Effective Adolescent Substance Abuse Treatment

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All inherited possibilities and all influences of the body, all environmental influences, including educational application, are perceived, assimilated, digested, and answered by a living and striving being, striving for a successful achievement in his view. The subjectiveness of the individual, his special style of life, and his conception of life mold and shape all influences. The individual life collects all these influences and uses them as provocative bricks in building a totality which aims toward a successful goal in relating itself to outside problems.

Alfred Adler, Individual Psychology

To see with the eyes of another, to hear with the ears of another, to feel with the heart of another. For the time being, this seems to me an admissible definition of what we call social feeling.

Alfred Adler, Individual Psychology
Abstract

Many adolescent substance abuse treatment programs decline to incorporate the essential and effective tools to assist adolescents toward change in overcoming substance abuse problems. This paper examined effectiveness of several treatment methods by comparing and contrasting their key elements. Adlerian concepts of social interest and the creative self were considered in a context of substance abuse treatment. The current findings suggest there are several evidence-based substance abuse programs readily available and accessible for professional practitioners to utilize. The research recommends adhering to the researched protocols and guidelines when delivering adolescent substance abuse treatment to ensure program effectiveness.
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Effective Adolescent Substance Abuse Treatment

Substance Abuse Data Trends

Since 1975, *Monitoring the Future Survey (MTF)* has been conducting reviews in school classrooms to eighth, tenth, and twelfth graders nationwide, to measure drug, alcohol, and cigarette use. Forty-six thousand, three hundred forty-eight students from 386 public and private schools were investigated in 2008. Students report their drug use behaviors and substance use patterns across three time periods: lifetime, past year, and past month. The survey is managed by researchers at the University of Michigan (National Institute on Drug Abuse, 2008).

Recent MTF investigations had shown a steady decline in marijuana use since the mid-1990s. The 2008 MTF survey shows the use of marijuana among eighth, tenth, and twelfth graders as leveled off with 10.9 percent of eighth graders, 23.9 percent of tenth graders, and 32.4 percent of twelfth graders admitting past-year use of marijuana. The concern over the stabilization in use is that compared to last year, the proportion of eighth graders who perceived smoking marijuana as harmful and the proportion disapproving of its use have decreased (NIDA, 2008).

Stevens and Morral (2003) report that marijuana used alone or in combination with alcohol and other drugs is dangerous and is presumed to be one of the major contributing factors to violent deaths and accidents among teens. It has been described as being involved in as many as 30 percent of adolescent motor vehicle crashes, 20 percent of adolescent homicides, 13 percent of teen suicides, and 10 percent of unintended injuries among adolescents. Marijuana has become the leading substance mentioned in adolescent emergency room visits and autopsy reports.
The MTF review indicated that, seven of the top ten drugs abused by twelfth graders in the year prior to the survey were prescribed or purchased over-the-counter. Cigarette smoking has reached an all time (recorded) low in the survey history. Alcohol use has declined between the years of 2007 and 2008 among tenth graders on all measures. More than one in ten high school seniors say they smoke daily; 5.4 percent smoke more than a half a pack a day (NIDA, 2008).

The report shows a downward trend in alcohol consumption, however, 25 percent of seniors report drinking five or more drinks in a row in the two weeks prior to the survey. Binge drinking is defined as five or more drinks in one episode and is reported by over 30% of 12th-graders in any two-week period. These statistics have been stable for many years and appears to be an indicator of common experimental drinking (Clark, 2004). Most teenagers can and do stop (or cut back) using substances on their own. Many teens who begin using at an early age (15 years or younger) have been found to progress and use more substances as they mature.

Other problems can occur that are often characteristic of adolescent substance abuse to include: delinquent behaviors, school truancy, and/or emotional behavioral problems (Stevens et al, 2003). Research reports evidence that childhood psychopathology predicts adolescent substance abuse. Major depressive disorder (MDD), attention deficit hyperactivity disorder (ADHD) and anxiety all have been found to have a genetic component. Therefore, the relationship between substance abuse and mental health disorders may be due to common genetic influences. At the same time, environmental influence may exist as it relates to family substance abuse risk factors that have been shown to replicate over generations. Major depressive disorder, anxiety, chemical dependency, and attention deficit and hyperactivity
disorders are not independent characteristics and their overlap may play an important role in
treatment outcomes (Clark, 2004).

Adolescent Substance Abuse Treatment History

Between the years of 1915 and 1985, only a few assessments of adolescent substance
abuse treatment studies took place. The studies that did were formatted around adult treatment
models that included teens as part of the program. The lack of community resources to help
youth in the 1950’s inspired new research enthusiasm within cities being harmed by heroin
addiction. As a result, new modern community-based treatment systems began (Stevens et al,
2003).

The transitions from adolescent treatment admissions for narcotics to admissions for
marijuana and alcohol did not begin until the late 1960’s and early 1970’s. This process
accompanied a series of national program evaluations of existing practice and attempts to apply
adult treatment models to adolescents. Several years of treatment studies included many
evaluations that were using adult treatment models with minimal modifications for teens. Despite
the long-acknowledged importance of the adolescent developmental period in understanding
drug involvement, adolescents with substance use problems have been a focus of substantial
systemic study for only the past decade (Clark, 2004). The need for effective treatment is crucial,
less than 10 percent of adolescents with symptoms of substance dependence receive treatment.
Former studies that investigated adolescent treatment methodologies include: The Drug Abuse
Reporting System (DARP) 1979, the Treatment Outcome Prospective Study (TOPS) 1985, The
Services Research Outcome Study (SROS) 1995, The National Treatment Improvement
Evaluation Study (NTIES) 1999, and The Drug Abuse Treatment Outcome Studies of
Adolescents (DATOS-A) 1998. The research indicated that there is a definite need for
scientifically stringent treatment model development and evaluation for adolescents (Stevens et al, 2003).

One of the responses to the knowledge gap was the Center for Substance Abuse Treatment’s establishment of the Adolescent Treatment Model (ATM). The center goals were to fund, evaluate and automate existing model programs, to establish treatment practices that include a more educated staff, a cooperative-less confrontational approach, flexibility with clients, and developmentally appropriate methods for adolescents.

The crucial advances of the Adolescent Treatment Model will ensure that programs have an extensive standardized assessment and follow-up measurement instrument to ensure appropriate treatment planning. The Global Appraisal of Individual Needs (GAIN) is becoming the assessment ‘gold standard’ for adolescent treatment. In 2003, a major study took place by Drug Strategies outlining adolescent treatment across nine domains in 144 programs that are “highly regarded” by experts in the addiction field. The domains assessed were called, ‘essential key elements of effective adolescent drug treatment’, and included: assessment and treatment matching, a treatment approach that is comprehensive with regard to the adolescent’s life, family involvement in treatment, development appropriateness, strategies to engage and retain adolescents in treatment, qualified staff, the tailoring of treatment to address gender and culture differences, continuing care, and program evaluations of treatment outcomes (Drug Strategies, 2003).

Current Treatment Concerns

Recent research has demonstrated the lack of adolescent treatment quality in outpatient and inpatient programs. Investigator Hannah K. Knudsen concluded in her research that there is a large gap between teens needing treatment and those that actually receive it. Observations from
the Treatment Episode Data Set recorded an increase in adolescent treatment admissions in 2003 from 99,000 to around 156,000. There has been a recent decline in treatment admissions however, the study reported only 10 percent of those needing treatment actually receive treatment (Knudsen, 2009).

Organizational obstacles have been cited as reasons for the recent gap. Two hurdles are said to interfere with adolescent treatment: program admission policies and availability of adolescent-only treatment programming. Parental substance abuse issues can also be barriers and can influence the treatment process.

History has outlined that adolescents need separate and specialized treatment services that are different from adult programs because of the unique needs they encounter including, developmental changes, emotional stability, environmental and family concerns.

