention are 1) to help parents and adolescents regulate arousal and negative affect more functionally, 2) thus decreasing the incidence of coercive and conflictual interactional cycles, 3) allowing an opportunity to heal their past resentments and re-attach to one another, 4) ultimately (experiencing less stress and negative affect and more support and positive affect), enabling adolescents (and parents) to decrease the use of symptomatic behaviors. Concomitantly, once re-attached and armed with more functional affect and arousal regulation skills, the adolescents may be able to manage their decision-making processes more constructively, hence reducing their own problematic behaviors that may lead to association with deviant peers and delinquency. The result may be that parents can then support their adolescents in their development toward adulthood in a more effective manner.

The Protective and Risk Factors for Externalizing / Internalizing Behaviors

Characteristics of Adolescents at-Risk for Externalizing / Internalizing Behaviors

Adolescents at-risk for externalizing or internalizing behaviors often have already experienced these behavior problems in early (Opposition Defiant Disorder) or late (Conduct Disorder) childhood. As a result they may have social information processing and other cognitive deficits such as hostile attributional bias and poor problem solving abilities (Dodge, 1993). These processing biases support adolescents' views of the world as hostile. Seeing only hostility, they limit the means that they use to obtain desired goals to behaviors that are coercive, if not aggressive (Dodge, Pettit, & Bates, 1994a). Aggressive youth with these cognitive deficits and biases that interfere with the development of social competence then may be rejected by typically-developing peers, associate with deviant ones, and experience academic failure (Dishion & Andrews, 1995). These adolescents often feel alone, fearful of negative evaluation, depressed, and full of self-blame (Dodge, 1993). In fact, Loeber and his colleagues (1994) have found that many of these youth also suffer from internalizing and substance abuse disorders. The resulting preponderance of negative affect, lack of useful affect regulation skills, and problems in relationships that the youth experiences is frequently self-medicated by the use of substances (e.g., alcohol, drugs), by associating with deviant peers, sexual acting out, or aggression.

Characteristics of Parents and Families with Adolescents who are at Risk for Externalizing or Internalizing Behaviors

Parental psychopathology is highly related to the development of externalizing or internalizing behaviors in youth (Kazdin, 1993). Maternal depression and paternal substance abuse are some of the best predictors of later adolescent problem behaviors (Frick, 1992). Parental psychopathology is hypothesized to affect the development of adolescent problems through its influence on parenting practices (Frick, 1994).

Parenting practices such as harsh, lax, erratic, or inconsistent discipline, monitoring, and

supervision are, in themselves, a negative influence on parent-child interactions (Kazdin, 1993). This influence is most likely bi-directional; that is, parenting behavior has an effect on the child's behavior which, in turn, has an effect on further parenting behavior (Patterson, Reid, & Dishion, 1992). Patterson has called the resulting coercive cycle a form of escape and avoidance conditioning (Patterson, 1982). In response to parents' aversive intrusions into relatively trivial noncompliant behavior, the child counterattacks in a less trivial manner, the parents respond with further escalations of demanding behavior; and a coercive cycle ensues (Dishion & Andrews, 1995). Seventy percent of the time, children outlast their parents and get what they want, which reinforces their deviant behavior (Dishion, Duncan, Eddy, Fagot, & Fetrow, 1994; Patterson, 1982, 1995). These cycles of coercion and abdication of control by parents leave the child in a powerful position, but with little experience of effective problem-solving. Reuter and Conger (1995), in a causal-modeling study, found that, when problem-solving interactions such as these were ineffective, adolescents were more at risk for poor adjustment and substance abuse. These behaviors used by children to gain control over disruptive, chaotic, and aversive circumstances at home carry over to their relationships with peers and teachers often resulting in school failure and associations with deviant peers (Dishion et al., 1994).

Marital discord or divorce is often associated with externalizing and internalizing behaviors in youth (Gottman & Katz, 1989; Kazdin, 1993). As with parental psychopathology, the effect of marital conflict may be through its effect on parenting practices (Gottman & Katz, 1989; Frick, 1994). In investigating the mechanisms by which marital discord might interfere with parenting, Gottman and Katz (1989) examined emotion regulation processes between parents and their children that will be reviewed below.

Another important aspect of families who are dealing with externalizing and internalizing behaviors in adults or adolescents is the larger system in which they are embedded. These families frequently are exposed to violence in their neighborhoods, many life stressors, and few

economic resources (Dodge, Pettit, & Bates, 1994b). The extensive causal-modeling studies by Conger and his associates (Conger, Rueter, & Conger, 2000) have supported the development of interventions that include attention to larger contextual issues (economic, peer, school, community) that have an impact on parents' functioning (psychopathology, marital relationship, parenting) and ultimately on the adolescents' adjustment or maladjustment. The constructs they have investigated (marital conflict and distress, parental emotional distress or depressed mood, parental nurturance) are elements of the family members' affect regulation and attachment strategies.

Affect Regulation and Attachment Risks

Affect regulation involves the tolerance, awareness, expression, and control of the physiological, behavioral, or experiential aspects of an affective experience (Cicchetti, Ackerman, & Izard, 1995a; Garber & Dodge, 1991; Keiley, 2002a). In general, affect is regulated to reduce adverse conditions or increase favorable ones, thus allowing one to endure or tolerate the experience (Tomkins, 1963). When affect is under-controlled, externalizing or out-of-control behaviors may emerge; when over-controlled a more constricted or internalizing behavior may occur (Keiley, 2002a). The regulation of affect includes both internal (self-regulation) and external (social-regulation) relational processes which are co-constructed initially with caregivers as part of the attachment process (Cassidy, 1994; Keiley, 2002a).

