

CHAPTER 10

Substance Abuse

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Chapter Overview

This chapter utilizes a protective and risk factor framework to understand the onset and progression of adolescent substance abuse (Hawkins et al., 1992; Jessor et al., 1995; Rutter, 1987). The chapter begins with a discussion of the definitions of adolescent substance abuse and the substances most often used by youth. The frequency and severity of substance abuse is reviewed as well as differences in substance abuse between females and males. Additionally, individual and family clinical interventions for addicts are presented. The chapter concludes with a case example and questions.

CASE EXAMPLE

Who Are the Youth Represented in This Chapter?

The following case example represents some of the concerns related to adolescents and substance abuse. Considering the implications for this case within the context of the risk factors, theory, assessment, and intervention strategies presented in the following pages will prepare you to assess and suggest interventions for the more developed case study at the end of the chapter.

Peter is a 16-year-old European American boy who attends a suburban high school. Peter is a smart student, but often does not work very hard at his studies. He gets mainly B's in school with barely studying. He is popular with both the boys and girls

at school. Peter is a great skateboarder and spends a lot of time after school at the skate park. He has visions of competing in the X Games. Recently, Peter has been smoking joints that are given to him at the park. He feels that it makes him calmer and less stressed at trying and completing big tricks. His friend Matt told him that he has become a better boarder by smoking DMT (dimethyltryptamine, a psychedelic drug) before attempting big tricks. Peter wonders if doing more drugs will improve his boarding or just mess him up. He has one friend, Ben, who has done so many drugs that he can hardly speak in coherent sentences. He remembers when Ben was a great boarder, now he is just a stoner.

Defining Substance Abuse

Adolescents who become involved in drugs are a diverse population with a variety of individual characteristics and social experiences. Researchers interested in the assessment, prevention, and treatment of substance use have tried to understand why some youth who experiment with alcohol or marijuana are at increased risk to progress to the use of more serious drugs such as opiates, heroin, OxyCotin, methamphetamine, and “club drugs” (Ecstasy and GHB [gamma-hydroxybutyrate]) and why others will not progress to “hard” drugs and will discontinue drug use after a period of experimentation (Botvin & Griffin, 2007; Petraitis, Flay, & Miller, 1995). Still other youth will become quickly addicted to marijuana or alcohol (Urschel, 2009). It has been suggested that many adolescents who experiment with drugs do not develop dependence on substances into adulthood or become drug addicts (Shedler & Block, 1990). However, approximately 10–15% of American youth will become addicted to substances (Hanson, 2008).

Historically, marijuana was not considered an addictive drug, but it has been found to be extremely addictive and the *addiction cycle*, the time between use where increased cravings and desire for the drug is manifested, may be as long as 42 days (Urschel, 2009). Therefore, addiction to marijuana may not initially be considered since the marijuana addict, unlike the heroin addict, does not need the drug daily. Due to more stringent laws regarding underage purchasing of alcohol and underage serving of alcohol to minors, alcohol is difficult for youth to obtain. However, marijuana is ubiquitous and inexpensive. Additionally, some states have reduced penalties for marijuana possession. Thus, marijuana use is on the rise in the United States with youth.

Marijuana has also been cultivated to be more potent with higher levels of tetrahydrocannabinol (THC), the psychoactive substance in marijuana. Therefore, the drug that the parents of these youth may have experimented with in their adolescence may be 10 times as potent as the

drug that they used. Parents who are unaware of the changed potency of marijuana may underestimate the effect on their children.

Developmental Pathways to Substance Abuse

Adolescent substance addiction usually has its onset in late adolescence and early adulthood (Corcoran & Walsh, 2006). Adolescents who begin to experiment with drugs at an early age (prior to age 16) are at increased risk for continued drug-related issues into adulthood (Dishion & Owen, 2002; Hawkins et al., 1992; Rohde, Lewinson, Kahler, Seeley, & Brown, 2001).

From a developmental perspective, adolescence is associated with increased risk taking and experimentation. For some adolescents, experimentation with drugs and/or alcohol is part of the negotiation of transitions between adolescence and adulthood (Shedler & Block, 1990). These transitions include cognitive shifts about self, identity, sexuality, future orientation, changes in parental relationships, and increased peer group involvement (Schulenberg, Maggs, Steinman, & Zucker, 2001). In the United States, media and popular culture messages about drinking and smoking often spur experimentation with alcohol and tobacco in early to middle adolescence (Botvin & Griffin, 2007). Some adolescents may become a member of a drug subculture to find acceptance and social connection. However, a significant proportion of youth are at risk to become regular drug users, and will increase their use of a particular drug or across several drugs, and develop severe substance abuse problems (Botvin & Griffin, 2007; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997).

