

THE CLINICAL INNOVATORS SERIES

Adolescent Drug Abuse

A Family-Based Multidimensional Approach

CLINICIAN'S MANUAL



HOWARD A. LIDDLE, ED.D.

THE CLINICAL INNOVATORS SERIES

Adolescent Drug Abuse

CLINICIAN'S MANUAL

THE CLINICAL INNOVATORS SERIES

Adolescent Drug Abuse
A Family-Based Multidimensional Approach

CLINICIAN'S MANUAL

Howard A. Liddle, Ed.D., A.B.P.P.

Hazelden®

Hazelden
Center City, Minnesota 55012
hazelden.org

© 2009 by Howard Liddle
All rights reserved. Published 2009
Printed in the United States of America

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means—electronic, mechanical, photocopying, recording, scanning, or otherwise—without the express written permission of the publisher. Failure to comply with these terms may expose you to legal action and damages for copyright infringement.

The names, details, and circumstances may have been changed to protect the privacy of those mentioned in this publication.

This publication is not intended as a substitute for the advice of health care professionals.

Alcoholics Anonymous and AA are registered trademarks of AA World Services, Inc.

ISBN: 978-1-59285-743-2

13 12 11 10 09 1 2 3 4 5 6

Cover design by David Spohn
Cover photography by Tad Saddoris Photography
Interior design by Kinne Design
Typesetting by Mayfly Design

Contents

List of Figures	vi
Acknowledgments	vii
Editor's Note	ix
Introduction	1
Chapter 1: Adolescent Substance Abuse: An Overview	11
Chapter 2: Treatment for Adolescent Substance Abuse	33
Chapter 3: Multidimensional Family Therapy	53
Chapter 4: Adolescent Substance Abuse and Juvenile Criminal Justice	81
Conclusion	107
Appendixes	
Appendix 1: Screening and Assessment Instruments	117
Appendix 2: Additional Resources	125
Notes	143
About the Author	163

Figures

1	Risk and Protective Factor Framework	23
2	Co-occurring Psychiatric Problems	27
3	Implementation Is Essential	51
4	Sources of Adolescent Substance Abuse Treatment Referrals	84
5	MDFT Guidelines for Effective Intervention in the Juvenile Justice System	98
6	Impact of the Numbers of Favorable Features on Recidivism	100
7	Keys to Intervention with Juvenile Offenders: Correspondences with MDFT Theory, Interventions, and Outcomes	102

Acknowledgments

Cathy Broberg, this manual's editor, was a breeze to work with. Cathy is a talented writer who labored flawlessly and with impressive grace beneath bone-crushing time pressures created by an overcommitted researcher. Rosemarie A. Rodriguez, Ph.D., and Lacey T. Greathead, B.S., research colleagues at the Center for Treatment Research on Adolescent Drug Abuse at the University of Miami Miller School of Medicine, were indispensable to this work's creation. Their creative eye and attention to detail contributed enormously to our product's successful completion. DVD director Kelly Youland and her team at StoneArch, including Jean Kanten, were patient, respectful, instructive, and kind to their rookie performer at our DVD shoot. Mindy Keskinen's manuscript editing was comprehensive and clarifying. Working with Richard Solly, senior acquisitions editor at Hazelden Publishing, was amazing. Having the opportunity to actualize his vision for the Clinical Innovators Series was a top-of-the-line professional—and, in the end, personal—experience. Appreciation goes to other Hazelden team members, especially Jodie Carter. Thanks as well to the other colleagues at Hazelden who have become friends and supporters over the years, including, of course, Val Slaymaker. Thanks to all of you for this incredible opportunity to be part of your series and your contribution to the field.



Editor's Note

Hazelden's Clinical Innovators Series was designed with innovation in mind. The series features current topics by leading, cutting-edge experts in the field. Each topic in the series is composed of a DVD, a clinician's manual, and a post-test offering continuing education hours.

The *DVD* should be viewed first. It allows the viewer to participate in a workshop led by an internationally recognized, highly trained speaker.

The *clinician's manual* should be read after viewing the DVD. The manual is authored by the workshop speaker and expands on the material found in the DVD. As a NAADAC-approved provider, Hazelden offers continuing education hours for successful completion of the *post-test* based on the material, when applicable.

The Clinical Innovators Series is a professional development tool useful to practitioners such as chemical dependency counselors, psychologists, health care professionals, and clergy. It offers practical new techniques that can be applied immediately.



Introduction

It is an exciting moment in the field of adolescent substance abuse treatment, one marked by enormous growth and change. No longer an afterthought to treatment programs designed for adults, adolescent substance abuse treatment has emerged from the shadows of adult treatment as a separate, clinically creative field of study where considerable scientific progress has been made in our knowledge about the causes and correlates of adolescent problems, and about treatment and what makes it work. Policymakers, treatment providers, and funding agencies now recognize this scientific area for its uniqueness, theory base, clinical model diversity, clearly presented and logically organized clinical approaches, and accumulating body of basic and outcome research.

One of the most exciting changes in the field is our deepening understanding of the problem we seek to treat. It is now recognized that multiple factors contribute to the development of adolescent substance abuse and its accompanying emotional and behavioral problems. Therefore, to effect change we have to work in multiple areas of an adolescent's life. One way we accomplish this is by broadening the unit of assessment and intervention. It's not enough to intervene only with the teen. Today's best practices strive to be comprehensive, involving parents, family, peers, and other significant individuals in the teen's life. The interventions are comprehensive as well in how they attend to different areas of the youth's life. Drugs and drug-taking are a focus, naturally, but so are the teen's peer network, relationships, family life, the functioning of his or her parents, school work and behavioral performance there, as well as neighborhood, community, and cultural factors.

When treating adolescents who are abusing substances in any form or to any degree, it's important to recognize that substance abuse is significant for this age group because it derails development. Because teenage drug users bypass the conventional sequence of healthy development—school, work, and family formation—they transition prematurely into the adult roles of job and family without the development of all skills necessary to be successful in these roles. This derailing of development sets these youth on a path toward failure in several realms of their future life. In this sense, focusing on adolescent substance abuse treatment is not only about making the teen's life better in the present, but it's also about prevention. While not all teen drug users go on to develop adult addiction, problems with drugs in the teen years is a strong predictor of adult problems of many types, not only drug addiction.

This derailing of development sets these youth on a path toward failure in several realms of their future life.

“Drug Treatment Works”: this news has been communicated through professional and media venues quite effectively over the years.¹ Given the advances in the adolescent drug abuse specialty, we can now say with confidence that “Adolescent Drug Treatment Works Too.” Empirical studies support a multifaceted approach to treatment and prevention efforts for youth. Treatment models today are more effective, whether we consider engagement or retention rates, reduction or elimination of drug use and related behavior problems, or the increase of protective factors in the teen's and family's life.

But whether it's drug abuse treatment for adults or for teens, not any old treatment works, and not all treatments are created equal, despite any claims to the contrary. What's exciting about the addiction treatment field is that we now have a scientific basis on which to make treatment recommendations and referrals. While the evidence-based practice

movement has its excesses,² as does any relatively new movement “feeling its oats,” evidence-based or empirically supported therapies have changed the addictions and psychotherapy fields forever. In the realm of adolescent treatment, we know about the characteristics of effective therapies for drug abuse, and we now also have research-based knowledge about ineffective or even harmful programs and therapies. This manual will tell you about some of the new developments on the basic science side of the field, but mostly we’ll focus on the core ideas and clinical methods of an effective evidence-based, family-based treatment: Multidimensional Family Therapy (MDFT).

One of the most exciting advances in the adolescent drug abuse specialty is family-based therapy. Rigorous research has proven these therapies particularly effective. Indeed, independent reviews are now noting the excellent quality of evidence in family-based treatment studies,³ and some independent reviewers call for family-based treatments to be the treatment of choice for teen drug problems.⁴ The verdict is clear: by their new ways of conceptualizing adolescent drug problems and their use of clinical methods that target known determinants of drug use and problem behavior, family-therapy approaches are recognized as a successful way to treat adolescent substance abuse.

Terms and Definitions

General Terms in Adolescent Substance Abuse Treatment

In the study of alcohol and drug abuse and addiction, different professionals and researchers favor different terms. Before we go any further, let’s stop and focus on some of the language we’ll use in this book.

Addiction

This term is widely used by the general population to refer to substance dependence. *Webster’s* defines it as a “compulsive

need for and use of a habit-forming substance . . . characterized by tolerance and by well-defined physiological symptoms upon withdrawal.”

Substances and Related Terms

The *DSM-IV* defines “substance” as “a drug of abuse, a medication, or a toxin.” The manual also characterizes the features of “substance dependence” in this way: “The essential feature of Substance Dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behavior.”⁵

The criteria used in making an assessment of “substance abuse,” on the other hand, do not include tolerance, withdrawal, or compulsive use. The *DSM-IV* defines abuse as “a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.”

For the purposes of this manual, I will be using “substance use disorder” to include all of the above.