In the attachment process, children learn strategies, including affect regulation strategies, to maintain the proximity of the caregiver, especially in stressful situations (Bowlby, 1969/1982; 1973). The attachment behavior system is activated by stress and has the goal of reducing arousal and reinstating a sense of security in order for the infant or child to explore. If the caregiver is warm, sensitive, available, and responsive, distress will be regulated with strategies that involve seeking comfort and support and the infant will develop a secure attachment (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969/ 1982). If the caregiver is emotionally

unavailable or rejecting during times of distress, the infant may develop an avoidant-insecure attachment in which affect strategies that de-emphasize the importance of attachment, restricting the communication of anger and distress, will be adopted. Avoidantly-attached children often focus on the inanimate environment, away from any cues that might intensify their desire to seek comfort from a parent who rejects attachment behaviors (Keiley, 2002a). These children may become the classic "withdrawer" in the interactional cycle of "pursue-withdraw" that characterizes many later relationships. If the caregiver is inconsistent, the infant may develop an ambivalent-insecure attachment. Later, these children may become hypervigilant to attachment experiences and use affect regulation strategies that heighten distress with displays of fear and anger toward the caregiver (Magai, 1999). These children often emerge as classic "pursuers" in relationships. A third insecure attachment category, insecure-disorganized, represents children who lack, or have been unable to construct, a consistent strategy for obtaining comfort and security when under stress (Keiley, 2002a). The caregiver appears frightening to the child, which leaves the child in the unenviable position of being afraid and in need of soothing from a caregiver, but that contact is fear-arousing rather than comforting. All three of these insecure attachment styles will interfere with a child's ability to regulate affect and maintain exploration and self-confidence in novel situations (Magai, 1999).

Affect Regulation and Attachment in Adolescence

As children move into adolescence they begin the tasks of peer relationship formation and achieving autonomy. During this time, both parents' and teens' attachment systems may become overwhelmed as adolescents explore areas of their lives to which parents have no access. Their strivings toward autonomy will most likely not undermine the basic attachment, but as adolescents dabble in some deviant behaviors, the attachment may become strained (Allen & Hauser, 1996; Allen, Moore, & Kuperminc, 1997).

Current theory and research on adult and adolescent attachment draw on Bowlby's

(1969/1982) concept of attachment representations or working models. These models consist of beliefs and expectations about how attachment relationships operate and what one gains from them. Working models of the world include ideas of who the attachment figures are and how one might expect them to respond (Bowlby, 1973). Working models of the self include ideas about how acceptable/unacceptable an individual is in the eyes of attachment figures. In addition, these internal working models of the world and the self include information about what affect an individual may acknowledge and how that affect may be expressed in order to maintain attachment bonds (Bowlby, 1973; Magai, 1999).

Researchers have suggested that affect regulation and the attachment relationship in which it is constructed are the major mechanisms through which parent psychopathology, ineffective parenting practices, and marital discord influence children in the development of problem behaviors such as externalizing and internalizing behaviors (Cicchetti, Toth, & Lynch, 1995b; Robinson, Emde, & Korfmacher, 1997). For example, in families in which marital distress was high and parent-child exchanges were highly-charged, children were unable to regulate their emotions effectively, exhibiting high levels of uncontrolled negative affect (Gottman & Katz, 1989). These children had poorer outcomes (quality of play, peer interactions, and physical health) than did the children who had non-distressed parents and were able to regulate their affect. Assessments of parent-child interactions, such as these, often include evaluation of the affective bond, involvement, warmth, and emotional tone that are part of the parent's relationship with the child. These aspects of relationship are elements of parents' attachment and affect regulation strategies. That is, parents' internal working models of attachment and their regulation strategies influence how they behave with their children that, in turn, influence the internal working models of attachment and the regulation strategies of their children (Robinson et al., 1997). In fact, Lyons-Ruth (1996) has reported agreement rates of attachment styles for mothers and their children of seventy percent.

Dodge (1993) has suggested that early life experiences interact with children's organization and functioning to produce evolving knowledge structures (schemas of the past, expectations of the future, affectively-charged vulnerabilities) which organize their information processing and therefore their behavior. He further hypothesized that early abuse and exposure to aggression might result in insecure attachments with caregivers. From these initial insecure attachments, cognitive biases, and early coercive behavior further development of problem behaviors commonly follow (Dodge et al., 1994a).

Holland, Moretti, Verlaan, and Peterson (1993) have suggested that disruption in the attachment bond is actually one of the critical underlying features of problem behaviors, including externalizing and internalizing behaviors. A disruption might occur with parents who have a dismissing attachment organization. These parents tend to be controlling, rejecting, emotionally unavailable, and conflictual with their children, with anger being their predominant affect (Cicchetti et al., 1995a). As a result, their children may become avoidantly attached themselves, demonstrating their own hostile and aggressive patterns of behavior (Greenberg, Speltz, & DeKlyen, 1993), leaving them lonely, perhaps depressed, and at-risk for using substances to soothe themselves. Alternatively, parents who are ambivalently attached often develop dependent, unresponsive, neglectful, and inconsistent behavior (Cicchetti et al., 1995a), which can also be disruptive to attachment. Their children frequently become ambivalently attached, impulsive, over-stimulated, restless, inattentive, and intolerant of frustration which can also lead to self-soothing addictive behaviors, such as substance use, eating disorders, sexual acting out, or other compulsive behaviors (Greenberg et al., 1993).

The difficulties in attachment and affect regulation established in childhood frequently continue into adolescence. In a study of adolescent offenders, the chronically violent youth had insecure attachment to parents compared to the nonviolent youth (Farrington, 1991). In Huizinga, Loeber, and Thornberry's (1994) three site study (Denver, Pittsburgh, and Rochester),

adolescents with insecure attachment to parents had higher rates of delinquency and substance use compared to those with secure attachment. In addition, adolescents who became involved in substance use and delinquency early had insecure attachment to parents than did those who became involved later in adolescence. Finally, in the Rochester Youth Study (Thornberry, Lizotte, Krohn, Farnworth, & Jang, 1991), adolescents with insecure attachment to their parents in junior high school reported more substance use and delinquent behaviors three years later.

As children, who are already at risk for externalizing and internalizing behaviors because of any of the above personal or familial characteristics, enter adolescence, the entire family system may experience conflict and a sense of estrangement. Failure of parents and adolescents to maintain relatedness during this process may result in the development of externalizing and internalizing behaviors which are as dangerous as any failure to achieve autonomy. Adolescents who exhibit externalizing and internalizing behaviors are likely to have parents who are less involved and rejecting which, in turn, leave the adolescents feeling less motivated to please their parents because of this disconnection (Liddle et al., 1998). This cycle is reminiscent of the coercive cycle, described by Patterson (1982) that develops between parents and children in early childhood. Parents and adolescents involved in these cycles have been shown to suffer great despair and disconnectedness (Liddle, 1994).