Knudsen (2009) concluded in the report that there are several limitations still existing in adolescent treatment care. A large percentage of treatment centers exclude teens from admission as a matter of program policy. A substantial percentage of treatment organizations still integrate adolescents with adults. The programs most likely to combine adults and teens are abstinence-based 12-step treatment programs.

Adolescent-only treatment services are very limited, suggesting how difficult it can be for teens to receive the necessary help when needed. Current research states that most adolescent treatment is delivered on an outpatient basis utilizing group therapy as the primary treatment modality. The average treatment program offered only half of the quality components needed for treatment effectiveness. This reaffirms that adolescent treatment services must continue efforts to improve the quality of care in adolescent treatment (Knudsen, 2009).
Key Elements of Treatment Effectiveness

Assessment and Treatment Matching. Treatment programs advocate an extensive assessment that screens for medical problems, mental health impairments, educational placement, learning disabilities, family functioning, and other areas of the teen’s life. This will ensure appropriate program matching with client and treatment needs. Screening instruments include, Screening Instrument for Teenagers (POIST), Personal Experience Screening Questionnaire (PESQ), CRAAFT, Comprehensive Addiction Severity Index for Adolescents (CASI-A), and the (GAIN) Global Assessment of Individual Needs evaluation (Drug Strategies 2003).

Comprehensive and Integrated Treatment Approach. Treatment programs need to offer intensive, comprehensive, developmentally appropriate services for adolescents and their families. The services will not only focus on substance abuse but the entire system of the teen’s life. This may include: family, school, friends, criminal justice programs, mental health, and the social systems that shape and influence the adolescent. Treatment programs should offer a variety of services to teens and/or assist the family in connecting with the appropriate community sources. This would be a good time to encourage and introduce the teen to new ideas and ways of living that will enhance the skills needed to make good choices toward a healthy lifestyle (Drug Strategies, 2003).

Family Involvement in Treatment. Parental involvement is extremely important when measuring the success of teen substance abuse treatment. Research shows that when parents and caregivers are involved in the treatment process the progress improves. Rehabilitation is more successful and post-treatment stability is more likely. The three most important elements of success reported by adolescents (who stopped using drugs without formal treatment) are parental
involvement, new friends, and motivation. Family involvement is defined as participation in telephone conversations with counselors to actively engage in group counseling and meetings (Drug Strategies, 2003).

**Developmentally Appropriate Program.** Adolescent treatment programs cannot be a replicated or a modified version of an adult treatment program. Teens experience a variety of biological, psychological, environmental, emotional and social changes that are different from those of adults. Specialized treatment programs that practice exclusively with teens need to be pragmatic and consider the different conditions which shape the teen’s environment and influence behaviors. Integrating and utilizing creative arts as an activity has shown to be an effective tool to enhance the learning and recovery process. This can be an effective means to keep teens interested and focused in treatment. Researchers have questioned the effectiveness of the 12-Steps in the treatment of adolescents. Teens are not interested in thinking about abstinence or having a lifetime disease and turning their ‘will’ over to a higher power. Many are uncertain of these concepts and are not ready to make that type of connection and/or commitment at this point in their developmental stage (Drug Strategies, 2003).

**Engage and Retain Teens in Treatment.** Three out of four adolescents in outpatient treatment programs quit treatment within ninety days. It is imperative that a climate of trust is built between client and therapist. Designing the treatment program to include creative activities to enhance motivation can help retain teens in treatment. Recruiting qualified counselors can also assist in client retention. Therapeutic skills that are needed to work with adolescents include: empathy, flexibility, sense of humor, patience, good interpersonal communication skills, creativity and appropriate educational credentials (Drug Strategies, 2003).
**Qualified Staff.** Having an educated, skilled, and experienced staff makes for a strong and stable treatment program. The therapeutic alliance between the client and therapist will enhance and influence program effectiveness. Staff requirements vary from state to state. There is a growing need for licensed counselors who have an expertise in both addiction and mental health therapy. It is necessary for the clinician to have the fundamental skills needed to work with teen’s who may have both substance abuse tendencies and a mental health disorder such as depression or attention deficit hyperactivity disorder (ADHD), for an example (Drug Strategies, 2003).

**Gender and Cultural Competencies.** Alcohol and drugs affect both girls and boys, although males have a tendency to drink more alcohol than girls. Trauma induces girls towards substances as they attempt to change the way they feel and to avoid negative post-traumatic related feelings. Boys who struggle with conduct disorder, anger, and aggressive behavior have a tendency to use alcohol and/or drugs to mask their emotions. Girls have a tendency to become more dependent on substances because of the way they can affect the change in feelings associated with abuse, abandonment, and depression. Current research is limited, but does indicate that there is a lack of cultural understanding, which affects the ability to effectively treat minority youth. It is suggested that substance abuse among Hispanic teens increases with the length of stay in the United States. There appears to be a family breakdown of social support that interferes with the acculturation process. Traditional and cultural roles weaken as the children assimilate into the dominant culture (Drug Strategies, 2003). Ethnic group differences compared alcohol abuse in African American and Asian American adolescents with European American and Hispanic American adolescents. Reports show that European and Hispanic Americans
present higher levels of alcohol involvement than the rest, and that there is no significant age difference in alcohol initiation between males and females (Clark, 2004).

**Continuing Care.** Relapse is common among the adolescent population, especially during the first few months following treatment. It is important to have a plan following treatment that includes community resources, self help groups, hobbies and interests, health education, how to handle triggers, and how to meet new friends and relate to old ones. Family members need to provide support and positive influence in the teen’s life by being good role models (Drug Strategies, 2003).

**Treatment Outcomes.** Treatment outcomes are a necessary part of evidence based programs. Follow-up data must be available for client retention and evaluations. Program completion is correlated to positive treatment outcomes. Important questions need to be asked to determine treatment progress about school performance, disruptive behaviors, and family relations. Programs need to keep track periodically during and following treatment to monitor the client’s progress and to see that he or she is receiving the appropriate help (Drug Strategies, 2003).
Literature Review

Harm Reduction HR

Hippocrates writing in the 5th century B.C. advises arriving in a new city prepared to examine the surroundings and determine whether it is a place they would consider “healthy”. Observe the behavior of the people living there. Do they work hard and exercise or do they indulge in excessive behaviors? Evaluate the geography and water supply. These thoughts and expressions were an early attempt at a harm-reduction approach to living.

Marlatt writes in the book Harm Reduction (1998), that observing individuals as responsible for their own choices and as both agents and receivers of environmental influence is central to the harm reduction theme.

He outlines in the book,

1. Harm reduction is a public alternative to the moral, criminal and disease models of drug abuse and addiction.
2. Harm reduction recognizes abstinence as an ideal outcome but accepts alternatives that reduce harm.
3. Harm reduction has emerged primarily as a “bottom up” approach based on addict advocacy, rather than a “top down” policy promoted by drug policy makers.
4. Harm reduction promotes low-threshold access to services as an alternative to traditional, high-threshold approaches.
5. Harm reduction is based on the tenets of compassionate pragmatism versus moralistic idealism (pp. 49-56).

Harm reduction emerged from a public health position, explained as an option to the moral and criminal disease models of substance use and abuse. Harm reductionists accept the reality that some people will participate in alcohol and drug use and the perfect picture of a drug-and alcohol-free society is wishful thinking. A ‘zero tolerance’ philosophy has defined most alcohol and drug treatment programs in the U.S. accepting only a lifelong commitment to abstinence and participating in a Twelve-Step recovery group as the primary forms of treatment.
With the disease model approach, abstinence is a requirement upon entering a rehabilitation program; this illustrates a high-threshold approach which can be an obstacle to many who are seeking help. Treatment providers and receivers partner and collaborate to construct a low-threshold approach that promotes ‘meeting the client where they are’ rather than ‘where they should be’.