Evidence-Based Treatment

This refers to treatment that is based on the best available research and clinical expertise. Such treatment is based on reliable and valid assessments, offers guidelines for working with specific populations and specifies desired outcomes, and provides a means to measure success at both the individual and program levels.⁶ An evidence-based treatment is an intervention that has been evaluated in rigorous studies and demonstrates clinical effectiveness.

Integrative Treatment

Integrative therapies address multiple problem areas of a teen’s life, including alcohol or other drug abuse and mental

health problems, and they combine theory and networks from different therapeutic traditions.

Family

The importance of the family cannot be overemphasized in a discussion about adolescents and substance use. A teen's parents and family may play a role in the teen's drug use as well as his or her recovery. For our purposes, "family" includes everyone who plays a significant role in the home life of the teen: siblings, parents, stepparents or blended family members, and guardians.

A teen's parents and family may play a role in the teen's drug use as well as his or her recovery.

Co-occurring Disorders or Comorbidity

These terms refer to the presence of one or more psychiatric disorders along with substance abuse. More often than not, adolescents referred for substance abuse treatment will receive a "dual diagnosis" of substance use disorder and a co-occurring psychiatric disorder, such as conduct disorder, mood and anxiety disorder, post-traumatic stress disorder, or attention-deficit/hyperactivity disorder.

Risk and Protective Factors

These are factors or ingredients in an adolescent's life that make drug use either more likely (risk factors) or more unlikely (protective factors). Risk and protective factors are relevant in all areas of a teen's life, including family, school, job, and peer and other interpersonal relationships.

Juvenile Delinquency and Juvenile Criminal Justice

These terms will arise later in our discussion as we consider how teens who have encountered legal problems can benefit from a multi-focused approach to drug treatment. These terms themselves are used in a general way to refer to any level of involvement with the juvenile justice system.

Terminology in Multidimensional Family Therapy

Outcome

The outcome dimension refers to the model's and the therapist's overriding goal. In every contact with the case or with individuals with whom the family interacts, the therapist asks himself or herself the question, "What are the optimal and the 'good enough' outcomes for this interaction?" Thus "outcome" refers to overall case results (e.g., abstinence or great reductions in substance use, and stronger connections to healthy influences and activities) as well as to the smaller, more immediate results (e.g., the outcomes of a particular session or a phone conversation with a parent). This outcome orientation permeates every session and every contact with a client. It encourages, indeed organizes, a therapist to think of long-term, intermediate, and short-term goals and the mechanisms to achieve them.

Process

Whereas a goal orientation is a necessary and critical starting place in clinical work, it is incomplete without a vision of the way particular outcomes might be achieved. "Process" refers to the way hoped-for change is facilitated.

Development

"Development" is an indispensable knowledge base of clinical work. Therapists use their knowledge of human development to set an overall treatment course, as well as to pinpoint particular interventions or adjust those already in motion. Knowing about the expected and normal changes in the parent-adolescent relationship, and in the individual aspects of a teen's development (e.g., focus on self-identity, puberty, sexual experimentation, identity development, changing peer and family relations, cognitive changes allow-

The therapist's appreciation and use of developmental knowledge also come into play with the teen's family.

ing new perspectives) informs the therapist's assessment and intervention ability. The therapist's appreciation and use of developmental knowledge also come into play with the teen's family.

Problem Behaviors

“Problem behaviors” are deviations from normal development. In research literature, the developmental psychopathology perspective allows clinicians and researchers to understand the development of problem behaviors over time, their interrelationship and sequencing, and the risk and protective factors of high-risk adolescent behaviors. As a systemic approach, MDFT includes the behaviors of the parents or caretakers most involved with the teenager.

Ecology

Adolescent development and treatment necessarily include the multiple psychosocial “ecologies” of teens and their families. The ecology dimension reminds the clinician not to narrow his or her understanding to the individual or family level. The therapist has available multiple assessment tools and levels of intervention—and some of these pertain to adolescents' everyday functioning in social ecologies outside their families.

Psychotherapy

This sphere pertains to particular forms of therapy that have influenced the MDFT model. Particularly in MDFT's early development, behavioral and client-centered therapies influenced the approach. In recent years, thinking and methods from both the drug counseling and chemical dependency perspectives have informed MDFT.

Family Therapy

Structural Family Therapy⁷ and Strategic Family Therapy (SFT)⁸ were among the earliest influences on the MDFT approach, which was originally called Structural-Strategic

Family Therapy.⁹ The influences of SFT can be observed in MDFT's adoption of the enactment principles of change and intervention. Another major influence, Problem Solving Therapy, emphasizes crafting a treatment strategy, thinking in stages of therapy and of change, and focusing on out-of-session tasks as a complement to in-session change enactments. Stanton and Todd's¹⁰ integrative structural and strategic therapy with heroin-addicted adults also was a significant early influence.

Treatment Parameters

This term refers to the structural or organizational aspects of the treatment approach. Sessions are held in clinical offices, the home, school, juvenile court, or wherever the appropriate parties can be convened. Using the phone is common—to call the parent, adolescent, or other family members (e.g., to follow up after face-to-face contact or to make more suggestions for following the action plan set previously). It is important not to let traditional ways of service delivery (e.g., in-clinic sessions, working only with an individual client, one hour of treatment per week) determine one's approach with multi-problem adolescents and their families.

What This Manual Offers

This manual provides a brief synopsis of the latest research findings on teen substance use disorders and on adolescent development itself. It presents clinically relevant information about the knowledge base that is needed, the mind-set that has to be cultivated, and the keys to success in using a family-based, contextually oriented clinical approach with adolescents who are using and abusing alcohol and other drugs.

In chapter 1, we'll begin with an overview of teen substance abuse, reviewing the epidemiology, discussing the importance of an ecological/contextual perspective, examining the role of risk and protective factors, and briefly consid-

ering adolescent neurobiology and brain development. We will also explore the central role of family, both in early substance use and in its progression, and, most important, its role as a force that can help solve the problem.

Chapter 2 will provide a closer examination of the specialty of adolescent treatment. We will discuss what is required to treat this population successfully, including the necessary knowledge base for clinicians, and we'll consider how the disorder is diagnosed in teens and what assessment tools are helpful. Next, family-based interventions will be defined and detailed. We will review the effectiveness and outcomes of family-based treatment and outline the various types of family therapy.

Multidimensional Family Therapy (MDFT), one of the new generation of empirically validated family-based therapies, will be the focus of chapter 3.¹¹ This type of family intervention will be introduced, including an overview of the therapy's background and development, its organizing principles, and phases of treatment and clinical features. We will discuss the skills and characteristics clinicians need to best utilize this multifaceted treatment system, and a case study will be presented.

Chapter 4 will explore how adolescents involved with the juvenile justice system present unique and important challenges when it comes to substance abuse treatment. Research findings will be summarized and we will discuss key elements of effective interventions with this underserved population.

What does the future of adolescent treatment and research potentially look like? This will be the subject of the conclusion of this book, which will summarize how the field has evolved, review some challenges and tips for treatment providers, and comment on areas that need further research and development.

Appendix 1 includes more details on screening and assessment tools, and appendix 2 is an annotated list of resources for clinicians who work with teens and families.

Using This Manual with the DVD

This manual provides an overview of the latest research on adolescent substance abuse and of family-based treatment models, notably Multidimensional Family Therapy (MDFT)—a comprehensive, science-based approach. For an overview of teen drug abuse and a family therapy approach as it applies to substance abuse and treatment, view the DVD first. Then turn to this manual for a detailed explanation of key concepts. To receive continuing education hours, complete and submit the included test.



Adolescent Substance Abuse: An Overview

From a developmental standpoint, adolescence includes risk-taking and experimentation. Taking healthy risks in a controlled environment contributes to growth for teens. It helps them test their boundaries, develop their strengths, and move toward independence. But that's not what we're referring to here. We're talking about a disorder that stems from unhealthy risk-taking: the use and abuse of alcohol or other drugs. We're discussing a disorder that derails a teen's development and potentially leads to a host of both short- and long-term problems. A public health problem of considerable national and international importance, teen drug abuse goes beyond normal experimentation with substances—it is part of a deviance syndrome that may persist into adulthood if left untreated.¹

Epidemiology

Let's begin by looking at some trends in adolescent drug use in the United States. Although research on teens is showing declining use for some drugs, the figures nevertheless remain alarming and it is clear that more effective interventions for teen substance abuse are needed.

Studies indicate that some children are already abusing

drugs at age 12 or 13. Early abuse often includes such substances as tobacco, alcohol, inhalants, marijuana, and prescription drugs such as sleeping pills and anti-anxiety medicines. If drug use persists into later adolescence, abusers typically become more heavily involved with marijuana and then advance to other drugs, while continuing their abuse of tobacco and alcohol. Studies indicate that abuse of drugs in late childhood and early adolescence is associated with greater drug involvement later in life. It is important to note that most youth, however, do not progress to abusing other drugs.