Model of Treatment of Externalizing and Internalizing Behaviors

In both the psychopathology and family therapy field, researchers have focused on the importance of attachment and affect regulation in the etiology and treatment of adolescents' difficult behaviors (Allen et al., 1997; Cicchetti et al., 1995a; Johnson & Greenberg, 1995; Liddle, 1994, 1995; Moretti, Holland, & Peterson, 1994). In a large home-based prevention program with at-risk mothers aimed at reducing current abuse of the children and their later development of criminal behaviors, the alliance that interventionists developed with the mothers was one of the most important parts of the intervention (Robinson et al., 1997). In the 15 year follow-up,

children whose mothers had received home visits had fewer arrests in adolescence than did the control children (Olds et al., 1998). The mother's relationship with the home-worker was probably reparative of her experience with her own caregivers. The alliance appeared to model to the mother that she was deserving of care and support which allowed her to see that her child deserved this same care and support (Robinson et al., 1997). These findings, along with the work of Henggeler and his associates (Cunningham & Henggeler, 2001; Henggeler& Santos, 1997), underline the importance of attending to the therapeutic alliance when treating multi-stressed families such as those struggling with externalizing and internalizing behaviors.

In randomized, clinical trials, Emotionally Focused Therapy (EFT; Greenberg & Johnson, 1988; Johnson, 1996) has proved effective in treating couples with intractable emotional and attachment patterns (Johnson & Whiffen, 1999) and in treating similar unrelenting cycles of negative affect and conflict in families with a bulimic child (Johnson, Maddeaux, & Blouin, 1998). Equipped with more functional affect regulation skills, family members and adolescents re-connect, problem-solve and negotiate more effectively, hence reducing their problematic behaviors (Johnson & Talitman, 1997). One of the key assumptions of EFT is that emotion is primary in organizing attachment behavior in relationships. Central factors in relational distress are excessive levels of negative affect and destructive and constrained interactional patterns that arise from, reflect, and create this negative affect (Johnson & Greenberg, 1995). EFT proposes that new emotional experiences and interactions with others are necessary for change to occur in internal working models and hence in relationships with significant others. But, in order to institute these changes, the participants must learn how to regulate high arousal in order to maintain cognitive control over their behaviors. This is a major focus of the intervention.

Liddle and his colleagues (Diamond & Liddle, 1996, 1999; Liddle, 1994; Liddle et al., 1998) have designed multi-dimensional family therapy (MDFT) for families who have a drug- or alcohol-abusing adolescent. The focus of MDFT is reattaching parents and adolescents who

become disconnected because of continual engagement in angry, coercive cycles described by Patterson (1982). Part of this re-attachment process is helping family members "shift" from escalating negative affects of anger, hostility, rage to more vulnerable emotions of hurt, fear, anxiety, and resentment (Liddle, 1994). Family therapists use the "shift" intervention to focus family members on more vulnerable emotions which allows them to reconnect with each other, resolve their impasses, heal past resentments, and address current problems. In a task analysis of five successful and five unsuccessful therapist interventions into problematic interactions in therapy, presence of a "shift" event was documented in the five successful interventions, but not in the unsuccessful ones (Diamond & Liddle, 1996, 1999). In successful interventions, adolescents became more cooperative and engaged in therapy while parents shifted from trying to control them to understanding them (Diamond & Liddle, 1996). These preliminary results were used to develop a performance map of family members' and therapist's behaviors that accomplish this "shift" in escalating negative affect to underlying feelings that allows the participants to connect with one another (Diamond & Liddle, 1996, 1999).

As outlined in the research literature, effective adolescent and parent functioning is related to a family environment that balances individuality and connectedness, while providing opportunities for expression of positive and negative emotions and problem solving. In families with adolescents who are using externalizing and internalizing behaviors, problem situations frequently result in difficulties with attachment and affect regulation negotiation. In a qualitative pilot study (Keiley & Seery, 2001), we focused on developing insight into attachment and affect regulation strategies used by adjudicated youth with externalizing and internalizing behaviors and their families and how those strategies compared to those used by adolescents and parents who were not adjudicated. We then developed the Multiple Family Group Intervention (MFGI) that we have implemented with incarcerated adolescents and their families (Keiley, 2002a, 2002b). In this section, the framework of the treatment model, the MFGI protocol, and

preliminary evidence of effectiveness of the MFGI will be presented.

Framework of the Multiple Family Group Intervention

Attachment between adolescents and parents is crucial as it provides a secure base from which adolescents can explore and investigate the world while demonstrating psychosocial competence (Liddle et al., 1998). The parents' responsibility is to provide an environment of support that encourages independence and individuality while at the same time maintaining an emotional connection to the adolescents. If parents themselves have not had this experience with their own parents, this task is more difficult. The escalation of emotions and conflict during adolescence is often used by both parents and adolescents as a mechanism to manage closeness and distance with each other (Keiley, 2002a). Adolescents will often express emotions that are out of control and will disengage emotionally from their parents during such displays of negative emotion in an attempt to manage their arousal level. The parents then try to exert control over the adolescents in order to re-attach emotionally, but instead they are unable to make any meaningful connection with the adolescent because of their own escalating negative emotions. This cycle is played out over and over again becoming coercive and increasingly disconnecting for both parents and adolescents.

Attachment relationships are defined partly by the expression of affect or emotion. During a period of stress and conflict, when the emotional arousal has risen to intolerable levels, parents and adolescents may be unable to manage their intense feelings. As the conflict escalates to even more unmanageable levels, participants begin to feel unsafe and more focused on gaining control and submission of the other in order to regain a feeling of safety. The vulnerable feelings (e.g., fear, sadness) that are being experienced by individuals often may be masked by the expression of instrumental overt feelings (e.g., anger, resentment) (Johnson, 1996; Keiley, 2002a). Vulnerable feelings are hidden primarily as a defense in order to protect the self. Participants often feel that these more vulnerable feelings would be seen by the other as

a weakness. Instead, participants express their more obvious feelings such as anger or rage, which distances individuals from one another. As a means of managing these high levels of arousal, both parents and adolescents may turn to problematic affect regulation strategies such as substance abuse, sexual acting out, violence, aggression, withdrawal.