A pragmatic approach to harm reduction is based on the premise that harmful behavior occurs, and it always will. It is based on a philosophy that is humane and compassionate similar to the person-centered approach theory of Carl Rogers, among others.

Instead of judging those as good or bad with substance abusing behaviors (often portrayed by moral idealists), harm reductionists’ ask the questions: To what extent are the consequences of the individuals’ behaviors harming themselves or others? What can be done to reduce these harmful consequences? (Marlatt, 1998).

Most drinkers in the United States report their highest level of alcohol consumption in their late teens to early twenties, making the high school and college years a “high risk window” for drinking-related injuries and problems (Marlatt, pp.94, 1998). Harm reduction attempts to lessen the negative consequences associated with the choice.

Australian researchers view harm reduction as the scope that spans between the extremes of prohibition and legalization, realizing the harmful effects to the individual and community, while understanding that a complete restriction of drug and alcohol use is an impractical goal. Bonomo and Bowes (2001) develop a relevant and consistent message about adolescent substance use, aiming to minimize drug related harm. Treatment programs need to consider that acceptable and achievable goals can include treatment for mental health and a reduction in
alcohol use to reasonable levels, placing an emphasis on the elimination of underlying substance-related problems.

Investigators (Bonomo & Bowes, 2001) suggest using harm reduction with substance abusing adolescents in an appropriate social and developmental context to reduce the risk of harm. They advocate a multidisciplinary comprehensive approach to include medical, mental health, social work and youth services. Harm reduction appears to have emerged as a viable and workable strategy to assist youth in reducing the risk of substance abuse.

**Harm Reduction-Key Elements**

**Assessment and Treatment matching.** Harm reduction matches the client to the appropriate treatment needs. Motivational interviewing/enhancement techniques will determine how motivated the client is and how willing he or she is to commit to rehabilitation. Harm reduction methodology does not depend on one specific evaluation measurement but utilizes a variety of techniques to determine client readiness. Community and social services are recommended to assist the client when he or she has made the commitment for change.

**Comprehensive, integrated treatment approach.** Harm reduction incorporates a comprehensive approach to treatment. Communities’ resources are offered to the client to ensure that individual needs are met. Advocates of the harm reduction technique acknowledge that abstinence is the ultimate goal for many substance users; however, they understand that individuals’ are unique and are at different motivational stages. A ‘one size fits all’ approach is acknowledged as ineffective for supporters of harm reduction. Adolescents that have both substance use and mental health problems are encouraged to see a harm-reduction psychotherapist. Motivational interviewing (MI) and Brief Intervention (BI) are techniques that work together and to uncover ambivalence and to encourage the client toward change. Harm
reduction is a comprehensive term that reaches across a broad number of modalities to offer treatment flexibility for the client (Marlatt, 1998).

**Family Involvement in Treatment.** Family involvement is encouraged. Harm reductionists understand the importance of family involvement with adolescents during the rehabilitation process.

**Developmentally Appropriate.** The harm reduction approach notes the importance of developmental appropriateness for adolescents when structuring a treatment program. The pragmatic approach recognizes adolescent psychosocial development and notes curiosity and experimentation as examples that can impact teenage decision making. It notes that traditional rehabilitation programs promote non-use as normative and equate use with abuse.

**Engaging and Retaining Teens in Treatment.** Harm reductionists encourage adolescents to gather at schools or get together in homes to discuss the effects of substance use and abuse. They can talk openly and honestly about their own substance use without judgment from the facilitator. It is believed to be important to let the group discuss their real life experiences with alcohol and drugs and to brainstorm ways of responsible and safe use, and avoid telling adults what they want to hear as opposed to speaking openly and honestly about substance use. This type of venue usually educates the teen about risk reduction and keeps them interested by being active in the conversation.

**Qualified Staff.** Specific staff credentials are not emphasized, except it is noted that a harm reduction therapist is considered a psychologist, a graduate level clinician.

**Gender and Cultural Competence.** The harm reduction approach calls for consideration of each culturally diverse community to consider healthcare, a stable living environment, a spiritual connection, self-determination, personal choice, and individual goal-setting, as
determined by the cultural group. Well-intended white harm reductionists have (in the past) mimicked patterns of white dominance/black submission in attempts to work with African American clients. Every individual and ethnic group sees the world through a different lens (Marlatt, 1998).

**Summary.** Harm reductionists assert that not all drug use is abuse and that substance use problems exist on a continuum from the very minor to the very fatal. Reductionists realize the embedded roots in America that surround abstinence and the disease model of addiction. They believe that an individual who chooses to use substances should be free of stigma and shame that accompany free choice. Reductionists recommend being educated about substance use and knowing how to take care of oneself and assume responsibility for one’s own actions. Harm reductionists differ in philosophical orientations from the traditional abstinence/disease methodology. Reductionists believe alcohol and drug abuse may be indicative of a troubled lifestyle.

Abstinence advocates believe if alcohol and drugs cause trouble in your life you are an addict. Reductionists do not necessarily believe that once a person admits to an addiction that the admission means forever. They understand that some people can quit for awhile and then moderate their substance use. Abstinence believers advocate ‘once an addict, always an addict’ and people cannot ever moderate their substance use. Most importantly, harm reductionists understand the complexities of human beings. Their goal is to meet clients where they are in an effort to minimize harm (Marlatt, 1998).

**Motivational Interviewing MI & Brief Intervention BI**

Ready or not here comes change. Nothing remains static, from a planetary to a molecular level. Prochaska, Norcross, & DiClemente (1994) suggest that humans can influence and
intentionally change many parts of their lives; they can improve economic conditions, living
environments, thoughts, feelings, and behaviors. Facilitating change through motivational
interviewing offers a way to conceptualize and deal more effectively with problems of client
resistance and ambivalence and to move clients into a commitment to change behaviors.

Addiction is a motivational disorder, a disease of the ‘will’, and self destructive (Heather, 2005).

The theoretical assumption for motivational interviewing is grounded in an integrated
 counseling approach based on several types of therapies and empirical observations (Winters et
 al, 2007).

Investigators have found that counselors with behavior traits such as empathy,
genuineness, acceptance and warmth have a positive impact on clients. Counseling attitudes like
non-acceptance, judgment, and negative confrontation reduce the therapeutic effect and have
shown client harm. The developments of social learning theories have helped to expedite the
realization and the impact of the external environment and the individual’s interactions in
motivation for changing drinking behaviors. The transtheoretical model of behavior change
(Tevyaw et al., 2004), brought about insight and attention to a series of stages or steps that
promote motivation to change and also recognize that some individuals may be at different
stages along the continuum of change. Cognitive behavioral therapy includes interpersonal skill-
building that promotes relapse prevention.

Motivational enhancement interventions provide a plan for determining how ready the
client is to change his or her behavior, and for treatment matching intervention. Motivational
interviewing and brief intervention techniques work best with a population who are not
chemically dependent and are able to reduce their substance use as a therapeutic method. They
are based on the hypothesis that individuals who are motivated from within will experience
greater change rather than when others attempt to force it. They promote empathy for clients who are ‘stuck’ in a particular stage of the process rather than viewing resistance as pathological. An individual needs to be accountable and take ownership and responsibility for change. This method has shown to have a positive influence on substance using adolescents and adults by reducing health risk behaviors.

Prochaska, Norcross, and DiClemente (1994) established and implemented techniques based on six stages of change. They include: precontemplation, contemplation, preparation, action, maintenance, and termination. The stages of change represent the way someone can move through the change process. The idea is that an individual can be at a particular stage of change that is predictable and well-defined. Each stage takes place in a course of time and involves certain tasks that need to be accomplished before moving to the next one. Completing one stage does not mean you will automatically advance to the next; some people become stuck in one stage or another.