Marijuana continues to be the most popular drug of abuse for youth. Data from Western countries suggest that up to half of adolescents have used cannabis at least once, and up to 10 percent may develop cannabis abuse or dependence.² According to the 2007 National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by the Substance Abuse and Mental Health Services Administration, 62 percent of the 2.1 million new marijuana users were younger than 18 when they first used; the average age of first use was 16.2 years.³

Marijuana continues to be the most popular drug of abuse for youth.

Alcohol is another serious problem among teens, with almost a third of high school seniors and approximately a quarter of tenth graders being heavy, binge drinkers. According to the 2007 NSDUH, 15.9 percent of 12- to 17-year-olds were current alcohol users; 27.9 percent—10.7 million adolescents—reported drinking alcohol in the past month. Approximately 7.2 million (18.6 percent) were binge drinkers, and 2.3 million (6.0 percent) were heavy drinkers.⁴ The survey also showed an increase in use with age: 3.5 percent of 12- or 13-year-olds, 14.7 percent of 14- or 15-year-olds, 29.0 percent of 16- or 17-year-olds, and 50.7 percent of

18- to 20-year-olds drank alcohol during the thirty days before they were surveyed. Rates for current drinking were similar for 12- to 17-year-olds of both genders: 15.9 percent of males and 16 percent of females. The survey also revealed that alcohol use is a problem for teens of all racial/ethnic groups, though more whites use than other groups. It reported these rates for use in the past month:

- 18.2 percent of white youths
- 15.2 percent of Hispanic youths
- 12.5 percent of those reporting two or more races
- 10.1 percent of black youths
- 8.1 percent of Asian youths

The high rates of marijuana and alcohol use among teens point to high tobacco use as well. Cigarette smoking, a neglected area in the adolescent substance abuse and intervention field, has a well-documented connection to cannabis and alcohol use and has severe long-term health consequences.

As for illegal drug use, the 2007 survey found that, among 12- to 17-year-olds, 9.5 percent were currently using illicit drugs: a decline from the 2002 rate of 11.6 percent. In 2007, use among various drugs was as follows:

- 6.7 percent used marijuana
- 3.3 percent abused prescription drugs
- 1.2 percent used inhalants
- 0.7 percent used hallucinogens
- 0.4 percent used cocaine

Males and females had similar current use rates for most illicit drugs (males 10.0 percent; females 9.1 percent); current marijuana use, however, was more common among males (7.5 percent) than females (5.8 percent). As with alcohol use, illegal drug use also increased with age: 3.3 percent of 12- or 13-year-olds had used within the last thirty days; 8.9 percent of

14- or 15-year-olds; and 16.0 percent of teens age 16 or 17. By age 18 to 20, 21.6 percent were current users. In fact, 18 was the average age of first use among drug users ages 12 to 49. These rates are significant, as research shows that the earlier a teen starts using alcohol or other drugs, the more likely he or she is to continue using—and experience problems well into adulthood. For example, one study found, “In 2006, adults aged 21 or older who first used alcohol before age 21 were more likely (9.6% versus 2.4%) than adults who had their first drink at age 21 or older to be classified with alcohol or drug dependence or abuse.”⁵

It is also important to note the connection between drug use and criminal activity for teens. Among justice-involved youth, substance abuse continues to increase steadily,⁶ and many (60 percent) have drug problems severe enough to require intervention.⁷ Indeed, four out of every five children and teen arrestees in the juvenile justice system have some involvement with drugs and alcohol.

Development and Costs of Adolescent Substance Abuse

Although we cannot pinpoint one factor that is most responsible for adolescent substance abuse, science has revealed much about the causes and correlates.⁸ There are in fact multiple interdependent factors that contribute to the development and maintenance of drug problems, which explains why it is called a multidimensional and multidetermined phenomenon, and why it requires interventions addressing these multiple areas of functioning.⁹

In most cases, teens who use alcohol or other drugs are experiencing a number of problems simultaneously. They may include interpersonal difficulties and family, school, and legal problems. Other contributing factors may include the teen’s personality and temperament, values and beliefs, family relationships, peer relationships, environmental influ-

ences (such as school and neighborhood/community), and sociocultural factors (such as norms and media influences). Biological factors, such as a family history of drug or alcohol abuse, and factors such as gender and race may also play a role in how and when kids begin using drugs.

In most cases, teens who use alcohol or other drugs are experiencing a number of problems simultaneously.

Researchers have found that youth who rapidly increase their substance abuse have many risk factors and few protective factors. Let's consider the main reasons why teens—and adults, for that matter—use alcohol and other drugs:

- **To feel good.** Most drugs, including alcohol, produce intense feelings of pleasure. This initial sensation of euphoria is followed by other effects, which differ with the type of substance used. For example, with stimulants such as cocaine, the “high” is followed by feelings of power, self-confidence, and increased energy. In contrast, the euphoria caused by opiates such as heroin is followed by feelings of relaxation and satisfaction.
- **To feel better.** Some people who suffer from social anxiety, stress-related disorders, and depression begin abusing substances in an attempt to lessen feelings of distress. Stress can play a major role in beginning use, abuse, dependence (addiction), and relapse.
- **To do better.** The increasing pressure that some individuals feel to chemically enhance or improve their athletic or cognitive performance can play a role in initial experimentation and continued abuse.
- **Curiosity and “because others are doing it.”** Adolescents are particularly vulnerable because of the influence of peers; they are more likely to engage in “thrilling” and “risk-taking” behaviors and experiment with alcohol and/or other drugs.¹⁰

Just as there are multiple pathways that lead a teen into drug abuse and multiple reasons why drugs are desired, the consequences of this use vary as well. Drinking alcohol or using drugs affects multiple aspects of an adolescent's life. What's certain in all cases is that substance use comes with a number of costs.

Immediate costs and developmental consequences on youth, family, and society are well documented and include

- school failure
- delinquency
- car accidents
- arrests and incarcerations
- increased risk for HIV infection and other illnesses

The more dire long-term consequences include

- impaired psychological functioning
- debilitating mental health problems
- serious criminal activity and legal problems
- marital problems and divorce
- job instability and failure
- parenting troubles stemming from a parent's drug problems¹¹

These are some of the negative, long-term outcomes for kids who begin using early, surround themselves with drug-using peers, progress to drug abuse in the teen years, perform poorly and get thrown out of school and their homes, and subsequently become involved in the juvenile justice system. It's clear that teen drug abuse can also impair healthy adolescent growth, including the development of a positive identity and skills to become independent, assume adult responsibilities, and form healthy relationships. Such developmental derailment sets users on a path toward failure in several realms of life.

What's more, new evidence from animal studies, and most recently from human studies, has demonstrated the brain-altering hazards of regular marijuana use. Use in early life has been found to heighten the risk of continued problems in adulthood.¹²

The costs of adolescent drug use are indeed high and far-reaching.

The effects don't stop there, however. They extend beyond the teen and family to have an impact on society at large. As Hawkins, Catalano, and Miller write, teen drug use "extracts a high cost in health care, educational failure, mental health services, drug and alcohol treatment, and juvenile crime . . . The problems associated with alcohol and other drug abuse carry costs in lost productivity, lost life, destruction of families, and a weakening of the bonds that hold society together."¹³

The costs of adolescent drug use are indeed high and far-reaching. Now let's consider how to best approach this multifaceted problem.

A Contextual Approach to Adolescent Drug Use

As noted by Newcomb and Bentler, "Substance use and abuse during adolescence are strongly associated with other problem behaviors such as delinquency, precocious sexual behavior, deviant attitudes, or school dropout. Any focus on drug use or abuse to the exclusion of such correlates, whether antecedent, contemporaneous, or consequent, distorts the phenomenon by focusing on only one aspect or component of a general pattern or syndrome."¹⁴

When we look at adolescent drug use contextually and multidimensionally, we're stepping back and enlarging our perspective. Rather than focusing solely on the drug use, we're looking at the teen's life as a whole—the context or

social ecology, the teen's family, and other circumstances as well. Working from this approach, we worry not only about the easily identifiable list of clear and present dangers, but also about the interaction, trajectory, and acceleration of the teen's problems. Drug use, behavior problems, risky sexual practices, and driving while intoxicated—these all correspond with disconnection from social institutions that are instrumental to development (including schools, religious or faith-based institutions, healthy peers and groups, and families).

The more risk that is present, the more the odds turn against the teen, and something is bound to give. One problem can lead to and compound the next: school expulsion creates tension at home; legal and juvenile justice problems create less opportunity for attention to the underlying causes of problem behaviors, and so forth. As a teen is dislocated from developmentally important (indeed vital) social institutions, he or she is further disconnected from mainstream life. Here the teen has fewer chances to develop needed competencies, and more opportunities to form relationships with peers who are in the same situation. An insidious pessimism can overtake teens as well as parents. Failure in a treatment program (and the program's failure to help them), failure in school, and failure in and by families all create a powerful spiral of pain, pessimism, and, above all, inaction.

The more risk that is present, the more the odds turn against the teen, and something is bound to give.