Gender Differences

There are different pathways to abuse for females compared with males. Generally girls/young woman progress to addiction quicker, and suffer more severe consequences from drug abuse compared with males (Harvard Mental Health Letter, 2010). Moreover, treatment programs developed without regard for gender fail to influence the trajectory of substance abuse (Califano, 2003; Molidor, Nissen, & Watkins, 2002). While conduct disorder, propensity for risk taking, ADHD, and depression are related to substance use in males, depression is significantly associated with substance use disorders among females (Whitmore et al., 1997). Girls tend to use substances to reduce stress, ameliorate depression, and improve mood. Females are also more likely to use prescription painkillers, stimulants, and tranquilizers. Males tend to use drugs to enhance social status and for sensation seeking.

Race/Ethnicity

Membership in a racial/ethnic minority group may be a risk factor for substance abuse (Felix-Ortiz, Newcomb, & Myers, 1994). Race-related oppression, trauma, discrimination, value conflicts, and decreased access to opportunities for marginalized groups can result in increased levels of drug and alcohol abuse.

Rates of Adolescent Substance Use

Despite declines in illicit drug use in the 1990s, and the recent decline in methamphetamine abuse, a number of drugs remain steady in their use among adolescents such as marijuana, as previously discussed, alcohol, and prescription drugs. Alcohol use remains prevalent among teenagers, with 72% of students reporting consumption before completing high school (Johnston, O'Malley, Bachman, & Schulenberg, 2008). Raiding the family medicine cabinet and ingesting the pills that are found within is called *pharming*. Sometimes at parties the drugs found in many medicine cabinets are put together in a bowl and then a youth takes a handful, mixing a wide variety of prescription drugs, which can have very dangerous and sometimes fatal results. Additionally, there is substantial use at high schools and college campuses of Ritalin and Adderall (both ADHD medications), which work as a powerful stimulant for those not diagnosed with ADHD.

Clinical Perspectives on Substance Abuse

Adolescent substance abuse is a particularly challenging and complex phenomenon to understand and address in clinical practice. Some clinical settings have determined that the youth first needs to get clean and sober prior to being involved in other types of therapy.

Adolescents who abuse substances often present a range of co-occurring issues: delinquency or involvement with the legal system, propensity for risk taking or sensation seeking, mental health problems such as depression, anxiety, or obsessive-compulsive disorder (OCD), truancy, school suspensions, lack of interest in school, and family problems such as the breakdown of family trust or family support (Howard & Jenson, 1999; Loeber, Farrington, Stouthamer-Loeber, & Van Kammen, 1998; Newcomb & Bentler, 1989; Riggs, 2003; Robins & McEvoy, 1990). Additionally, abused and neglected youth may be at a greater risk for substance abuse as compared to nonabused youth (Wall & Kohl, 2007). Adolescents who

have experienced traumatic stress tend to score higher on substance abuse problem measures than nontraumatized youth (Hall et al., 2008).

Protective and Risk Factors Related to Substance Abuse

Developmental studies have produced a significant amount of information regarding specific risks that may increase the likelihood of developing a substance abuse problem, as well as protective factors that may mitigate the onset and course of substance problems and have important implications for recovery (Tarter, 2002).

Internal Protective and Risk Factors Related to Substance Abuse

Behaviors That Put Youth at Risk

There are particular behaviors that make youth more vulnerable to substance abuse. A youth is at greater risk for dependence if he or she binge drinks or began drug use prior to age 16 (Clark, 2004). Youth who have not found school to be a venue where they can be successful due to lack of aptitude, lack of interest in academics, or lack of involvement with school activities are more likely to be involved in substances. Additionally, youth who are sensation seekers or impulsive are at higher risk for substance use (Catalano, Kosterman, Hawkins, Newcomb, & Abbott, 1996; Dishion & Loeber, 1985; Hawkins et al., 1992; Jenson, 2004; Jessor et al., 1995). If the youth has poor coping mechanisms, he or she is more likely to use substances to self-soothe. Similarly, if the youth does not have an *internal locus of control*, the conviction that he or she can control his or her own destiny, the youth may look to external inhibitors of pain or increased pleasure through substances.