Precontemplation is a stage when a person cannot see that a problem exists and has no intention of changing. Contemplation is when a person acknowledges that there is a problem and has a desire to make a change. Preparation is planning on taking action in the next month or so. The individual may make a public announcement about it. Action happens when he or she make a move on their plan of preparation and the behavior is overtly modified. Maintenance means there is an attempt to prevent relapses and the client realizes that change does not end with action. If a client needs to he or she can start over at the beginning and recycle through all of the stages again. Termination means the temptation is gone and the problem behavior has dissipated, a lifetime of maintenance is required (pp.39-46).
The term *brief intervention* is often used interchangeably with motivational interviewing. It should not be confused with traditional treatment addressed in a faster, shorter or abbreviated time frame. Brief intervention is a method that targets problematic behavior in a short-term approach (Tevyaw & Monti, 2004). The common elements of useful brief interventions are defined by the acronym FRAMES: *feedback* or evaluation results that highlight the target behavior and its’ consequences, *responsibility* for change, *advice* on how to change, providing a *menu* of options for change, *expressing empathy* through behaviors of caring, understanding and warmth, *self efficacy* for change and encouragement that change can happen. Four broad principles are used by therapists’ to guide the conduct of the client interview: *empathy*, *developing discrepancy*, *rolling with resistance*, and *self-efficacy*. Brief interventions generally include four to five one-hour sessions that can be held in hospital emergency rooms, a physician’s office, a therapist’s office, schools, jails, and other correctional settings. They are led by substance abuse professionals, therapists, counselors, and doctors.

The adolescent stage of development epitomizes change (CABL, 2006), as the pursuit of autonomy increases during this life phase. Teens are seeking a sense of independence, to develop their voice and their point of view. They often challenge rules and authority by arguing or differing with parents and other dominant figures. Motivational enhancement techniques deflect power struggles and unfavorable confrontations. Brief and motivational methodologies, provide a view of adolescents as individuals who have independent thoughts and ideas that are (usually) different from those of teachers, parents and other persons of authority. The bulk of teens never come to the attention of substance abuse treatment professionals. Motivational interventions do not require client ownership of the problem like some traditional 12-Step therapy methods use. Teens do not need to admit to a problem to benefit from motivational techniques. They can be
applied during a full range of client readiness situations. Considering the teen years and the confusion they can bring, brief intervention with motivational interviewing techniques has been an effective method to help those tackling substance use (Teyyaw & Monti, 2004).

Motivational Interviewing Key Elements

Assessment & Treatment Matching. Motivational and brief enhancements utilize a variety of assessment measurements to determine client motivation. Materials used by MI practitioners include: AUDIT (Alcohol Use Disorders Test), Readiness to Change Questionnaire, and DAP (Drug and Alcohol problem Quick Screen), ADI (Adolescent Diagnostic Interview), TLFB (Timeline Follow Back), PCS (Personal Consequences Scale), and TSR (Treatment Services Review) to name a few. Evaluations like these can help place and match clients into the appropriate treatment.

Comprehensive and Integrated Treatment Approach. Five manual guided treatment models successfully integrated methods to produce an effective treatment protocol (Diamond, Godley, Liddle, Sampl, Webb, Tims, & Meyers, 2002). They include motivational enhancement therapy, cognitive behavioral therapy, family support network, adolescent community reinforcement approach, and multi-dimensional family therapy. This approach utilizes a comprehensive systemic opportunity to reach teens and their families. It incorporates the motivational interviewing principles (empathy, discrepancy, avoid arguments, roll with resistance and support efficacy) that are essential to building a client/therapist relationship.

Family Involvement in Treatment. Winters & Leitten (2007) reported that family involvement increased intervention effects when compared to those without family interaction. It is suggested that family involvement helps to increase family education and treatment retention, to promote recovery and reduce relapse, and to diminish barriers to treatment. Family therapy
treatment also includes developmentally appropriate connections between adult and teen. It helps to increase family organization, warmth and emotional investment, with the aim of re-establishing the family connection (Diamond et al., 2002).

**Developmentally Appropriate Program.** Motivational interviewing with brief intervention is tailored to the specific concerns and developmental stage of the client (Winters et al., 2007). This approach is fitting for youth because brief interventions are less confrontational than what teens are used to hearing from parents and teachers. The issue of ‘ownership’ of the adolescent substance use problem is not an issue with motivational enhancement as it is for other methods like Alcoholics Anonymous (AA). Teens do not need to admit to having a problem in order to benefit from MI techniques. Some 12-step recovery groups used in treatment require the individual to concede to having a problem when he or she does not admit to it. Because of their adolescent developmental status (Kelly, Ph.D.), teens usually have less addiction severity and do not understand the spiritual/religious principles inherent in AA/NA.

**Engage and Retain Teens in Treatment.** Motivational interviewing and brief interventions have shown success with reductions in alcohol consumption in college-age students (Teyyaw & Monti, 2004). Recent research has shown that teens who attended a single motivational enhancement session had a greater reduction in substance use compared to those receiving treatment as usual (Winters et al., 2007). Brief interventions are typically an action-oriented approach that promotes a cognitive behavioral emphasis like refusal skills rather than a highly didactic lecture-oriented method. Action-oriented interventions usually improve relevance treatment engagement.

**Qualified Staff.** It has been noted that motivational interventions can be delivered by a variety of providers with an assorted background including: medical doctors, therapists, school
counselors, and criminal justice professionals who are appropriately trained and are not opposed to implementing harm reduction goals (Winters et al., 2007).

**Gender and Cultural Competencies.** A study called *Alcohol Treatment Targeting Adolescents in Need (ATTAIN)*, conducted by several investigators researched the effectiveness of a brief motivational, cognitive behavioral intervention (Gil, Wagner, & Tubman, 2004). The participants include African American and Hispanic youth. The findings underscored the reduction in alcohol and marijuana use for both groups. Research found that foreign born Hispanics are less likely to participate in substance use than their second-generation US-born counterparts. The authors reported this study as preliminary and in its early stages.

**Summary.** Winters & Leitten (2007) reported that federal and state programs have invested more interest and money on prevention programs that serve the group of ‘little or no’ substance use and the group that need specialist (rehabilitation) treatment. Less attention has been placed on the (large) group of individuals that do not fall into either category but need to reduce their alcohol and drug use. Brief interventions provide an option to these midlevel substance abusers for those who do not meet the DSM-IV-TR criteria for substance dependence.

**Adolescent 12-Step Treatment Model**

Based on a 1998 national study, 90% of 450 treatment centers used the 12-Steps of Alcoholics Anonymous as a primary treatment method. One half of the remaining 10% incorporated the 12-Step model in combination with other methods and the recommendation of attendance at 12-Step meetings (Kelly, Myers & Brown, 2000). Prior research has revealed the developmental differences that necessitate the importance of different treatment strategies between adults and teens. There has been little investigation surrounding the effects of 12-Step treatment on adolescents. One of the criticisms of this approach suggests that the abuse of
substances is the primary cause in the clinical presentation. Chances are substance abuse is only
one part of a larger more complicated problem behavior pattern that the 12-Step approach does
not cover.

Psychopathology has historically been based on adult models. Children’s mental health
has unjustly developed into an extension of the adult model and teens have been viewed as “mini
adults”. Adolescents present different issues with alcohol and drug use. Compared to adults some
teenagers use less frequently, show fewer dependence signs with less medical and withdrawal
symptoms.

A few studies (Kelly et al., 2000) have shown some success (continued sobriety) with the
12-Step meeting attendance at 6 and 12 months post-treatment. One report not involving a
random assignment indicated that adolescents who completed a 12-Step Minnesota Model
(abstinence based) treatment program showed more success at 6 and 12 months post-treatment
than did those who did not finish treatment (Winters et al., 2000). Important to the outcome of
the study was treatment retention.