It is this progression that we seek to slow down and eventually reroute. To that end, therapists are taught not only about the risk and protective factors (how to block or facilitate them), but also about what we could call the “physics” of a situation—the relationship between cascading problems and terrible life outcomes. This “interaction effect,” the nega-

tive synergy that can build between problem areas, can saturate the lives of teens who enter treatment. Thus, a therapeutic orientation considers all of the adolescent's and family's psychosocial environments—from school to juvenile justice system—to promote positive, adaptive teen and family developmental outcomes. Such work addresses practical, everyday concerns and life problems, providing wraparound services that allow the family to receive practical support (e.g., financial aid, medical services, immigration and naturalization services, and other case management services) while learning to function differently. This approach intervenes in and coordinates social systems that impact the adolescent's and family's circumstances: school, work, tutoring programs, juvenile justice system, and job-training programs. These models require that treatment include a range of individuals besides the family (peers, probation officers, teachers, and so on), and that therapy not be confined to weekly sessions or to the therapist's office. Ecological family therapy models adopt a “do what it takes” approach to treatment—a term first coined by renowned family therapist Salvador Minuchin.

Risk and Protective Factors

Closely linked with a contextual and environmental approach to teen drug use is the framework of risk and protective factors. Just as this conceptual framework has revolutionized prevention and treatment in medical specialties such as heart disease, AIDS, and certain cancers, it has also greatly influenced the substance abuse prevention and treatment specialties. Assessment of adolescent substance abuse problems is greatly enhanced by a thorough understanding of the risk and protective factors that pertain to child and adolescent dysfunction generally, and to teen drug problems in particular. When clinicians work from this framework, they examine all aspects of a teen's life to see

which elements place him or her at risk for substance use and abuse. This includes assessing intrapersonal, social, familial, and extrafamilial risk as well as protective factors.

Let's begin by looking at some risk factors:

1. Intrapersonal risk factors: Teen alienation or rebelliousness, early first use of drugs, anxiety or depression, antisocial behavior, lack of self-control, favorable attitudes toward drinking, a lack of religious commitment, and a desire for sensation-seeking.
2. Family risk factors: Parents or siblings who use; distant, uninvolved, and inconsistent parenting; negative parent-child communication, unclear family rules and expectations regarding the teen's alcohol or drug use, and too much unstructured time alone for the teen with poor parental monitoring.
3. Times of transition: Divorce or death in the family, moving, starting at a new school.
4. Environmental risk factors: Associating with deviant peers, chronic poverty and unemployment, lack of community resources, living in a neighborhood frequented by gangs or drug dealers, and a poor school environment.

Some signs of risk can be seen as early as infancy or early childhood: a mix of shyness and aggressiveness, for example.

As the child gets older, interactions with family, at school, and within the community can heighten that child's risk for later substance abuse. Children's earliest interactions

Some signs of risk can be seen as early as infancy or early childhood.

occur in the family; sometimes family situations increase a child's risk for later drug abuse. Interactions outside the family can also elevate risks for both children and adolescents, such as classroom behavior problems and social skill deficits, academic failure, and association with drug-

using peers. Spending unsupervised time with such peers is often a teen's first exposure to drug abuse and delinquent behavior.

Research indicates that the key risk periods for drug abuse are during major transitions in children's lives. The first big transition for children is entering school. Later, when children advance from elementary to middle school, they often experience new academic and social situations, such as learning to get along with a wider group of peers. It's at this stage—early adolescence—that children are likely to encounter drugs for the first time. Entering high school, teens face additional social, emotional, and educational challenges. At the same time, they may be exposed to more readily available drugs, drug abusers, and social activities involving drugs. These challenges can increase the risk that they will abuse alcohol, tobacco, and other substances.

Entering high school, teens face additional social, emotional, and educational challenges.

If teens are exposed to multiple risk factors that encourage drug use and abuse over time, they are more likely to use drugs. Research reveals that the exact nature of the risk factors is not as important as the number of risk factors,¹⁵ although specific *clusters* of factors may point to specific types and stages of drug abuse.¹⁶ Indeed, it is the accumulation of risk factors that is important. As Newcomb states, "Adolescent drug involvement is multiply determined; the more risk factors that encourage drug use one is exposed to, the more likely one will use or abuse drugs. Exposure to more risk factors is not only a reliable correlate of drug use; it increases drug use over time, implying a true etiological role."¹⁷ Many of the risk factors for drug use also increase the odds that the teen will experience other problem behaviors such as delinquency, teen pregnancy, school problems, and dropping out.

Risk factors are offset by the presence of protective factors; the more such factors there are, the less likely the teen is to abuse drugs. Protective factors create resilience. They are aspects of an adolescent's life that serve to protect the teen from using drugs and other problem behaviors. As with risk factors, protective factors are found in various parts of a teen's life:

1. Intrapersonal protective factors: Positive self-esteem, intelligence, the teen's expectations for success, and social ease.
2. Family protective factors: A caring and involved family (positive parent-child relationships, positive and consistent discipline methods, appropriate monitoring and supervision).
3. Extrafamilial protective factors: Positive relationships with nonfamily adults.
4. Environmental protective factors: A positive attitude toward school, success in school, participation in extracurricular activities, and relationships with healthy role models.

Adopting conventional norms or beliefs about alcohol and drug use also serves as a significant protective factor for teens. Researchers note that when people feel bonded to society, or to a social unit like the family or school, they want to live according to its standards or norms.¹⁸

Working from a risk and protective factor framework, clinicians consider multiple areas in their assessment process. Key questions include

- Who lives in the home? Have there been any major transitions lately? What's happening in the family?
- How are the parents functioning? Are they using drugs? What are their strengths and competencies?
- What is the family environment like?
- What is the emotional temperature in the home on a day-to-day basis?

- Is the teen in school, and how is she or he doing there? Are there learning or behavior problems? Do the parents know what’s happening with the youth’s school situation, and do they have any contact with the school?
- What are the adolescent’s strengths—his or her developmental competencies?
- What about peer relationships? It’s critical to understand the teen’s friendship network as well as possible.
- How connected is the teen to a deviant peer culture or to antisocial ideals?

Figure 1 shows how risk and protective factors affect people in five domains, or settings.¹⁹ Think of these as “locales” where interventions can take place.

FIGURE 1		
Risk and Protective Factor Framework		
Risk Factors	Domain	Protective Factors
Early Aggressive Behavior	Individual	Self-Control
Lack of Parental Supervision	Family	Parental Monitoring
Substance Abuse	Peer	Academic Competence
Drug Availability	School	Anti-Drug Use Policies
Poverty	Community	Strong Neighborhood Attachment

The Influence of Family

The family's role is crucial in both the development of and the recovery from adolescent substance abuse and addiction. Family factors influence the onset of adolescent drug use and can exacerbate it, too. As mentioned previously, several factors are linked to teen substance use: parent and sibling drug use, parental attitudes that minimize the dangers or consequences of drug use, parents who are emotionally disengaged or in conflict with their children, developmentally off-target parenting practices, and problems within the family environment. It's critical to note, however, that while families may be part of the problem in some cases, they are not to blame for all troubles. Youth from essentially well-functioning families can develop substance abuse problems. Regardless of parents' role in the development of their teen's drug problem, with a skillful clinician's help, they are a key part of the solution.

Family factors influence the onset of adolescent drug use and can exacerbate it, too.

Research reveals the important role that parents and families play in treatment engagement and outcome.²⁰ Family factors, including parental influence and a positive parent-child relationship in a healthy family environment, are among the strongest protective influences against drug-taking. These findings have led to the increasing number of policy recommendations and practices that involve the family in the teen's treatment for drug abuse.

Three major aspects of family interaction are critical in preventing and treating adolescent drug use:

1. The family relationship
2. Guidance through supervision and support in making good friends
3. Transmission of skills and norms through discussion and role modeling²¹

Treatment must include the family. However, many parents with drug-abusing teens may have given up parenting; they've heard they have little influence compared to peers and the media. It's important that parents understand this is not true.

Longitudinal research suggests that parents have a larger impact on adolescent health behaviors than previously thought. According to Monitoring the Future, a highly regarded scientific annual national survey, concern about parent disapproval is the primary reason teens give not to use alcohol and drugs.²² The 2007 NSDUH revealed that youths aged 12 to 17 who believed their parents would strongly disapprove of their using a substance were less likely to use it than youths who believed their parents would somewhat disapprove or neither approve nor disapprove. Additionally, the suppressive effect of parental disapproval does not decrease as teens age. For example, even by the twelfth grade, boys report perceived parental disapproval as the number one reason not to use marijuana.²³ So the family influence must be considered during treatment and developed and used to promote a positive outcome.