For example, adolescents and parents may express overt and defensive feelings (e.g., anger or rage) when confronted with stressful event (e.g., truancy, alcohol or drug use). If parents are dealing with adolescents who are experimenting with high-risk behaviors (e.g., drinking, drugging, sex) their vulnerable emotion might be fear, however parents may choose to express this feeling by demonstrating anger which is a defensive and instrumental feeling, thus, trying to force the adolescents to quit those behaviors. As the conflict between parents and adolescents escalates, these instrumental and defensive feelings tend to be expressed more overtly than the more vulnerable feelings of sadness and fear. However, the expression of these instrumental feelings only serves to maintain an emotional disconnection between adolescents and parents. In order for them to make a deeper emotional connection, the primary, vulnerable, feelings need to be expressed and heard. Parents and adolescents tend to mask their vulnerable feelings such as sadness, hurt, and anxiety in order to protect themselves from further pain and disconnection. In fact, hiding these vulnerable feelings only perpetuates and increases the emotional distance and disconnection between them, again, frequently leading to the use of substances or compulsive behaviors for relief.

Thus for parents and adolescents to engage in an emotionally connected relationship, they must recognize their vulnerable feelings and express them in a manner that facilitates attachment (Johnson, 1996). Once these vulnerable feelings are addressed and validated, individuals are able to express those feelings more easily to other people without masking them with instrumental/ defensive emotions and substance use, or other problem behaviors. When parents or adolescents express their more vulnerable feelings the other feels invited to respond

on this same, more vulnerable level, thus decreasing the emotional arousal and the distance between them. In the prior example, if parents express their fears for their adolescents, the adolescents may be able to hear the caring and concern that the parents are feeling rather than just the anger and control (Diamond & Liddle, 1996; Keiley, 2002a, 2002b).

Multiple Family Group Intervention

For eight sessions adolescents and their parents meet with the facilitators of the intervention for an hour and a half to learn a six-step method for affect management and re-attachment based on the evidence-based treatment Emotionally-Focused Therapy (EFT; Johnson, 1996). The facilitators are all master's level family therapists enrolled in a family therapy program at a major university, although in later interventions, college graduates have been trained effectively as interventionists. For the 8 sessions of the MFGI, all participants (facilitators, adolescents, parents) meet together in one group. In the first session, the entire group establishes rules and then adolescents and parents talk about the problems they feel they have had with each other. (Please see Appendix A for complete description of the Curriculum and Process and Appendix B for the Weekly Plans.)

During week one, creating a safe, non-threatening environment is discussed, group members are introduced, and attachment, affect regulation, and the six steps of the intervention are described as well as the four major foci of the discussions that are used each week. These four foci will be discussed later. During weeks two through seven, the focus of each meeting is on one of the steps with the use of the four foci. Each MFGI group begins with a review of the six steps followed by more information about the specific step on which the group will focus for that meeting. The discussion is broadened to include how the step might relate to current or past experiences of the parents and adolescents. They are invited to role play similar situations in which they can learn, rehearse, and practice using more functional affect regulation or attachment strategies. These role plays are designed to elicit typical troublesome interactional

behaviors between adolescents and parents and then shape those interactions to resemble healthier behavior. Parents role-play adolescents and adolescents role-play parents to help them investigate what the other person's perspectives might be. In addition, facilitators meeting with family groups encourage everyone to coach the role-players about effective ways to manage the overt anger and express the more vulnerable g fear or sadness.

The first step is to become aware of feelings, particularly anger and resentment. Participants are asked about specific thoughts and behaviors that occur when they are feeling an emotion. For example, if they are angry they may feel their heartbeat accelerate. The second step highlights toleration of feelings. Participants learn to stop and find a way to endure intense feelings, rather than either shutting them down or acting them out. Participants are helped to find a moment in which they can calm themselves long enough to think about what their powerfully negative reaction might mean. The calming procedures they use may be deep breathing or lowering their voices or sitting down. The major focus of the second step is how to stop and do nothing for a moment. This step may be the hardest to implement given what is known about how quickly the neural pathway to the amygdyla is activated by affect (Atkinson, 1999; Faude, Jones, & Robins, 1996).When highly aroused, securely attached parents and youth can calm themselves and respond appropriately. Unfortunately, insecurely attached parents and youth are more likely to move into a highly aroused panic mode which is not cognitively controlled (Porges, 2001) which leaves them vulnerable to shutting down or leaving (avoidantly attached) or escalating the coercive interaction (anxiously attached). In either case, the resulting levels of arousal are usually soothed without thinking by the use of substances (alcohol, drugs, food) or processes (sex, aggression, violence, withdrawing). In the third step, in the moment of calm the participants create using the second step, they explore more vulnerable feelings that they are protecting themselves from by their defensive anger or other negative affect. Participants note how the feelings of anger and rage help to create disconnection while the feelings of sadness

and fear invite re-connection.

In the fourth step, participants learn how to take another's perspective by acknowledging that person's defensive affect, which is often anger, and thinking about what his or her vulnerable feelings might be. In this step, participants begin to experience more empathy and respect for the other person and his/her viewpoint. With this new information, they are more able, in the fifth step to risk expressing their own more vulnerable feelings such as sadness, fear, or shame. With the expression of these vulnerable feelings, a "softening" (Johnson, 1996) or "shift" (Diamond & Liddle, 1996) event occurs that invites the other person to respond similarly leading to the sixth step of re-connecting. Once both parents and adolescents are communicating at the level of their more vulnerable affect, are more connected, and thus able to be soothed without the use of externalizing and internalizing behaviors, they may be able to deal with the problems that have arisen between them, either current or historical (Johnson, 1996; Keiley, 2002a, 2002b; Liddle, 1994).