Investigators noted that treatment retention is an important contributor to a favorable
outcome, much more so than previous studies. It is also noted that more studies are needed to
reports adolescents who attend 12-step meetings with adults have difficulty identifying with
topic issues (marital problems, employment concerns, and severity of substance abuse) which
can interfere and diminish the therapeutic effects of the 12-step group meetings. According to the
demographic data collected from Alcoholics Anonymous Membership Survey of 2001, it reveals
the average age of membership is 46 years old, with only 2% of membership included 21 years
of age or younger (Kelly et al., 2005).
Youth treatment needs are different from adults. It is noted that there is a difference in substance use patterns with shorter drug use histories and more involvement with binge drinking of alcohol and marijuana abuse (Winters et al., 2000). Specialized treatment approaches are encouraged with adolescents to include appropriate developmental considerations like rapid physical and social changes that occur with multiple life challenges. The most promising methods to treat adolescent substance abuse appear to include a variety of factors: social, emotional, family and cognitive behavioral.

Investigators also found motivation to be an important characteristic to consider with teens. The degree of wanting help upon entering treatment from intake to post-treatment significantly explained preparedness for action. This explains motivation to be a principal factor that serves as an incentive for behavioral change in teens, overriding the need for specific abstinence-focused skills (Kelly et al., 2000). A myriad of studies with adult populations have indicated there is no consistent right or perfect approach to treating psychoactive substance use disorders that is equal to everyone, this appears to be a factor for adolescents.

Adolescent 12-Step Treatment Model-Key Elements

Assessment and Treatment Matching. Evaluations used in the literature reviews include: Timeline Follow-Back (TLFB) Procedure, Personal Experiences Inventory, Structured Clinical Interview for Adolescents, and (DTCQ) Drug Taking Confidence Questionnaire (Kelly et al., 2000). These instruments do not represent a comprehensive assessment treatment matching procedure.

Family Involvement in Treatment. Family involvement includes joining together with other parents of teens in treatment to receive weekly psycho-education. The educational platform usually involves group therapy lectures to include, substance abuse education, effective
parenting skills, setting appropriate boundaries, and client progress. It also offers a chance to connect with other parents for support.

**Qualified Staff.** Most 12-Step treatment programs employ counselors who have several years of sobriety with at least a Bachelors’ Degree in psychology. More states are requiring a minimum of a Master’s Degree to provide substance abuse therapy.

**Continuing Care.** Traditional 12-Step substance abuse treatment programs have incorporated the (RPT) Relapse Prevention Therapy (1985) by Marlatt and Gordan. This model is a cognitive behavioral approach to relapse prevention. It includes education and skill development to protect against high-risk situations like: emotional risks, anger management, feelings of loneliness and boredom, and how to manage social pressures. **Summary.** Current research suggests that adolescents who are involved in residential (intensive) treatment seem to find the 12-Step AA/NA meetings helpful. Other findings suggest that youth may benefit from attending AA/NA meetings following treatment however, the research is limited by four important areas: *limited number of empirical studies, no outpatient treatment samples, current findings come from observational samples, and only partial measurement of the 12-Step construct* (Kelly & Myers, 2007). More research is needed to determine if this type of treatment is effective.

**Brief Strategic Family Therapy**

The strategic model system approach advocates an efficient and technical orientation that tends to be brief and non-pathological in nature. The fundamental assumption is that the family is the foundation of child development. Strategic therapies developed from the work of Palo Alto
research group projects of 1952-1962. Family communication strategy emerged from Gregory Bateson and his colleagues who analyzed conversation patterns in families with schizophrenic members (Goldberg & Goldberg, 2008).

The systemic goal is typically active, highly focused, short-term methods that try to mobilize the family system and focus on solutions to problems. BSFT is based on three principles (Szapocznik et al., 2003).

1. Family systems mean that family members are interdependent. What affects one family member affects other family members. An adolescent who is drug using who displays symptoms and related co-occurring behaviors may be indicative of what else is going on in the family.
2. Patterns of interaction in the family influence the behavior of each family member and habituate over time.
3. BSFT is to plan interventions that carefully target and provide practical ways to change those patterns of interaction (pp.1-2)

Brief Strategic Family Therapy is an adaptable systemic methodology that can be applied to various settings that include mental health clinics, substance abuse treatment centers, and other social service programs. Its’ focus includes multiple domains of adolescent and family functioning to include: school, neighborhood, peers, and community resources. BSFT was initially developed to treat Hispanic youth and families, but it has evolved to include individuals and families across different ethnic and cultural groups (Macgowan and Wagner, 2005). The strengths of this approach can be summed up to include the following: maintains supportive systems in the family, individualized to meet diverse needs, implement in 8-24 sessions, effective and evaluated program for treating adolescent drug abuse, conduct problems, and impaired family systems, available training for counselors, and it appeals to cultural groups that emphasize family and interpersonal relationships (Szapocznik et al., 2003).
The BSFT method advocates a strategy that is described as *The Three P’s of Effective Strategy*. This involves the therapist to be practical, problem-focused, and planned. The counselor will use a variety of practical techniques to change the maladaptive interactions that contribute to or sustain the family’s presenting problem.

The BSFT professional chooses to work on problem-focused maladaptive interactions or to enhance existing adaptive behaviors. This style does not elaborate on all of the family problems that are not directly affecting the adolescent drug use. A choice needs to be made about what to focus on first as part of a time-limited counseling program. The therapist will help to change the nature of those interactions that are problematic and play the role as an observer and act as a guide to facilitate the communication process to bring about awareness of how the family relates to one another. This experience can help navigate the change process to secure resolution skills and transfer their new problem solving technique to other problems they may be facing. The counselor will decide where the problem interactions are and begin the planning stage of this process and craft a well-organized plan to begin the therapeutic growth (Szapocznik et al., 2003).

The Brief Strategic Family Therapy approach to assessing and diagnosing family system problems vary greatly from other kinds of therapies. Szapocznik et al, (2003) writes about how the BSFT therapist will focus on the interactions of the family members and spend less time on family history. The counselor will check for appropriate boundaries, leadership roles and triangulation. The BSFT facilitator will examine the roles and tasks that have been assigned to each family member and take into account the cultural heritage before making any judgments.

The counseling approach indicates the importance of the therapeutic relationship and how this can be a predictor of outcome success. The therapeutic relationship is built upon a mutual cooperative, collaborative, and optimistic partnership. The counselor assumes the role of both
member and leader, keeping in mind the importance of holding positive relationships with all family members who may be hostile with one another. The therapist will learn how the family interacts with each other and uses the information to establish a treatment plan. The plan will include a practical focus to include ways to eliminate the patterns that have contributed to the maladaptive behaviors (Szapocznik et al., 2003).

**Brief Strategic Family Therapy-Key Elements**

**Assessment and Treatment Matching.** Brief Strategic Family Therapy approaches the assessment process with five structural domains that include: *structure, conflict resolution, resonance, developmental stage,* and *identified patient hood*. BSFT has maintained a consistent focus on the centrality of ‘within family’ work. Some measurement tools used during the BSFT counseling process include: *Baseline Demographics Form, Diagnostic Interview For Children Predictive Scales (DISC), Addiction Severity Index, Parent Demographic Form, Brief Symptoms Inventory, Urine Drug Screens, Breath Analysis, Timeline Follow Back (TLFB), HIV Behavior Risk Survey, National Youth Survey, Pittsburgh Youth Survey, Youth Self Report, Comprehensive Adolescent Severity Index, Adverse Events, Service Utilization Review, Working Alliance Inventory, Revised Behavior problem Checklist,* and *Family Environment Scale* (Shea, 2009).

**Comprehensive and Integrated Treatment Approach.** BSFT centers on the foundation that the family is the foundation of child development. It covers multiple domains of adolescent and family functioning, including relationships with school, neighborhood, peers, and community resources (Austin et al., 2005).