Co-occurring Disorders

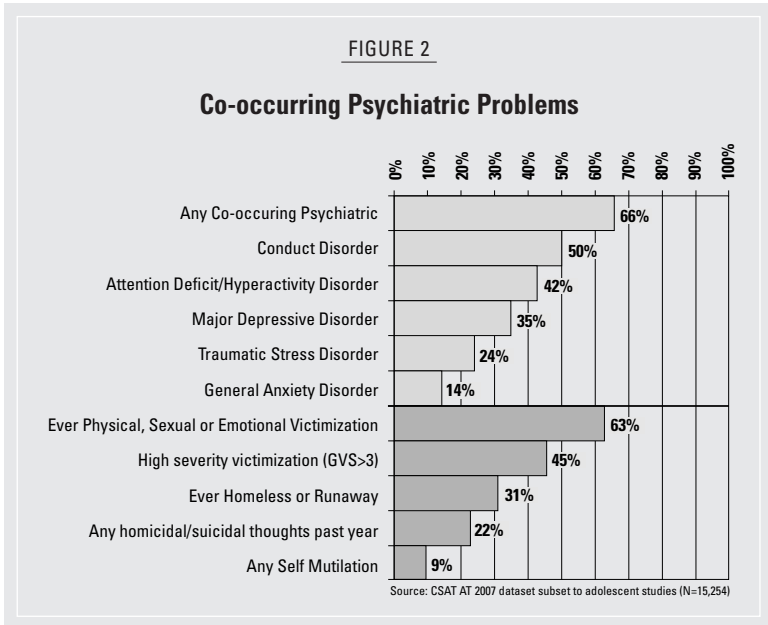
Frequently, adolescents who abuse alcohol or other drugs are also experiencing a co-occurring mental health disorder, also called comorbidity. For clinicians, this is essential to understand if one is to successfully treat teen drug problems. New reviews can be enormously helpful to therapists trying to learn about and make sense of this fundamental area of clinical knowledge²⁴ A “dual diagnosis” of substance use disorder with one or more co-occurring psychiatric disorders is the rule rather than the exception in the field. The Methods for Epidemiology of Child and Adolescent Mental Disorders (MECA) study found the prevalence of a current comorbid

psychiatric disorder in adolescents with a substance use disorder was 76 percent for any anxiety, mood, or disruptive disorder.²⁵ Similarly, findings from a review of fifteen community studies on psychiatric comorbidity in youths with substance problems revealed a 60 percent comorbidity level,²⁶ with conduct disorder (50 to 80 percent) and mood disorders (25 to 50 percent) being the most common. Mood disorders may develop either before or after problems with substance use develop.²⁷ In some clinical samples, the rates of co-occurring anxiety and substance use disorders are high as well: up to 40 percent. Additionally, teens in urban areas diagnosed with substance use disorder may also show high rates of PTSD (post-traumatic stress disorder), along with anxiety disorders and/or conduct disorder. Awareness of PTSD is critical for clinicians because of its high incidence—especially in young women, who have an increased risk of physical and sexual abuse. Additionally, teens with substance use disorder are at higher risk for suicidal behavior and suicide.²⁸ Co-occurring bulimia is another concern.²⁹ Figure 2 shows the prevalence of such co-occurring disorders among substance-abusing teens.³⁰

Mood disorders may develop either before or after problems with substance use develop.

These high rates of co-occurring disorders explain why the American Academy of Child and Adolescent Psychiatry recommends that teens with substance abuse problems also be assessed for mental health problems.³¹ The presence of some psychiatric illnesses can also affect drug-using behaviors in teens, including increasing the likelihood of developing a substance use disorder. Teens with both types of disorders are more likely to be dependent on drugs and to experience more extensive problems in other areas of their lives, including criminal behavior.³²

It is important to recognize that a dual diagnosis complicates case conceptualization and treatment delivery, and



that these adolescents have worse outcomes and are more than twice as costly to treat than their counterparts who have either substance abuse or mental health problems alone.³³ Adolescents with co-occurring disorders are more resistant to traditional treatments and are less likely to benefit from them.³⁴ For example, researchers found that teens with disruptive disorders, especially attention-deficit/hyperactivity disorder (ADHD), were less likely to participate successfully in substance abuse treatment programs, pointing to the need to modify parts of the treatment plan to meet individualized needs—perhaps developing more intensive treatment plans for these teens.³⁵ Additionally, a co-occurring disorder often indicates the need for an evaluation for possible pharmacological interventions,³⁶ which have shown much promise, although medications must be used with caution and in close collaboration with qualified medical personnel.³⁷

Despite the many challenges of treatment, the costs of non-treatment for these youths can be severe and long lasting. Teens often engage in serious criminal behavior before treatment for their substance use and mental health disorders becomes available. It's important to watch for warning signs of co-occurring disorders and begin an integrative treatment as soon as possible.

In summary, when co-occurring disorders are present, the process of assessing, making an accurate diagnosis, creating a practical, priority-oriented case conceptualization, and designing an appropriate treatment regimen becomes even more complex. Evidence now suggests that adolescent substance abuse in combination with psychiatric disorders is more challenging clinically than either problem alone.³⁸ Yet both need immediate and simultaneous attention,³⁹ which is why integrative treatment is recommended.⁴⁰ This undertaking often requires extensive knowledge on the part of the clinician as well as an openness to working with other professionals. Therapists need to be knowledgeable about many factors—drugs, depression, anxiety, trauma, family conflict, learning problems, developmental delays, and dysfunction of all sorts.

Teens often engage in serious criminal behavior before treatment for their substance abuse and mental health disorders becomes available.

Neurobiology: Teen Brain Development

Understanding adolescent neurobiology and the impact of substance abuse provides clinicians with additional knowledge that can be used to determine appropriate treatment regimens. Indeed, this understanding also helps clinicians take a contextual approach to adolescent drug use.

The study of how our brain works has progressed greatly in recent years, due mainly to advances in brain imaging

technology (CT, MRI, and PET scans). Research is disproving the assumption that adolescents who have physically mature bodies also have physically mature brains, capable of reason, delaying gratification, and impulse control. Neuroimaging has revealed that the adolescent brain is pre-programmed to undergo massive changes. According to Jay Giedd, chief of brain imaging in the child psychiatry branch at the National Institute of Mental Health, not only is the adolescent brain far from mature, but it also undergoes extensive structural changes well past puberty. One can say that the teenage brain is a *work in progress*. Researchers now estimate the human brain is not fully developed until age twenty-five. By this point, many youth have developed extensive problems with drug use, particularly the most accessible ones, such as tobacco and alcohol. Young people are at the highest risk of becoming dependent on these drugs in late adolescence.⁴¹

We've learned that adolescent brain development is uneven. Certain regions mature before others, in a sequence from the back of the brain to the front. During adolescence, the brain is also reorganizing—pruning away brain cells and neural connections that are rarely used and strengthening those that get used the most.

Researchers now estimate the human brain is not fully developed until age twenty-five.

By early adolescence, the region controlling physical coordination, emotion, and motivation is well developed. The very last region to fully develop is the prefrontal cortex—home of the executive functions. This is the area responsible for planning, setting priorities, organizing thoughts, suppressing impulses, making complex judgments, and weighing consequences. We can say that this is the final part of the brain to “grow up”—which may explain why teens tend to get into so much trouble. According to Ken Winters:

Neurodevelopment suggests that the adolescent is more “under the influence” of the physical activity and the emotional structures of the brain, compared to the judgment (prefrontal cortex) portion of the brain. Thus, we can expect that teenagers tend to

- prefer sensation seeking and physical activities over ones that require a great deal of complex thinking;
- show less than optimal planning and judgment;
- engage in more risk-taking and impulsive behaviors compared to older individuals; and
- be less inclined to consider the possible negative consequences of such risky behaviors.⁴²

What does this mean for teens when it comes to drug use? It doesn't mean teens are unable to make rational decisions or tell right from wrong, because they can. But what it does mean is that because they have fewer brain-based control mechanisms, they are more likely to act impulsively and with gut reactions when confronted with stressful or emotional decisions. They just don't get the immediate consequences of their actions. Their stage of development also makes them more likely than adults to use alcohol and marijuana more often and to experience more severe problems and complications related to this use.⁴³

Recently, researchers have explored how teens' proclivity for uninhibited risk-taking drives them to experiment with drugs and alcohol. In the past, such experimentation has been attributed to peer pressure, novelty seeking, and loosening of sexual inhibitions. Now, researchers believe that dopamine plays a role. Dopamine is the brain chemical involved in motivation and reinforcing behavior—and teens have an abundance of it. It's possible that rapid changes in dopamine-rich areas of the brain may add to teens' vulnerability to the stimulating and addictive effects of drugs and alcohol.

Since the brain's reward circuitry (the dopamine system) becomes imbalanced when under the influence, teens feel adverse effects when not using drugs or alcohol. But going back for more only makes things worse, and the ability to bounce back to normal after abusing drugs may be compromised due to effects on the brain. We now know that extensive drug use during times of critical brain development can actually permanently alter the way the brain works, particularly when it comes to rewards and consequences.⁴⁴

In studies using animal models, Linda Spear at the State University of New York at Binghamton showed that adolescence is a developmental period in which teens experience alcohol very differently than adults do. Her research showed two significant findings: adolescents have a diminished sensitivity to alcohol's negative effects and an enhanced sensitivity to its positive effects—a “recipe” for teen binge drinking. Spear's animal studies also suggest that drinking in adolescence leads to more brain damage than in adulthood, and memory problems as well.⁴⁵ Other studies are beginning to confirm these results in humans.⁴⁶

Linda Spear's animal studies also suggest that drinking in adolescence leads to more brain damage than in adulthood, and memory problems as well.