Major Foci

Introduction each week. As we begin each week (no matter what the step), we talk about how to 1) pay attention to first sense of arousal/feeling and find a way to stop and calm yourself, 2) know your vulnerable feelings (e.g., what are you defending against others finding out), 3) step into the other persons' shoes and develop empathy, and 4) risk telling them what your vulnerability is. These are our four major foci that we use during every discussion and step.

Stop. We ask everyone to think about a time in the past week in which they found themselves aroused. What was the situation that got them into trouble? Was it similar to other times that they have gotten into trouble? Were they able to notice when they first began feeling this arousal? What part of their body clued them in that they were getting upset? Situations that usually arise in group are instances of fighting, sexual arousal, drinking, drugs, criminal behaviors, and others. Then, we ask if they were able to stop and do nothing. If not, how could

they have done that?

Fear. Fear is the great motivator of many of the behaviors that get people into trouble. Usually, people are afraid that others will find out something about them that they do not want them to know. Many are fearful that they are not seen as 'men' ('women') or that they are seen as 'sexual offenders' or 'criminals.' If these fears are not acknowledged and shared, people are likely to become defensive and angry to keep their vulnerabilities hidden. This defensiveness and anger pushes others away or escalates the interaction into a confrontational cycle. Either way, the instigator is left alone and often in trouble. We ask the participants to think about what their vulnerability was in the situation that they brought up for discussion. What were they afraid would become known?

Empathy. Being able to put yourself into the position of another person is essential to human communication and connection. If the participants are able to stop their arousal and focus on their own vulnerability, we then ask them to think about how the other person might be feeling. In the discussion of the example on which we are focusing, we ask if some way existed in that moment that they could have understand what the other person must have been experiencing. If they could have done that what might have changed for them in that situation?

Risk. Now with their arousal under control, their fears acknowledged, and a sense of what the other person might be experiencing, would it be possible to risk telling the other what their fears are? What they are ashamed of? What makes them feel vulnerable? To risk being vulnerable and allow some connection.

Therapy group format. During these discussion, when participants say something about what they did (whether a good response or not) and what their fears were, we ask the others in the group to talk to them about how they are now seeing/experiencing them. Using this major mechanism of group therapy of allowing the participants to hear how others are experiencing them and finding out that it is not what they thought that others would be feeling is

very enlightening and surprising to many of the participants.

It is from the discussions of these foci that we come up with role plays to enact during the meeting. We will do one or several depending on the time we have.

Evidence-Based Strategies of MFGI

Engagement

During the MFGI, the primary role of the facilitator is to engage the family members in the process of the intervention by acknowledging and challenging adolescents' and parents' sense of helplessness and despair (Liddle, 1994). Many of these parents and adolescents have been in their difficult and painful situation for a long time and, as a result, feel a sense of hopelessness that any intervention will help. This despair is an impediment for family members to stay in treatment. Throughout treatment, facilitators are expected to establish and maintain warm, supportive, and collaborative relationships with the group members; by so doing, they model and demonstrate appropriate ways of joining and connecting with others (Henggeler & Santos, 1997). In providing this atmosphere of support and understanding, a therapeutic alliance is created between the facilitators and the family members. The facilitators must demonstrate the belief that all family members can and must change. Often at the beginning of MFGI, parents feel that only the adolescents must change for the situation to improve and the adolescents feel that only the parents must change. The facilitators make clear to all family members that everyone must change.

Assessment of Interactional Cycles (Attachment and Affect Regulation)

By paying attention to the cyclical interactions, such as a parent yelling (pursuing, a behavior common to anxiously attached individuals) and an adolescent falling silent (withdrawing, a behavior common to avoidantly attached individuals), that arise in the discussions and then role-playing them, the facilitators help participants become more aware of similar interactions that may keep them separate from each other (Diamond & Liddle, 1996).

The pursuer, who is fearful of and hurt by rejection, protects him/herself by nagging and being angry, while the withdrawer, who really feels incompetent and fearful of never being good enough, protects him/herself by withdrawing into silent anger. The resulting cycle is repeated over and over again with no escape (Johnson, 1996).

Reframing

By focusing on the vulnerable feelings in these discussions and role-plays, the facilitators help parents to consider alternative reasons for their adolescents' disruptive behavior and adolescents to see their parent's behavior in a different light (Diamond & Liddle, 1999). For example, parents may perceive their adolescents as being afraid of growing independent, not just angry at restrictions placed upon them by their parents. The adolescents may see their parents' sadness about the loss of connection, not just their anger about them being in trouble with the law. Facilitators also point out even the smallest change in interactional and behavioral patterns that might lead to increased caring and understanding. The parents' blaming and hopelessness is reduced by encouraging them to focus on their feelings of regret and sadness (Johnson, 1996).

In-Session Change

In the role-plays, the facilitators encourage the adolescents (who are often the withdrawers) to express their desires for a relationship with their parents in which the parents actually listen to them. In addition, the facilitators help parents demonstrate empathy for their offspring which decreases the adolescents' defensiveness and helps them to participate more openly. Respect from parents creates an environment of safety for adolescents to discuss feelings and thoughts that have led to misunderstandings and resentment. Facilitators encourage parents to listen and acknowledge adolescents' disclosures and not be defensive themselves. Adolescents' concerns are acknowledged as reasonable and justified at times. As trust develops between adolescents and parents, adolescents speak more directly to parents

while parents see adolescents as more mature. During the MFGI, an important shift occurs with parents moving from trying to control adolescents to trying to understand them (Diamond & Liddle, 1996; Keiley, 2002a, 2002b). A connection between parents and adolescents is re-instituted as parents accept more responsibility for problems in the relationship and as adolescents feel safe in engaging in dialogue with parents. Adolescents welcome this appropriate accountability from their parents (Diamond & Liddle, 1996). Parents' offers of comfort are no longer seen as threatening or controlling, but as a genuine attempt to engender closeness in the relationship.