MENTAL HEALTH ISSUES

Youth who have been diagnosed with ADHD, bipolar disorder (BPD), conduct disorder (CD), depression, anxiety disorder, or OCD are more likely to use or abuse substances. Adolescents with ADHD are more likely to have co-occurring substance abuse problems. Adolescents with a CD diagnosis were 10 times more likely to have drug abuse histories than adolescents without a CD diagnosis (Kuperman et al., 2001). Youth with adolescent-onset BPD were at greater risk for substance abuse (Wilens et al., 1999). Additionally, increased levels of depressive symptoms and illicit drug abuse were found among suicide attempters compared with those who had not attempted (Windle & Windle, 1997). Interestingly, it has also been found

that early-onset substance use alongside neurohormonal changes during puberty impacts brain development and exacerbates symptoms of CD and ADHD (Riggs, 2003; Rutter, Giller, & Hagell, 1998). Therefore, the substance use can make mental health issues worse.

Frequently, youth with mental health issues use substances to self-medicate prior to a mental health intervention and diagnosis. The youth knows there is something wrong and the substances numb the pain and may decrease negative or embarrassing symptoms. Occasionally after diagnosis, youth use illegal substances in lieu of their prescribed medication because they do not like the way the prescribed medication makes them feel or reduces their ability to think clearly.

Practitioners should assess the youth's history of mental health symptoms to determine the relationship between *comorbid*, co-occurring disorders, and substance abuse in order to evaluate whether symptoms of conditions such as ADHD, BPD, CD, OCD, anxiety, or depression was present during periods of abstinence. In some instances, the symptoms of drug dependency may look like mental health problems. Conversely, substance abuse problems may mask underlying mental health issues. It is considered best practice to wait until an adolescent has discontinued using substances before assessing the existence of a mental health disorder since substances can mask or intensify the appearance of a mental health disorder.

Behaviors and Characteristics That Decrease Drug Use in Youth

Youth are less likely to be involved in substances if they have good problem-solving skills, a positive orientation to school, easy temperament, good intellectual capability, and have high self-efficacy (Catalano et al., 1996; Dishion & Loeber, 1985; Hawkins et al., 1992; Jenson, 2004; Jessor et al., 1995).

Protective and Risk Factors Related to Substance Abuse in the Family Microsystem

Risk Factors

Within the family system, youth who have parents or siblings who abuse substances are more likely to abuse substances themselves (Dishion & McMahon, 1998). Youth who experience violence in the family, whether it is child maltreatment, chronic family conflict, or domestic violence, sometimes try to get away or remove themselves from the painful situation through substance use. Additionally, youth who have parents with mental health issues are more prone to use substances.

Protective Factors

The positive influence of adult caregivers has been found to be an important variable in assessing adolescent substance abuse (Dishion & McMahon, 1998). The organization and structure of the family may serve to mediate or reduce contact an adolescent has with substance-using peers. Specifically, the presence of parental guidance, support, supervision, and a clear and consistent parental message disapproving substance use can be an effective intervention for reducing substance use. Similarly, youth who spend time with their family in sports or activities are also less likely to be involved in substance use.

Protective and Risk Factors Related to Substance Abuse in the Peer Microsystem

Risk Factors

Association with peers who use substance is related to adolescent substance abuse. Similarly, spending time with youth who are involved in deviant activities increases the likelihood of substance use for that youth (Dishion & Loeber, 1985; Elliott, Huizinga, & Ageton, 1985). Youth who have a great deal of unsupervised free time to spend with other youth are also more at risk for substance abuse.

Protective Factors

Youth who spend time with peers who are future oriented are more likely not to be involved in substance abuse. Youth who are in the company of friends who possess healthy *resistance skills*, the ability to turn down drugs or alcohol when offered, are more likely not to be involved with substances themselves. Additionally, youth who spend time with friends who have a positive orientation to school are less likely to be involved in substance use.

The Problem Severity Continuum

Winters (2001) proposed that drug and alcohol involvement among youth occur on a problem severity continuum, from abstinence on one end to recovery on the opposite end; adolescents may relapse and go through the stages again. Three categories follow the abstinence category and precede the dependence threshold: *experimental use* (limited recreational use); *early abuse* (greater frequency or *polysubstance* of more than one drug); *abuse*

(frequent use with adverse consequences), followed by *dependency* (signs of tolerance to the substance, cycling through the addiction cycle: pre-occupation, ritual, compulsivity, despair), and finally, *recovery* (no longer using substances). Implications for treatment for the problem severity continuum suggest interventions should reflect a continuum of care and be consistent with the severity of drug use, from least restrictive treatments for low-level users, such as harm reduction, checking sobriety through urine analysis, individual or family counseling or psychoeducational groups, to more intensive residential treatments for those youth who are polysubstance abusers or use chronically. Practitioners need to be able to distinguish between experimental use, abuse, or dependency in order to make the appropriate treatment recommendations (Burrow-Sanchez, 2006).