Essentially, current research in neurobiology finds that the area of the brain responsible for complex reasoning and judgment is the last part of the adolescent brain to develop. This means teens are often driven by physical activity and emotional impulse. Though they still know right from wrong, teens are often developmentally unable to resist negative behaviors or comprehend the potential consequences. The use of alcohol and drugs is associated with adverse effects on brain development, making it harder for teens to cope with social situations and life pressures.

2

Treatment for Adolescent Substance Abuse

In chapter 1 we discussed recent research about adolescents and substance abuse, including how abuse develops and how it affects multiple areas of a teen’s life. This chapter focuses on treatment—how to help adolescents who have developed a problem with substance use. We will explore interventions that have proven effective, take a closer look at family-therapy models, and consider different outcome criteria that define success. Within an environmental, contextual, and developmental view of substance abuse and adolescents, we see that the teen embodies a drug-using lifestyle; this is what treatment must alter.

Many factors—including the number and improved quality of completed and ongoing studies, and the successful outcomes of these studies—lead us to conclude that the adolescent treatment specialty has entered a renaissance. At the same time, we’ve made only minimal progress in transporting evidence-based therapies into routine care settings.

Diagnosis and Assessment

The first step in treating an adolescent for substance abuse problems is conducting an accurate and thorough assessment of the effects of the abuse on the teen’s life. A therapist can

carry out this assessment through multiple means. A detailed, contextually oriented chemical history is critical to this early stage process.¹

Screening Instruments

Significant advances have been made in the techniques available to assess adolescent substance abuse.² Contemporary standards for how best to assess adolescent substance abuse problems match the consensus on how best to conceptualize this disorder. That is, since teen drug problems are understood contextually and as usually impacting several developmental tasks concurrently, assessment must explore functioning in the multiple, interconnected areas of psychosocial development. Adolescent drug use occurs on a continuum of use and abuse, so assessment needs to consider drug use severity as well as patterns of use over time. Today's state-of-the-art assessment instruments provide this kind of information. They also offer an understanding of how many developmental and contextual systems are involved in and affected by drug taking or abuse, and help reveal related problems in developmental functioning. Psychometrically sound screening instruments include

- Adolescent Domain Screening Inventory (ADSI)
- Adolescent Drinking Index (ADI)
- Adolescent Drug Abuse Diagnosis (ADAD)
- Adolescent Drug Involvement Scale (ADIS)
- Adolescent Problem Severity Index
- CRAFFT Test
- Diagnostic Interview Schedule for Children (DISC)
- Drug Use Screening Inventory-Revised (DUSI-R)
- Drug and Alcohol Problem (DAP) Quick Screen
- Global Appraisal of Individual Needs (GAIN)
- Multidimensional Adolescent Assessment Scale (MAAS)

- Personal Experience Inventory (PEI)
- Personal Experience Screening Questionnaire (PESQ)
- Problem-Oriented Screening Instrument for Teenagers (POSIT)
- Rutgers Alcohol Problem Index (RAPI)
- Severity of Dependence Scale (SDS)
- Teen-Addiction Severity Index

Appendix 1 offers details on these assessment and screening instruments.

Urinalysis

Clinicians should remember that underreporting of drug use is common (for example, with juvenile justice–involved adolescents). In drug treatment settings, urinalysis is still the most widely used biological measure of substance use, and new tests provide instant results. However, these tests must be used with caution. Depending on such factors as the frequency of use and the nature of the drug that was used, the tests can mislead. For example, marijuana’s active ingredient, THC, can remain detectable in a teen’s system for a month after use. Another development that addresses data validity issues is the adaptation of various of the above referenced instruments into audio (headphones) and computer-assisted versions. Evidence is accumulating attesting to the increased validity of computer-assisted self-report assessments on sensitive topics such as drug use, sexual risk behavior, and delinquent activity.³

In drug treatment settings, urinalysis is still the most widely used biological measure of substance use, and new tests provide instant results.

Treating Adolescents Successfully

Comprehensive, multifaceted, multicomponent treatment

models are needed to successfully treat adolescents. This approach acknowledges that there have been multiple pathways into substance abuse and there are multiple pathways out.

The major challenges for clinicians are to become

- knowledgeable about various aspects of adolescent development
- able and willing to collaborate with various professionals and other individuals and institutions who are influential in the adolescent's life
- willing to break away from old treatment models and learn new models with many components that target individual, family, and multisystemic aspects
- aware that engagement is key—particularly with the adolescent, but also with parents

Here are five things to remember about treatment for adolescents:⁴

1. Relapse is common. Most adolescents initiate treatment two to four times before they are able to maintain recovery.
2. It is important to recognize the signs of relapse (spending time with using friends, breaking rules, staying out, inattention, anger, poor hygiene, declining grades) and get adolescents back into treatment and on the road to recovery right away.
3. Helping adolescents participate in continuing care and other recovery support services during the first ninety days after treatment (and ideally the first year) is a key factor in helping them to maintain recovery.
4. While treatment is focused on getting an addicted person to stop, self-help groups, recovery schools, and other recovery support services are typically designed to help maintain recovery. It is important

to try to link adolescents to continuing care services with other adolescents.

5. Most adolescents are seen in an outpatient setting several hours a week. Residential treatment is reserved for adolescents who are not succeeding in outpatient treatment.

Knowledge of Adolescent Development

Working with drug-using teens requires skill and knowledge in many areas, often outside one's area of specialization. Therapists need to be well versed in adolescent and family development, including how the brain and body mature, and the opportunities and vulnerabilities related to that growth. As we discussed in chapter 1, the dramatic transformations occurring in the brain during adolescence significantly impact behavior and psychological functioning.⁵ Therapists translate this knowledge into needed clinical skills for working with the teen, parents, and families, as well as others in the teen's world. While therapists will spend most of their time with parents and teens, as well as with the family, emphasis must also be placed on understanding and intervening in extrafamilial systems. This way of working requires considerable skill not only in therapy but also in intervention organization and orchestration.

Working with drug-using teens requires skill and knowledge in many areas, often outside one's area of specialization.

The use of developmental knowledge to guide understanding of adolescent problem behaviors and substance abuse has been transformative. Clinicians need to understand specific principles derived from developmental psychology and psychopathology. For example, it's essential to understand the importance of parental monitoring in the context of an ongoing, emotionally supportive parent-teen

relationship. But clinicians must also grasp the growing influence of peers throughout the adolescent years and how this fact, among other developments, calls for a renegotiation of the parent-adolescent relationship.

A therapist's knowledge of local resources, policies, and procedures about important aspects of family life is also fundamental to success. Therapists who wish to advocate for their teens and families must be knowledgeable about such topics as court hearings and proceedings and school regulations regarding testing, tutoring, expulsion, alternative school options, and so on.

A Systemic Approach to Therapy

Given the complexity of adolescent substance abuse and the multiple dimensions involved, the answer to helping teens lies not only in *what* is needed but also in *who* is needed. We now have a much broader understanding of adolescent substance abuse, one that encourages the inclusion of the perspectives and expertise of many disciplines: medicine, devel-

Treatment requires an integrative, systemic approach involving a number of perspectives and people who play vital roles in the lives of adolescents.

opmental and clinical psychology, addictions studies, social work, and others. Thus, treatment requires an integrative, systemic approach involving a number of perspectives and people who play vital roles in the lives of adolescents. These may include teachers, school counselors or vice principals, juvenile justice representatives such as probation officers or juvenile court judges, primary care doctors, psychotherapists, social workers, parents, and other family members.

One of the keys, then, to treating adolescents successfully is the clinician's ability to collaborate with others and intervene in various aspects of the teen's life. The clinician must

- be motivated to work in this way
- see the case through a complex lens (systems thinking)
- have or develop skill in family therapy
- be knowledgeable about social systems and systems of care
- possess relationship and intervention skills for working multisystemically with parents, adolescents, and others
- be practical and outcome oriented
- embody Salvador Minuchin’s “do what it takes” attitude

New Models

Adolescent substance abuse treatment models have evolved and grown in many ways. The most recent development in the field has been a movement away from individual or group therapy alone and toward a more integrative and combined therapy. These state-of-the-art, evidence-based models are broad-based, yet tailored to the particulars, complexities, and multiple systems that make up the teen’s environment.

The best treatment programs are multicomponent—they provide a combination of therapies and other services to meet the needs of the individual patient. These key elements are summarized in an influential report titled *Treating Teens: A Guide to Adolescent Drug Programs*.⁶ In this report, the Drug Strategies expert panel identified nine key program elements:

1. **Assessment and Treatment Matching:** Programs should conduct comprehensive assessments that cover psychiatric, psychological, and medical problems, learning disabilities, family functioning, and other aspects of the adolescent’s life.