**Family Involvement in Treatment.** Brief Strategic Family Therapy includes the family members whenever possible and defines the family as the central theme to therapy. Family
therapy approaches adolescent substance abuse from an ecosystems perspective, to include developmental, family, social, and community and cultural needs (Austin et al., 2005).

**Developmentally Appropriate Program.** The BSFT approach to substance abuse treatment emphasizes the importance of addressing the developmental needs of both the adolescent and family. Diagnosing the family problem includes taking into consideration the individual and family stage of development.

**Qualified Staff.** Counselors are usually trained at the master’s level of education with a license in social work or marriage and family requiring clinical skills and work experience in family therapy. Individuals with a bachelor’s degree who have extensive family experience can qualify.

**Gender and Cultural Competencies.** BSFT was developed at the Spanish Family Center for Family Studies, University of Miami. This approach has been practiced there since 1975. The Center is the oldest and most prominent center for research and development of minority families, for prevention and treatment of adolescent substance abuse and related behavior problems. It is the nation’s leading trainer of research-proven family therapy for Hispanic families (CSAP, 2001).

**Treatment Outcomes.** Treatment outcomes include: reductions in substance use, negative attitudes and behaviors, improvement in conduct problems, improved family cohesiveness, conflict resolution, and problem solving skills (CSAP, 2001).

**Multidimensional Family Therapy (MDFT)**

Multidimensional Family Therapy is an outpatient, family based treatment developed for clinically referred adolescents with substance abuse and behavioral problems (Liddle, 2002). The treatment program is not a narrowly based approach. It has been operational in different
treatment applications including treatment length, intervention locale, and inclusion of particular therapeutic methods and formats. The protocols have been exercised in a variety of settings. The MDFT treatment avenue has evolved and been tested since 1985 in several randomized clinical trials at various urban locations in the United States. The populations studied were ethnically diverse, high-risk adolescents including both males and females with co-occurring disorders referred from juvenile justice officers.

MDFT is included in NIDA’s list of empirically supported drug treatments and in the American Psychological Association’s Division 50 issue on empirically supported drug therapies in *The Addiction Newsletter* (2002) and is considered an evidence-based therapy (Liddle et al., 2006). The theory is developed from the strong traditional models of family therapy of Minuchin and Haley to include Structural and Strategic Family Therapy influences.

Multidimensional Family Therapy method is a family based ecological, multiple systems approach. It is comprehensive with a stage-oriented counseling process. The treatment concentrates on the individual characteristics of the adolescent to include: temperament and attitude, perceptions about harmful drug use, emotional management, communication patterns, and problem behaviors. Its focus is on the contemporary empirical knowledge base of risk and protective factors and known determinants of adolescent substance abuse (Liddle, 2002).

Dimensions of Multidimensional Family Therapy include: *outcome, process, development, problem behaviors, ecology, psychotherapy, family therapy, and treatment parameters* (Liddle, 2002). *Outcome* refers to the therapist asking the therapeutic question “What are the optimal and ‘good enough’ outcomes in this interchange?” *Process* attributes to the way change is facilitated and hoped for. *Development* is the knowledge base of therapeutic work. Therapists understand the developmental changes in the teen and the parent-adolescent
relationship. *Problem behaviors* are understood as deviations from the stages of normal development. *Ecology* refers to the therapists’ inclusion and understanding of the integration of multiple levels of intervention and functioning in social ecologies outside their families. *Psychotherapy* pertains to the influence and the variety of therapeutic interventions to include behavioral and client-centered therapies that have altered the chemical dependency and drug counseling approaches and impact the MDFT process. *Family therapy* and MDFT has its roots in structural and strategic family therapies developed by both Minuchin and Haley. Several areas of influence include: problem solving therapy, principles of change and development and the thinking of stages of change and intervention. *Treatment parameters* refer to the structural or organizational ways of providing treatment. The MDFT approach suggests that therapists remain flexible in their approach in providing treatment (in home, clinical settings, schools, telephones etc.) It is important not to let traditional therapeutic limits interfere with the essential needs of the multiproblem adolescent and their families (Liddle, 2002).

MDFT has been formulated to consist of 16 total sessions to include four modules in three stages over 12 weeks that cover the adolescent, parent, family interaction, and extra familial systems. Individual and family sessions are incorporated throughout the treatment process. Liddle (2002) has outlined ‘Principles of Multidimensional Family Therapy’ that are defined as fixed or predetermined rules guiding clinical orientation and behavior.

1. Adolescent drug abuse is a multidimensional phenomenon
2. Problem situations provide information and opportunity.
3. Change is multi-determined and multifaceted.
4. Motivation is malleable.
5. Working relationships are critical.
6. Interventions are individualized.
7. Planning and flexibility are two sides of the same therapeutic coin
8. Treatment is phasic, and continuity is stressed.
9. The therapist’s responsibility is emphasized.
10. The therapist’s attitude is fundamental to success (pp.14).

Similar to the BSFT approach, it is important to establish therapeutic alliances with all family members and any other sources that could influence the counseling process. A comprehensive assessment to include various social systems is evaluated to understand the adolescent’s history from multiple perspectives. Interventions with the adolescent and the family members attempt to renew the relationship by reconstructing a foundation and develop a new pattern of communication. Therapists coach the family to develop new problem solving skills to learn new ways of relating to one another.

The counselor will work with the adolescent and the family to educate and enrich communication skills, parenting practices, and the understanding of adolescent development. The therapist will also assist in job development and HIV/STD education. Individual sessions focus on current difficulties the teen is experiencing in school, in their family and relationships (Liddle et al., 2006). Family sessions with parents and the adolescent focus on everyday events that occur in family relations.

During the rehabilitation process the multidimensional family therapist (MDFT) will make an effort to help the teen to examine their substance use habits and discuss the impact it is having on their life and will do what it takes to support the adolescent in a recovery process. The professional counselor will take an initiative and connect with community resources in hopes to assist the family in need.

**Multidimensional Family Therapy-Key Elements**

**Assessment and Treatment Matching.** Multidimensional Family Therapy evaluates each adolescent’s risk factors such as school failure, parental drug abuse, and connection with drug using peers. The family assessment includes an understanding of family conflict as well as
examining the protective factors to check for family bonding. Evaluation instruments utilized
during this process can be the *Timeline Follow-Back Method*, a retrospective report of daily
substance using a 30-day calendar and other memory prompts to help the teen recall substance
use. *Urine Screens* can also be used at the assessment to check for any drug use (Drug Strategies,
2003).

**Comprehensive, Integrated Approach.** Individual and family counseling sessions are
flexible and can take place in a variety of settings. The family and individual usually meet with
the therapist anywhere from one to four times a week for four to eight months depending on the
magnitude of the intervention being used. MDFT views any interaction between the members an
opportunity for treatment. Families will meet in court rooms, visit at a local park or meet where-
ever it is convenient to discuss issues that are important to enhance trust between therapist and
family (Drug Strategies, 2003). Multidimensional family therapists (MDFT) will work with
multiple social systems to ensure that therapeutic needs are met.

**Family Involvement.** MDFT counselors will work diligently to involve family members
in the therapeutic process. Treatment providers understand the importance of the parent/teen
relationship and the powerful protective factor it offers against substance abuse. Therapists will
help parents work through any personal substance abuse or mental health issues that need to be
addressed and teach parenting skills and target the family environment as a whole (Drug
Strategies, 2003).

**Developmentally Appropriate.** MDFT strives to encourage the adolescent’s functioning
in multiple domains at the relevant stage of development that was interrupted by substance
abuse. Therapy is aimed at the emotional and developmental maturity rather than chronological
age. Therapists teach parents how to parent for that specific age and how to change parenting as
the teen matures. Counseling sessions include identity formation, peer relationships, and school and daily coping skills (Drug Strategies, 2003).