Social Support

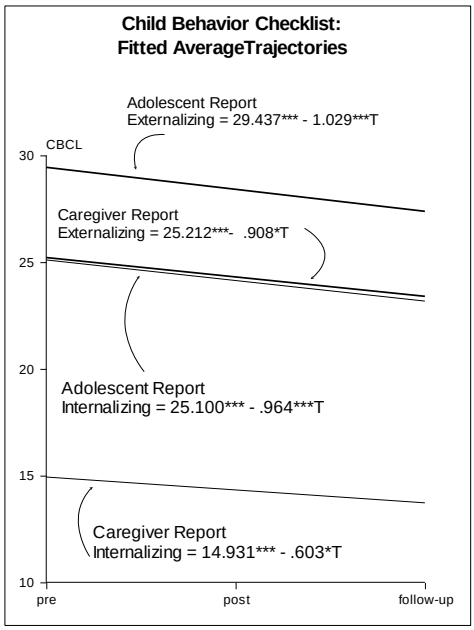
Another of the benefits of multiple family groups is that family members, by interacting with other families in the group who are struggling with similar problems, create extended therapeutic networks which are continued after treatment. These networks enable families to help each other solve some of the difficulties that they have when interacting with larger systems, such as schools and probation departments.

Preliminary Support for the Multiple Family Group Intervention

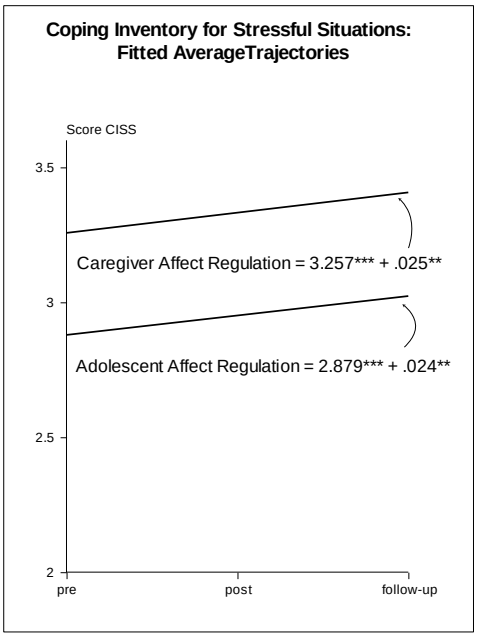
The MFGI was developed to address the need for an effective and yet affordable treatment for reducing recidivism for incarcerated adolescents and altering the families' coercive interactional patterns from an affect regulation and attachment perspective. The 8-session MFGI program was conducted in two juvenile correctional institutions with adolescents who had sexually offended and/or been delinquent. The research study utilized pre- and post-intervention assessments and a 6- month follow-up assessment. Data from both males (*n*=43) and females (*n*=30) were combined, yielding a total sample of 73 families (73 adolescents, 73 caretakers). The 6-month follow-up assessment indicated a recidivism rate of only 44% compared to the national norm of 85%-90%. Linear growth models were fit to determine the nature of the changes in adolescent behavior over the three assessments. Adolescents and caregivers

reported that adolescents' externalizing behaviors significantly declined over time. Adolescent-reported internalizing symptoms as well as their alcohol and drug use significantly declined over the follow-up period, while caregiver reports of these behaviors showed no change over time. Adolescent reported attachment to their caregivers, particularly mothers, increased significantly as did both adolescent and caregiver reported functional affect regulation.

The interviews that were conducted with the incarcerated adolescents and their parents indicated that the intervention was meaningful and helpful to them. For example, one male adolescent said, "When I get mad, I find some space and stuff. I like that. I was using that when I was locked up and when I'm out here. I learned how to respect people. When you in trouble, listen to what you got to hear. It might help you out better." A mother said, "I really felt good about it, but I think it should be a little bit longer. I looked forward to those Wednesdays coming around. I wouldn't even work overtime and I need the money. I said, 'Forget it, I got to go'" (Keiley, 2007).



a.



b.

Figure 1. Trajectories of change in a) externalizing and internalizing behaviors and b) affect regulation.

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Appendix A

Curriculum and Process

Curriculum and Process

I. Intervention Curriculum:

1. Overview (Week 1): After introductions and getting to know a little about each other, we use week 1 to introduce the ideas of attachment, affect regulation, and problem behaviors. We talk about how we need to learn to deal with our feelings in a more useful way (e.g., not drinking or drugging, fighting, sexual offending) and to become closer to people who are important to us. We introduce the 6 steps of the intervention.

2. Step 1 -- Becoming Aware (Week 2): Becoming aware of the beginning of an incident of powerful feelings. The ones that are hardest for us are often about anger.

FOCUS: How do I know what I'm feeling?

3. Step 2 -- Toleration, Stopping, and Finding Some Space (Week 3): We need to stop and find some space to calm ourselves just long enough to think about what this powerfully negative reaction means to us.

At this point, we need to find ways to control our own experiences of the feeling (deep breathing, counting to 10, relaxing, lowering our voice, etc) and our expression of the feeling (keeping quiet, moving away for a moment, etc.)

NOT SHUTTING THEM DOWN OR ACTING THEM OUT.

FOCUS: How to stop.

4. Step 3 -- Identifying Vulnerable Feelings (Week 4): We then need to begin to think about our hidden or vulnerable feelings. These are often shame, fear, sadness, hurt. (If it is possible at this point, becoming aware of what the other person's perspective might be and the other person's vulnerable feelings might be would be useful. Doing this is not always possible. If it comes up, we go with it.)

Example: When I get really angry at my adolescent for staying out all night, I am also really scared for my adolescent's safety.
Other person's perspective might be: I'm really angry because my parent doesn't trust that I will take care of myself. BUT, I am also hurt that my parent doesn't trust me.

Example: When I get really angry at my parent for going through my things, I'm also really hurt that my parent doesn't trust me and has violated my privacy.
Other person's perspective might be: I need to go through my adolescent's things, because he/she has stopped talking with me and I'm afraid for his/her safety. I want to know more about his/her life. It makes me sad that we don't talk any more.

FOCUS: Fear.

5. Step 4 -- Other Person's Perspective (Week 5): If this idea has not come up previously, in reviewing Steps 1-4, we focus on both our own and the other person's feelings.

FOCUS: Empathy, respect.