2. **Comprehensive, Integrated Treatment Approach:** Program services should address all aspects of an adolescent's life.
3. **Family Involvement in Treatment:** Research shows that involving parents in the adolescent's drug treatment produces better outcomes.
4. **Developmentally Appropriate Program:** Activities and materials should reflect the developmental differences between adults and adolescents.
5. **Engaging and Retaining Teens in Treatment:** Treatment programs should build a climate of trust between the adolescent and the therapist.
6. **Qualified Staff:** Staff should be trained in adolescent development, co-occurring mental disorders, substance abuse, and addiction.
7. **Gender and Cultural Competence:** Programs should address the distinct needs of adolescent boys and girls as well as cultural differences among minorities.
8. **Continuing Care:** Programs should include relapse prevention training, aftercare plans, referrals to community resources, and follow-up.
9. **Treatment Outcomes:** Rigorous evaluation is required to measure success, target resources, and improve treatment services.

These nine elements offer a yardstick so programs can assess how they stack up against the best practices in the field.

The clinician's own ability and approach determine the next course of action to address the target areas.

Contemporary adolescent treatment advocates a systems approach that more accurately reflects the real life of teens. Clinicians begin their work by identifying the teen's risk fac-

tors—behaviors and circumstances that keep the teen connected to a drug-using lifestyle—as well as protective factors. The clinician’s own ability and approach determine the next course of action to address the target areas. The new, comprehensive family-therapy models focus on both removing problems and strengthening and adding protective forces in the teen’s and family’s life.

Cognitive-behavioral therapy (CBT) has also proven effective in treating adolescent drug use. CBT is a state-of-the-art, empirically based, generally brief individual treatment for many psychological problems. A goal-oriented, psychotherapeutic approach that is manual-guided, it is based on a broadly defined cognitive-behavioral theory,⁷ and adolescent-focused CBT is also influenced by dialectical behavior therapy.⁸ These models view substance use as a learned behavior started and maintained in the context of environmental factors. The social learning model uses classical and operant learning principles, acknowledges the influence of environmental events on behavioral development, and recognizes the role of cognitive processes in health and dysfunction.⁹ Family-based therapy and CBT have been combined with considerable therapeutic success.¹⁰

One national study found that only 27 percent of adolescents completed a standard three-month outpatient treatment program.

The Importance of Engagement

The success of any therapeutic approach depends on its capacity to engage and retain clients. Engaging teens in treatment can be difficult. One national study found that only 27 percent of adolescents completed a standard three-month outpatient treatment program.¹¹ That means that more than 7 in 10 teens quit the program prematurely. Typically this finding is interpreted as proof of adolescent

resistance or evidence of the inevitable difficulty of treating teenagers. But new evidence indicates that this interpretation is too narrow. Ineffective or inappropriate treatment strategies are also accountable. We know now that developmentally inappropriate, punitive or “get tough” approaches—shock incarceration or boot camp, for instance—don’t work and can even cause harm. Therapist skill is instrumental in engaging teens and, of course, in improving overall outcomes.

Family-Based Therapy

Group counseling is still the most common approach to teen drug problems. This is likely a function of tradition, economics, and the slow pace of change in professional training programs, rather than available data about best practices. Although certain group-based approaches to teen drug problems have been shown to be effective, particularly cognitive-behavioral therapy, more research has been conducted on family-based treatments than on any other model. Numerous scientific reviews, practice guidelines published by professional societies, and government and foundation reports confirm that certain family-based treatments are highly effective in treating teen substance abuse as well as other behavioral problems, including delinquency and co-occurring disorder symptoms. These treatments also improve known protective or resilience-producing factors, such as family functioning and school performance.

We also know that parents have the potential to be strong preventative agents for teens when it comes to drug use.

Today’s family-based interventions emerged from a recognition of the family’s central role both in early substance use and its progression.¹² Yet these comprehensive treatments have evolved beyond targeting only the family to include other areas and people important to the teen’s life.

Indeed, family-based therapies now address many interconnected problem areas in the lives of teens who abuse substances.

In chapter 1 we discussed the critical influence of parents both in the acquisition of a teen substance abuse problem and in therapy outcomes. These family factors indicate the need for effective family-based interventions for alcohol and drug problems.¹³ We also know that parents have the potential to be strong preventative agents for teens when it comes to drug use. Recent studies have revealed new details about how parents remain important to their teenager's ongoing development.¹⁴ Furthermore, positive family relationships can also slow or stop the progression of problems once they have begun. Steinberg, Fletcher, and Darling¹⁵ found that particular parenting practices, such as monitoring in the context of emotional support, can reverse the course of negative peer influence even after problem behavior starts.¹⁶ For these reasons, forming close alliances with parents and other family members has been a logical development in the adolescent treatment field.

Recent studies have revealed new details about how parents remain important to their teenager's ongoing development.

Family-therapy clinicians intervene in areas where risk factors are present and, using protective-factor thinking, also work on practical matters that improve the teen's life in general. For example, clinicians may help teens to secure a more functional school placement, to address any juvenile justice and legal circumstances, and to develop interests in and find venues for fun, non-drug-related activities. They work directly with the teen, focusing on feelings and thoughts that support drug-taking behaviors; directly with the parent on changing aspects of the family environment; and with the parent and teen together on changing important

aspects of their everyday psychosocial world, including the all-important caregiver-youth relationship.

The family-therapy models intervene differently according to the stage of treatment. Initial individual meetings with a parent focus on motivating that adult to get more involved in the child's life because the teen's development is off track and long-term well-being is in question. In therapy's second (middle) stage, clinicians teach, coach, and actively shape a parent's responses to the teen's problems in individual sessions and in meetings with both

Changing the functioning of an individual parent, and of the parent-teen relationship, is instrumental in altering the youth's drug-taking and other problem behaviors.

together. Playing both sides of the interaction, clinicians help teens speak their mind and show aspects of themselves to their parents that are usually unavailable. Session locale varies. Frank discussion may happen in the home, in the clinic, in the waiting room at court, in the visitors' area of the juvenile detention center, or in a spare room at the school. Therapists use the structural family-therapy method called *enactment* to decentralize their own role in family interviews, encouraging family members to literally and figuratively face each other and discuss important but sensitive relationship topics and recent unsettling events. These methods have in-session goals (e.g., new behavior alternatives, experiencing each other in new ways) and longer-term goals, such as developing a new way of relating, resolving conflict, and building a foundation for healthier future interactions. Changing the functioning of an individual parent, and of the parent-teen relationship, is instrumental in altering the youth's drug-taking and other problem behaviors.

Types of Family Therapy

Weinberg, Rahdert, Colliver, and Glantz¹⁷ identify three varieties of family-therapy approaches with empirical support:

structural-strategic family therapies, ecological-integrative models, and a family skills approach (which is not family therapy per se, but is frequently associated with it).

Structural-strategic family therapies (SSFT) are treatments shown to be effective in reducing adolescent substance use and improving parent-adolescent relationships.¹⁸ Substance abuse is viewed as being related to dysfunctional family structures and interactional patterns; thus all family members are involved (whether present in sessions or not), and the main focus is on the therapeutic alliance between the therapist and family members.¹⁹

The ecological-integrative models, which include Multi-dimensional Family Therapy (MDFT) and Multisystemic Family Therapy (MSFT), have roots in the SSFT theoretical framework, but the treatment focus is more comprehensive. In addition to treating the adolescent and family, these models address a wider array of problems by intervening in broader systems of social influences—for example, teachers, peers, and probation officers—that may impact the teen’s drug use and related behavioral problems.²⁰

The family skills approach consists of training for parents of substance-abusing adolescents. In this approach, change is elicited in the parent’s or caretaker’s family management practices in order to reduce adolescent drug use.²¹ For example, in skills training, the therapist may instruct caregivers on setting limits and model other appropriate parenting behaviors.²²

Examples of Family Therapy Interventions

Contemporary evidence-based family-therapy models include these approaches:

1. Family Behavior Therapy (FBT) is an outpatient treatment for alcohol and drug problems. It is also used with youth who have co-occurring disorders. Therapy consists of fifteen sessions over six months;

sessions typically include a teen and one parent. Multiple interventions are used, including behavioral contracts, skill-based interventions, skills training, development of communication skills, and vocational and school training.

2. Functional Family Therapy (FFT) is both a prevention and intervention program designed for adolescents and their families. This evidence-based program has been used with a wide range of youth with antisocial problems. When used in juvenile justice facilities, the model has been shown to reduce recidivism at a rate of 25 to 60 percent.²³
3. Integrative FFT-CBT is a combined treatment. Developed by Waldron and colleagues,²⁴ it blends functional family therapy (FFT) with a behavioral family therapy developed initially with delinquent rather than drug abuse samples and a substance-oriented cognitive-behavioral therapy (CBT). This treatment outperformed both of the component approaches—CBT and FFT—in reducing drug use among substance-abusing teenagers.
4. The Purdue Brief Family Therapy Model (“Purdue Project”) originally combined structural, strategic, functional, systemic, and behavioral family therapies,²⁵ an integrative approach that proved successful with nearly 70 percent of cases. The model was adapted to reach other families that were often in denial about a substance abuse problem. This new version of the model uses a positively oriented approach and builds on strengths that the family identifies.
5. Brief Strategic Family Therapy (BSFT)²⁶ is an integrative family-therapy approach that has developed cul-

turally specific interventions for Hispanic youth with conduct and early stage substance-using disorders.