**Engage and Retain.** Drug Strategies (2003) reports retention rates have been successful partly due to incorporating the family for intensive forms of family therapy versus ‘treatment as usual’. Therapists work hard to identify and develop the teen’s treatment goals and outline how the program can help meet those goals. Treatment includes incorporating the family and discussing together their past hopes and dreams for the teen and family. This can help to motivate the parents to ‘try again’ and not to give up.

**Qualified Staff.** MDFT therapists are required to have at least a master’s degree with two years of experience in family-based interventions. Professional counselors are required to complete 100 hours of model-based training and a weekly clinical supervised review session (Drug Strategies, 2003).

**Gender and Cultural Competence.** MDFT approaches gender and cultural issues on an individual basis. Therapists incorporate the use of media, print materials, videos, DVD’s and other publications to use as teaching tools to help bridge the family’s cultural divide (Drug Strategies, 2003).

**Continuing Care.** Most MDFT clinics offer an aftercare program. Some clinics suggest 12-Step meetings and others educate clients about triggers and relapse. Some may refer to a less intensive program (Drug Strategies, 2003).

**Outcomes.** The MDFT program has substantial amount of research from four randomized clinical trials and several therapy process studies that illustrate its’ effectiveness with positive results in symptom reduction.
Co-Occurring Disorders-Integrated Treatment

Co-occurring disorders (COD) refers to clients having one or more disorders relating to the abuse of alcohol and other drugs as well as one or more mental disorders (Center for Substance Abuse Treatment, 2005). A diagnosis takes place when at least one disorder of each type can be determined independent of the other and is not a collection of symptoms resulting from the one disorder. Some may speculate that COD means that a person has a severe mental illness (like schizophrenia) in conjunction with a substance abuse disorder like alcohol dependence. Often counselors working in an addiction clinic see clients with a chronic addiction problem coupled with a mild to moderate mental health disorder like anxiety or depression. Psychiatric problems of adolescent substance abusers in an outpatient treatment study (Diamond et al., 2006) found that 57% were diagnosed with conduct disorder (CD), 13% with attention deficit hyperactivity disorder (ADHD), and 14% with major depressive disorder (MDD).

The past two decades have shown improvement in the treatment of co-occurring disorders (CSAT, 2005). Practitioners in the 1970’s began to see a correlation between mental health and substance abuse disorders when providing treatment. The connection between depression and substance abuse was the most forthcoming and became an interest and the subject most explored. Research discovered that depression was not the only mental health disorder associated with substance abuse but a wide range of mental health disorders existed. During the 1980’s and 1990’s it was reported by substance abuse professionals that 50 to 75 percent of clients had some type of co-occurring mental disorder and the studies in the mental health settings reported that 20 to 50 percent of their clients had COD. It was time to begin thinking about a plan and best methodologies that would help this type of client.
In 2005, The Center for Substance Abuse Treatment (CSAT) developed a Treatment Improvement Protocol (TIP 42) to help practitioners to work effectively with the co-occurring disorder client (COD). They established a list of guiding principles to serve as essential building blocks for programs that offer services to clients with COD. The principles come from a variety of sources: program models, understanding of essential components of COD, clinical experience, and empirical evidence. There are six guiding principles to help guide the treatment process: employ a recovery perspective, adopt a multi-problem viewpoint, develop a phased approach to treatment, address specific real-life problems early in treatment, plan for the client’s cognitive and functional impairments, and use support systems to maintain and extend treatment effectiveness.

**Employ a recovery perspective.** The main perspective of COD recovery is the acknowledgement that recovery is a long term process of internal change. A treatment plan needs to employ a continuity of care over time and the professional clinician understands that recovery process may take place in different settings (outpatient, residential) and is advised to use a reasonable stepwise approach. Individual considerations that are unique to each person such as: cultural, social, or spiritual are meaningful and need to be considered throughout the treatment and recovery process.

**Adopt a multi-problem viewpoint.** Most people who present for COD services usually have a combination of issues that need to be covered. Most clients need rehabilitation and treatment should include support for a variety of issues depending on age and circumstance.

**Develop a phased approach to treatment.** Engagement, stabilization, treatment and continuing care are the effective and essential phases that are included in COD recovery process.
Motivational Enhancement Therapy has been effective when working in a phased approach to recovery.

**Address specific real-life problems early in treatment.** It is important to implement specialized treatment interventions to assist the client in their personal and social lives. Helping them with money management or housing is an example of keeping the client engaged in the recovery process while they solve existing problems.

**Plan for client’s cognitive and functional impairments.** Some clients may have a learning disability or some other functional concern that may need to be addressed in the treatment plan. Careful assessment and individualized treatment planning is essential to client improvement. It may be necessary to shorten the counseling session and/or it may be important to incorporate educational tools to help the client adjust and understand.

**Use support systems to maintain and extend treatment effectiveness.** Family, faith community, self-help groups within the client’s community can play a vital role in the client’s recovery. There can be a stigma attached to having a substance abuse or mental health problem. Families can be alienated by the community because of past behaviors. The clinician can play a vital role in helping the client to find outside support (CSAT, 2005).

Many adolescent substance abusers believe they can quit whenever they choose to and some do. Others believe their use is ‘normal’ and some is. Many teens will display a different pattern of substance use than adults. Reports show that teens experience more episodic and binge using than adults experience (Stevens, Schwebel, and Ruiz, 2007). Some teens may be abusing drugs and alcohol to cope with life and therefore believe that their life would not be better without substances.
The Seven Challenges Program

Developed by Schwebel (2007) believes that an adolescent treatment program must be developmentally appropriate based upon psychological research and science to assist the client in the change process. The Seven Challenges Program has been defined as an evidence-based program. It was studied and published in peer reviewed journals and demonstrated the effectiveness of The Seven Challenges as a “co-occurring” program, that decreases substance use of adolescents and greatly improves overall mental health. The author advocates for a holistic methodology that includes co-occurring problems and life skills enhancement development with sensitivity to various cultures. Dr. Schwebel has worked with the minority groups of African American, Hispanic, and Native American youth while developing the program in 1991 (Stevens et al., 2007).

The Seven Challenges (Stevens et al., 2007) succeeds in working with youth by placing a special emphasis on creating a climate of mutual respect where individuals can openly discuss private topics honestly about themselves. The overarching framework of the program is based on the cognitive/emotional public health model of decision-making in which individuals weigh the benefits versus the costs of certain behaviors such as drug use. The heart of the program consists of seven distinct challenges which are worked through in treatment.

**Challenge One.** “We decided to open up and talk honestly about ourselves and about alcohol and other drugs”. Honesty and openness allows for a constructive dialogue between clients to allow an opportunity for healthy, informed decision-making and behavior changes.

**Challenge Two.** “We looked at what we liked about alcohol and other drugs, and why we were using them”. This challenge allows the client to dissect the reasons why they use substances and what needs they are attempting to satisfy and what they are getting out of it.

**Challenge Three.** We looked at our use of alcohol or other drugs to see if it had caused harm, or could cause harm”. Clients exploring this challenge look at what harmful behaviors could result from substance abusing behaviors like: drinking and driving, promiscuity, and breaking the law.
Challenge Four. “We looked at our responsibility and the responsibility of others for our problems”. This challenge allows the teen to examine their own shame and guilt to see if it is legitimate and to examine if he or she is blaming others for all they have done. Those who experience excessive shame or externalize all responsibility for problems often find it difficult to acknowledge their own mistakes and move forward towards healing.

Challenge Five. “We thought about where we seemed to be headed, where we wanted to go, and what we wanted to accomplish”. The fifth task is the developmental challenge of anticipation and a look ahead to adulthood to prepare for what is next. They need to consider the harm that could accompany substance use and tip the decisional scale toward balance. Optimism and hope are essential at this point to be able to visualize and anticipate a better future. Prochaska calls this moving from contemplation to the preparation stage of change.