6. **Step 5 -- Expressing Vulnerable Feelings (Week 6):** Then we can express our more vulnerable feelings to the other. Taking a risk. (Expressing your guess about the other person's more vulnerable feelings would also be a good idea, but, again, this is not always possible.)

   FOCUS: Risking Vulnerability.

7. **Step 6 -- Connecting (Week 7):** Becoming more vulnerable and attached to the other person as we begin to express our vulnerable feelings and have some understanding of the other person's vulnerable feelings.

8. **Week 8 -- A Celebration**.

II. MFGI Process: In each session, we present the 6 steps of the intervention program, discuss how to use one of the steps to manage this interaction, go through the 4 foci discussing similar situations from the adolescents' and caregivers' lives and our lives, engage in role-plays of more functional interactions based upon the steps of the intervention.

A. Discussions: 4 Foci: Stop, Fear, Empathy, Risk

B. Role Plays:
The participants are invited to role play situations that they feel are problematic for them in which they can learn, rehearse, and practice using more functional affect regulation or attachment strategies.

The facilitators help the family members and adolescents to focus on particular difficulties that they will encounter when the adolescents are released from prison. In particular, the possible enticements for the adolescent to hang with deviant peers, to use drugs or alcohol, to violate the terms of their probation (e.g., being alone with underage kids, not registering with officials) will be role played. In addition, focus will also be on behaviors that have been problematic for the adults (e.g., hyper-vigilance, harsh discipline); these, too, will be role-played.

These role plays are designed to elicit typical troublesome interactional behaviors between adolescents and parents and then shape those interactions to resemble healthier behavior.

Parents role-play adolescents and adolescents role-play parents to help them investigate what the other person's perspectives might be. And since this is a psycho-educational group, not a therapy group, this is more appropriate.

If the role-players have trouble getting into their roles, we can stop and have the role-players coached by the facilitators. We are interested in arousal levels being a quite high in these role plays.

After the role play is done the "poor" way, the facilitators and group members come up with a way in which one of the two role players could do this differently based on the steps. Then this new role play is enacted.

Appendix B

MULTIPLE FAMILY GROUP INTERVENTION

WEEKLY PLANS

WEEK ONE

I. Opening and Welcome

II. Introductions:

A. Multiple-Family Group:

1. Purpose: To add to the help that you all are already getting. In particular, to help all of us learn to manage our feelings a bit better so that we can connect better with each other in order to think about how to get along and help each other solve problems we have such as substance use, sexual offending, aggression, depression.

2. Examples:

a. In the arguments that I have with people I care about sometimes we just get angrier with each other or one of us just slams out of the room and things don't get resolved.

b. I notice that when I'm that angry and the other person is also angry, we both feel really far apart and like we won't ever be able to get together. It's like my anger pushes the other person away. And his or her anger pushes me away.

c. But the anger often hides feelings of sadness, hurt, or fear about something the other person has done. The other person is often feeling the same way. When I let the other person know that I'm not just angry, but also feeling those other feelings, we are often able to stop yelling at each other and just talk.

3. One Solution: We have a 6 step program we have used with people like you that helps us all to learn to be aware of our intense feelings (like anger), take some space to think about what might be under those angry feelings (like sadness, hurt, fear), think about what the other person might be feeling, express our feelings, and connect again to each other.

4. Discussion: 4 Foci: Stop, Fear, Empathy, Risk

5. Business of Group:

a. Discuss the rules of the institution with whom we are working.

b. Eight (8) sessions for 1 ½ hours. Give specific details (e.g., 6-7:30pm every Monday). We do like to start on time.

c. Each week, we will talk about the step for that night, have a discussion about the step as it relates to "real life," and do some role-playing. We've discovered some serious talent during the past few groups!

d. In order to make sure that the groups are really helping you, we also do a study. In order to keep this group going, we need to find out if it works. To do that we need to get some information from you now (tonight) and at the end of the group.

B. What we do each week:

1. We present the 6 steps of the intervention
2. Discuss how to use one of the steps to manage this interaction
3. Discuss similar situations from the our lives and focus on stop, fear, empathy, risk
4. Engage in role-plays of not-so-good and better ways to interact based upon the steps of the intervention.

C. Ourselves: Just go around the room and say who we are and do a simple introductory exercise, such as "2 truths and a lie."

III. **Overview of the 6 steps (see Curriculum and Process)**

IV. Role Play to Practice Role-Playing:

In the group role-play, one parent role-plays an adolescent and one adolescent role-playing the parent, are asked to engage in a conflict situation that has occurred in their lives that ended in a huge fighting match. The first time, the role-players are asked to role-play the situation in an ineffective manner, yelling and fighting.

These role plays are designed to elicit typical troublesome interactional behaviors between adolescents and parents and then shape those interactions to resemble healthier behavior. Parents role-play adolescents and adolescents role-play parents to help them investigate what the other person's perspectives might be. And since this is a psycho-educational group, not a therapy group, this is more appropriate.

If the role-players have trouble getting into their roles, we can stop and have the role-players coached by the facilitators. After the first role-play, the facilitators lead a discussion about a more productive way that one of the two role-players might have been able to act.

Facilitators must stay focused on the purpose of the role plays as these are the major mechanism of change in the MFGI.

V. SPEND SOME TIME ON THE QUESTIONNAIRES.

VI. Ending: Any ideas about a ritual? We allow the participants to come up with a ritual ending for the group that we might use each week.

WEEK TWO

I. Opening, Welcome, Check-in

II. Overview of the 6 steps (see Curriculum and Process)

III. Introduce Step 1: Becoming aware of our feelings.

Talk a little about how to identify your feelings, particularly anger. For example, talk about some positive emotion such as enjoyment. How do you know you are enjoying something. What specific behaviors, bodily sensations, thoughts occur when you are feeling enjoyment. Do the same for anger. For example, you might feel your heartbeat accelerate. Important to be able to identify specific behaviors, sensations, etc. that occur when they are feeling an emotion.

FOCUS ON FEELINGS (NOT THOUGHTS): Easiest to do this if you write this down somewhere: **MAD, SAD, GLAD, SCARED, EMBARRASSED, GUILTY, HURT.**

"How do you know when you're angry? That is, what bodily sensations, voice changes, thoughts occur when you feel anger." Give examples from your life and ask them to give examples. Note the warnings above. Same tendencies as discussed above apply here.