6. Multisystemic Therapy (MST) represents an approach that, depending on the particular case and assessment, selects from elements of family therapy, family preservation, parent training, and cognitive therapy methods.²⁷
7. Multidimensional Family Therapy (MDFT) is a family-based, developmental-ecological, multiple systems approach that is both clinically effective and cost-effective.²⁸ The approach is a comprehensive, multi-component, stage-oriented intervention. (See chapter 3 to learn more.)

Family-based therapies utilize basic research on developmental psychology and developmental psychopathology.²⁹ Considerable research testifies to the influential role played by family relationships and family environments in the development of adolescent alcohol and drug problems.³⁰ While these various forms of family-based therapy may differ in their clinical techniques and focus, all share a conceptual framework that acknowledges how dysfunctional family environments contribute to substance abuse problems.³¹

Family-based therapies utilize basic research on developmental psychology and developmental psychopathology.

Family-Based Intervention Outcomes

Outcomes for family-based treatment consider engagement, retention, and relapse rates. Large-scale evaluation studies reveal that on average, outpatient treatment outcomes have improved since the late 1990s. Unfortunately, dropout rates are still too high, and relapse to drug use, as is the case with adults, is not uncommon.

The first wave of controlled studies testing clinical outcomes and treatment engagement strategies in family-based treatment for adolescent substance abuse were conducted during the 1980s.³² Research during this period established family therapy as a safe, acceptable, viable, and promising approach for teen drug problems.³³ However, these studies were limited by relatively small samples, short follow-up assessment windows, and limited data on treatment implementation and fidelity. Today, the scientific quality of family-based adolescent drug treatment research continues to progress³⁴ and has garnered broad-based federally funded research support.³⁵ A host of randomized, well-controlled long-term studies have been reported in the scientific literature. Rigorous treatment process and outcome research has demonstrated that high-fidelity family-based treatment is an effective approach for adolescent substance abuse and related behavior problems.³⁶

Engagement can be defined as the initial participation in a treatment program. In treatment, therapists have to engage the adolescent in a productive manner. The quality of the therapist's involvement in the teen's life must demonstrate respect, interest, and caring, certainly, but also knowledge about his or her world—the world that teens live in today, not the world teens inhabited years ago. At the same time, working with the parent is fundamental to success as well. When therapists use a specialized, culturally responsive family-based engagement procedure, the rates of success for family-based therapies have been high. Controlled studies of specialized engagement procedures developed for family-based treatment models³⁷ find that well-articulated, intensive, family-based engagement strategies are superior to standard engagement practices (typically one initial phone contact to schedule a first session) in enrolling adolescents and families into outpatient counseling. Strangely enough,

the impressive engagement statistics and corresponding specialized techniques have, in general, started to capture the imagination of the teen-drug-abuse field.

Retention can be defined as completion of a full course of prescribed treatment. Retention rates in controlled trials of family-based treatments have been uniformly high, typically from 70 to 90 percent and even higher.³⁸ However, although family-based treatment has outperformed usual care and also some comparison treatments in retaining high-risk teens,³⁹ there tend to be fewer differences in retention rates when FBT is compared to other well-defined approaches with specialized engagement strategies of their own.⁴⁰

In a study with juvenile offenders, 57 of 58 cases (98 percent) assigned to Henggeler's MST completed a full course of treatment lasting an average of 130 days.⁴¹ Another study reported that 56 of 59 cases (95 percent) who received either FFT-only or a combination of FFT and cognitive-behavioral therapy (CBT) were retained in treatment.⁴² In a controlled study testing an intensive outpatient version of MDFT versus residential treatment, at six months post-intake, MDFT retained 88 percent of youth (who had been referred to residential treatment but were allocated at random to the experimental condition, the intensive outpatient alternative, MDFT).⁴³ Only 24 percent of youth in the residential program remained in treatment at the same six-month assessment point.⁴⁴

Empirical evidence documents the effectiveness of family-based therapy for reducing levels of adolescent drug abuse.

Reduction in drug use and relapse rates. Empirical evidence documents the effectiveness of family-based therapy for reducing levels of adolescent drug abuse. Although not all studies are consistent, the evidence suggests that drug use reductions are frequently more pronounced in

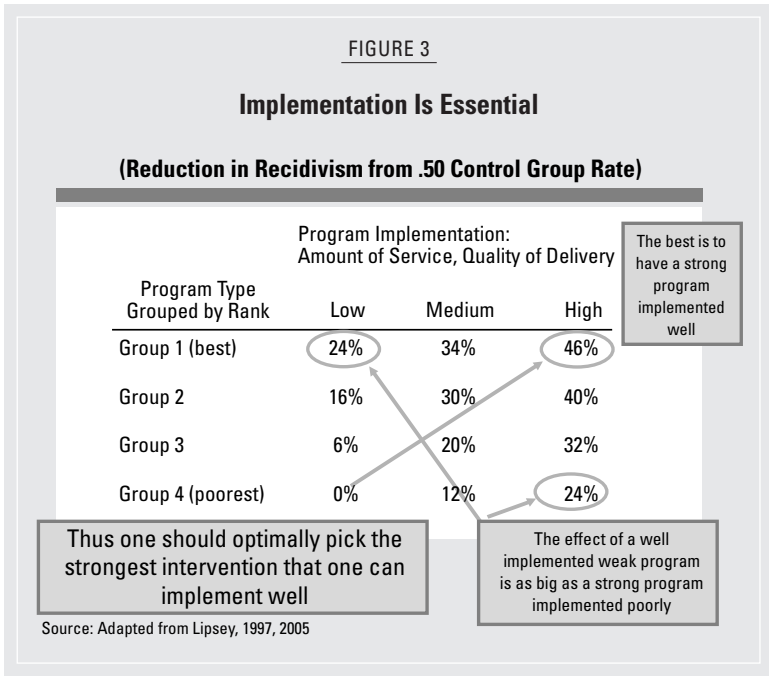
family-based therapy than in non-family-based treatments, and that these effects can endure at least six to twelve months and in some cases longer, beyond the end of treatment.⁴⁵

Family-therapy studies also typically report positive changes in other functional areas of the teen's life, including delinquency (arrests, time spent in out-of-home detention or placement) and mental health problems (internalizing and externalizing symptoms). Other outcomes include dramatic decreases in adolescent involvement with legal and juvenile justice systems. Prosocial aspects of the teen's life can also be facilitated: parents and families can change, kids can stop affiliating with deviant peers, and school attendance and performance can improve significantly.⁴⁶

Although complete abstinence from alcohol and illicit drugs is the benchmark used most often in determining whether a teen relapsed during or after treatment, outcome study reviews document relatively low rates of continuous abstinence following treatment. One review noted that the average rate of continuous abstinence six months after treatment was 38 percent (range: 30 to 55 percent); at twelve months it was 32 percent (range: 14 to 47 percent).⁴⁷ Another reported a six-month median rate of 39 percent abstinence (range: 16 to 54 percent); at twelve months it was 44 percent (range: 25 to 62 percent).⁴⁸

The most common precipitators of relapse following treatment are social pressures and negative affect.⁴⁹ Protective factors against alcohol relapse include after-care participation, better coping skills, including alcohol refusal, and positive supports for recovery.⁵⁰ Family functioning has also been found to play a primary role in helping teens achieve and maintain abstinence.⁵¹ These findings underscore the importance of building coping and relapse

Family functioning has also been found to play a primary role in helping teens achieve and maintain abstinence.



prevention skills during treatment and providing continued support and aftercare services following treatment.⁵² Figure 3 shows that consistent program implementation is as important as the choice of program itself.⁵³

Early reviews were cautiously positive about the available science supporting family-based treatment. The term we used to describe the status of the scientific evidence in the early 1990s was “promising but not definitive.” Today, some reviews nominate family-based therapies as the “treatment of choice” for adolescent substance abuse.⁵⁴



HAZELDEN'S CLINICAL INNOVATORS SERIES presents signature topics by industry leaders who define today's (and tomorrow's) standards of substance abuse treatment. Watch the video workshop, read the clinician's manual, then take the post-test. * Staying current and maintaining credentials has never been more convenient.

In this guide, Dr. Howard Liddle guides you through the latest scientific progress in the field of adolescent substance abuse, and clarifies how today's best practices strive to be comprehensive and all-encompassing. He emphasizes clinical methods of effective evidence-based, family-based treatment, while focusing on Multidimensional Family Therapy (MDFT).

This manual builds on the content of the video. The thirty-five question post-test is worth twenty continuing education hours upon successful completion.

*Hazelden is an approved continuing education provider by NAADAC (program #000381), CAADAC (program #OS-04-651-1008), and IAODAPCA (program #8737).

WATCH. LEARN. EARN.
The Clinical Innovators Series

Cover design: David Spohn

HAZELDEN®

hazelden.org
800-328-9000