Challenge six. “We made thoughtful decisions about our lives and about our use of alcohol and other drugs”. This requires the client to think for themselves and make their own decisions about their life and drug use.

Challenge seven. “We followed through on our decisions about our lives and drug use. If we saw problems, we went back to earlier challenges and mastered them”. This task requires the teen to understand setbacks and how to deal with them when they occur (pp.35).

Co-occurring Disorder Key-Elements

Assessment and Treatment Matching. ICT provides a comprehensive approach to assessment and screening delivery. Screening leads this process to detect the possibility of a co-occurring disorder. A comprehensive evaluation follows to examine the client’s history to include family background, health, marital status, education and work history, mental disorders, substance abuse, psychosocial problems, employment, and living arrangements which are all important to consider when developing a treatment plan. Other supplemental assessment instruments are utilized during this process. Measurements such as: GAIN, Treatment Motivation Index (TMI), Substance Frequency Scale (SFC), Substance Problem Scale (SPS), General Mental Distress Index (GMDI) can also assist in the treatment process (Stevens et al., 2007).

Comprehensive and Integrated Treatment Approach. Co-occurring disorders treatment includes a thorough integrated systemic approach. The program includes both
substance abuse and mental health rehabilitation where the emphasis is placed on learning, understanding and trust. It is characterized by a long-term paced process, where the focus is not placed on breaking through denial but on skill building and preventing anxiety (CSAT, 2005).

**Developmentally Appropriate Program.** Several co-occurring programs specifically develop and designed their programs to meet the developmental needs of the client(s) to enhance the learning outcomes (CSAT, 2005).

*Engage and Retain Teens in Treatment.* The Seven Challenges treatment Program (2007) contributes the client-counselor treatment alliance, attention to adolescents’ early stage change, developmentally appropriate curriculum, and the emphasis on the total lifestyle of the adolescent to treatment engagement.

**Qualified Staff.** Most co-occurring treatment programs require the clinician to have (at a minimum) a master’s degree in clinical counseling with special training in the substance abuse area (Drug Strategies, 2003). Every state has competencies implemented to ensure and regulate educational requirements.

**Gender and Culture.** COD treatment protocols recommend using culturally appropriate methods when working with different gender and cultures (CSAT, 2005). The treatment protocols suggest adapting services to meet the unique needs and value systems of persons in all groups. Work on stigma reduction with a culturally sensitive approach and acknowledge cultural and gender strengths.

**Continuing Care.** CSAT (2005) suggests a continuity of care when clients move across systemic services. Ensure consistency between primary treatment and ancillary services, seamlessness as clients move across levels of care, and coordination of present and past treatment episodes.
**Treatment Outcomes.** The Seven Challenges Program (Stevens et al., 2007) developed three and six month outcome measures to quantify treatment results. Regardless of the limitations of the studies, the treatment outcomes at both three and six month post-treatment entry are positive. The Challenges Program has been successfully adapted to several settings that are indicative to success (outpatient, residential; school-based).

**Adlerian Thoughts on Substance Abuse & Addiction**

Current Adlerian thinking regarding substance abuse problems are classified into several Adlerian categories. Joseph (Yosi) Prinz (1993) wrote about the alcoholic lifestyle describing it with a variety of challenges. Prinz interviewed several Adlerian therapists to understand what they thought were the best approaches in treating the addict. It is suggested that the alcoholic often experiences character flaws such as guilt, denial, emptiness, to include a genetic disposition and a gap between over-achieving goals and a low tolerance for life’s difficulties.

Several Adlerian principles can be applied to the treatment of substance abuse to include, *teleology, holism, self-determination, phenomenology, and social interest*. When working with a client, it is important to make a connection to try and understand what is motivating the client to use substances. An important question to ask is ‘if you could stop using, what would change in your life?’ It is understood that many addicts fight ‘denial’ and ‘resistance’. What is more productive is establishing the therapeutic relationship to create a cooperative alliance by negotiating methods and goals to enhance motivation (Prinz, 1993).

The focus of substance abuse treatment and recovery lies in the individual ability to address all the areas of one’s essence that Adlerians’ call *The Life Tasks*. The tasks include: *work, friendship and community, love, marriage and parenting, self (health, exercise and recreation) and existentialism* (Prinz, 1993). The goal of treatment is to become prepared to face
life’s challenges that were previously ignored by fear or some other obstacle and to stop using substances to cope with problems.

This brings forth the collective eclecticism that Individual Psychology has coined the creative self (Manaster & Corsini, 1982). This idea of soft determinism depends on what Adler called Schopferische Kraft; the ability to make individual decisions, to form individual ideals, to be inventive and spontaneous. Adler believed that life’s challenges can be best tackled by one’s individual creativity to face life thoroughly and have the potential to ‘make something’ of themselves. He believed people are naturally creative influenced by their heredity, environment, and societal setting. To define one’s existence by realizing it’s not what you have that counts but, rather, it’s what you do with it that matters.

**Conclusion and Recommendations**

Current research points out that adolescent substance abuse treatment is a relatively new field of study compared to adult treatment research and has only been a focus of systemic study for the past decade (Stevens & Morral, 2003). The current trend suggests the necessity of effective treatment methods to include evidence based practices. The Drug Strategies (2003) investigation surveyed several adolescent treatment programs to determine their quality and developed criteria for effective methodology. Since then, several quality treatment programs have been developed and/or modified to integrate the key elements. An in-depth review has taken place to examine programs that have incorporated the essential elements. The Center for Substance Abuse Treatment (CSAT) collaborated with the National Institute on Alcohol and Adolescent Treatment Model (ATM) to fund the manualization and empirical evaluation of existing admirable adolescent programs (Stevens et al., 2003).
Since then, several quality treatments have been developed and/or modified to integrate the key elements. Several programs have undergone scrutiny to meet the necessary challenges. Family therapies (multisystemic, multidimensional, and brief strategic) have experienced the most investigated approach showing positive results. Motivational interviewing and cognitive behavioral therapies have shown to be helpful for the most resistant client. The most effective treatment utilizes a comprehensive approach that includes both mental health and substance abuse involving the family and other systemic influences to reach across a broad range of needs (Orr-Brown et al., 2007).

This collaboration has sparked an up-surge of quality programming that was long overdue in the adolescent substance abuse treatment arena (Stevens et al., 2003). Programs and practitioners across the country have begun to implement changes and make the necessary improvements to meet the guidelines of evidence based protocols to enhance treatment outcomes.

Until recently, adolescent treatment providers offered adult treatment approaches to teens. Throughout the 1980’s there was a consistent effort to incorporate developmentally appropriate methods for working with adolescents. For an example, when asked if a teen has a drug problem he or she may say “no” but readily acknowledges three or more symptoms of dependence. Many teens are still intellectually operating at a “concrete” stage of thinking and many substance abuse programs operate at an “abstract” formal stage of thinking. This can influence how assessments and programming affect the adolescent (Stevens et al., 2003).

Adolescence is a developmental period of time when experimentation with alcohol and drugs can happen. Research reports that those that consume alcohol before the age of fifteen years were four more times likely to have a lifetime of alcohol dependence than those who first tried alcohol
after the age of twenty (Mcgue & Iacono, 2008). Adolescent treatment programming demands a developmentally appropriate concentration that is different from adult treatment methods.

Some of the challenges that are currently taking place in the industry are: the placement and training of qualified staff, adolescents not receiving treatment when needed, insurance reimbursement, adolescent treatment motivation, and innovative treatment strategies for the hard to reach adolescent.

Effective recommendations would include the access to efficacious, evidence-based programs readily available and accessible to families and communities. Treatment programs and staff would follow consistent protocols set forth by current research and practices by remaining flexible and malleable to incorporate future industry growth and change (Russell, 2007).
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