IV. Discussion: 4 Foci: Stop, Fear, Empathy, Risk

V. Role-Play:

VI. Ending:

WEEK THREE

I. Opening, Welcome, Check-in

II. Overview of the 6 steps: (see Curriculum and Process)

III. Review Step 1 and Introduce Step 2: Stopping and Finding Some Space: We need to stop and find some space to calm ourselves just long enough to think about what this powerfully negative reaction is all about. **NOT SHUTTING FEELINGS DOWN OR ACTING THEM OUT.**

FOCUS: How to stop.

Talk about finding a moment to calm ourselves so we can think about what our anger might mean. Calming procedures might be any of the relaxation techniques, such as deep breathing or lowering our voices. The focus in this step is on how to stop and do nothing for a moment. [Aside: This may be the hardest step to implement given what is known about how quickly the direct neural pathway to the amygdyla, which bypasses the cognition-processing portions of the cortex, is activated by intense affect.] You should think about some of the things that you use to just stop and wait when you feel a strong emotion. Share those with the group.

IV. Discussion: 4 Foci: Stop, Fear, Empathy, Risk

V. Role-Play:

VI. Ending:

WEEK FOUR

I. Opening, Welcome, Check-in

II. Overview of the 6 steps: (see Curriculum and Process)

III. Review Step 1, 2 and Introduce Step 3: Identifying Vulnerable Feelings: We then need to think about our vulnerable and hidden feelings. These feelings are often fear, sadness, hurt.

> **ANGER DISTANCES:** Anger tends to push other people away, while the more vulnerable feelings tend to connect us to others.
>
> **FOCUS: Connecting.**
>
> In the moment of calm created by using the second step, we want to explore the more vulnerable feelings that underlie our anger. Talk about how our feelings of anger and rage create disconnection between us, while our underlying feelings of sadness and fear invite re-connection.
>
> Give an example. For example, parents may feel angry at their adolescents for staying out all night, but they also are afraid for their adolescents' safety. On the other hand, these adolescents might feel angry because their parents don't trust them to take care of themselves. Underneath these feelings of anger, however, the adolescents may also feel hurt that their parents don't think they are competent enough to take care of themselves. These adolescents may also feel scared, even resentful, that their parents have done the same thing to them -- going out without telling them when they will be back.

IV. Discussion: 4 Foci: Stop, fear, empathy, risk

V. Role-Play:

VI. Ending:

WEEK FIVE

I. Opening, Welcome, Check-in

II. Overview of the 6 steps: (see Curriculum and Process)

III. Review Step 1, 2, 3, and Introduce Step 4: Taking the Other Person's Perspective: If this idea has not come up previously, in reviewing Steps 1-3 and introducing Step 4, we focus on both our own **and** the other person's feelings.

FOCUS: Empathy, respect.

In the fourth step, the participants learn how to take the other person's perspective by acknowledging that person's overt affect, which is often anger, and thinking about what his or her underlying feelings might be. Although we have already begun this process of identifying the other person's perspective by the way in which we construct the discussions about video interactions and the role-plays, in this step, we focus on helping the adolescents and parents experience more empathy and respect for each other.

Give an example of when you found that thinking about the other person's perspective has helped you to feel more empathy and respect for that person and therefore more connected.

IV. Discussion: 4 foci: stop, fear, empathy, risk

.

V. Role-Play:

the group to think about more effective ways to manage the overt anger and express the more vulnerable underlying fear or sadness.

The whole group then decides whom they want to do it differently in the role play. Then it can be switched or you can move to another role play. We do as many role plays as we can. At least two each week.

VI. Ending:

WEEK SIX

I. Opening, Welcome, Check-in

II. Overview of the 6 steps: (see Curriculum and Process)

III. Review Step 1, 2, 3, 4, and Introduce Step 5: Expressing Vulnerable Feelings: Then we can express our more vulnerable feelings to the other. Taking a risk. (Expressing your guess about the other person's underlying more vulnerable feelings would also be a good idea, but, again, this is not always possible.)

> **FOCUS: Vulnerability and fear of risking. Keep it simple: I feel angry and sad and disconnected from you.**
>
> With the new information participants gain about other people's perspectives, they are more able, in the fifth step to risk expressing their own more vulnerable feelings and listening to the other person's responses.
>
> Give an example of when you found that expressing your underlying feelings, even when that was scary, allowed you to feel more connected to the other person.

IV. Discussion: 4 Foci: Stop, fear, empathy, risk

V. Role-Play:

VI. Ending:

WEEK SEVEN

I. Opening, Welcome, Check-in

II. Overview of the 6 steps: (See Curriculum and Process)

III. Review Step 1, 2, 3, 4, 5, and Introduce Step 6: Connecting: Becoming more vulnerable and attached to the other person as we begin to express our underlying feelings and have some understanding of the other person's feelings and underlying feelings.

FOCUS: Softening.

With the expression of vulnerable feelings in step five, a "softening" or "shift" event occurs which invites the other person to respond similarly leading to the sixth step of re-connecting. We help the participants understand that when they express their vulnerable feelings to another person and hear the expression of feelings and underlying feelings of the other person, they are both better able to connect on this more vulnerable level. Once both parents and adolescents are communicating at the level of their more vulnerable affect and are more connected, they may be able to deal with the problems that have arisen between them, either current or historical.

From this perspective, the work of week seven is to begin to consolidate what has been learned in the previous five steps.

Give an example of when you found that taking the previous 5 steps has allowed you to feel more connected to the other person.

IV. Discussion: 4 Foci: Stop, fear, empathy, risk

V. Role-Play:

VI. Ending:

WEEK EIGHT

I. Opening, Welcome, Check-in

II. Overview of the 6 steps: (SEE Curriculum and Process)

III. Review the process of the last 7 weeks

IV. Discussion: 4 Foci: Stop, fear, empathy, risk

V. Consolidation: Final Role Plays

VI. Ending: We celebrate what we have learned by giving out certificates of completion.