Substance Abuse and DSM-IV

Since many practitioners providing treatment to adolescents will be required to diagnose substance use disorders, they should be aware of the considerations and controversies regarding the use of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) with youth. Martin and Winters (1999) questioned the validity of the DSM-IV criteria for substance abuse as applied to adolescents given the fact that the criteria were developed from research on adults. They noted that symptoms such as withdrawal and drug-related medical problems are prominent only after years of sustained abuse, which may not be developmentally relevant for adolescents (Martin & Winters).

The Social Development Model

The social development model (SDM; Catalano et al., 1996) utilizes knowledge of protective and risk factors that can contribute to, or moderate, delinquency or substance abuse in youth. The SDM hypothesizes that specific socializing individuals influence a child at each stage of development, which can result in either a prosocial or an antisocial pathway. In preschool, children are more likely influenced by parents; teachers and peers during elementary school, with an increasing role of the peer group during middle school; and more complex individual and societal influences are prevalent during high school. If consistent involvement occurs during each of the stages, a child will observe and remember the behaviors of those with whom he or she is connected. In terms of protection and risk, risk factors can block opportunities for prosocial relationships at each stage, which can result in substance use and other negative outcomes, and

protective factors can contribute to prosocial outcomes. According to the SDM model, positive peer group influences may potentially steer a youth away from substance use.

Externalizing Behaviors and Substance Abuse

Externalizing behaviors, antisocial behavior that involves disregard for the rights or property of others, such as stealing, graffiti “tagging,” destruction of property, and rule breaking, significantly coincides with substance abuse (Feldstein & Miller, 2007; Loeber et al., 1998). In a sample of young adults, Hussong, Curran, Moffitt, Caspi, and Carrig (2004) tested the “snares” hypothesis, which suggests that substance abuse ensnares or interferes with normative decreases in antisocial behavior from adolescence into adulthood. Snares are in contrast to the effects of protective factors that serve to buffer the risk of antisocial behavior as a young person develops. Interestingly, the researchers confirmed that men who abused substances during their youth showed increased antisocial behavior above what would have been predicted given their individual patterns of behavior. That is to say, during time periods where greater substance abuse was reported, increased levels of antisocial behavior were also reported. Overall, adolescents with externalizing behaviors tend to have compromised family functioning, lower academic competencies, and increased associations with negative peers, which are also all risk factors for substance abuse.

Traumatic Stress and Adolescent Substance Abuse

Traumatic stress involves an actual or perceived threat of serious injury, or a threat to the physical integrity of self or others, and the person may respond with fear, helplessness, or horror (American Psychiatric Association, 2000). Practitioners have begun to pay particular attention to trauma exposure and PTSD symptoms, such as hypervigilance, nightmares, and flashbacks among adolescents in substance abuse treatment (Jaycox, Ebener, Damesek, & Becker, 2004). Some youth may use illicit drugs to alleviate traumatic stress symptoms. Youth diagnosed with substance abuse had greater levels of anger, had more PTSD symptomatology, and were more likely to have been sexually abused (Evans, Spirito, Celio, Dyl, & Hunt, 2007).

Child abuse may bring about PTSD and subsequent substance abuse (Cohen, Mannarino, Zhitova, & Capone, 2003). Child maltreatment affects the cognitive, social, and behavioral aspects of youth. Child abuse also negatively impacts brain functioning and plays a role in organizing

neural systems in the brain that can create vulnerability (Perry, 2001a, 2001b). Some of the negative outcomes of child abuse include a range of *internalizing behaviors*, emotional problems, such as depression, and *externalizing behaviors*, behavioral disruptions, such as CD and high-risk behavior (Kisiel & Lyons, 2001; McNally, 2003). A large body of research has investigated the relationship between trauma and particular negative outcomes in adolescence: delinquency (Brosky & Lally, 2004; Finkelhor, 2008; Greenwald, 2002; Maschi, 2006; Perry, 1997; Smith, Lizotte, Thornberry, & Krohn, 1995), substance abuse (Cohen et al., 2003; Rutter, 2001; Tubman, Gil, & Wagner, 2004; Weiner et al., 2003), self-destructive behavior (Baer & Maschi, 2003), sexual behavior problems, and dissociation (Carrion & Steiner, 2000; Friedrich, Jaworski, Huxsahl, & Bengston, 1997; Leibowitz et al., in press).

Assessment and Clinical Intervention

Several areas must be considered in the assessment of and intervention for substance use in adolescents. Initial considerations include the context where drug use occurs, as well as defining *experimental use* versus *abuse/dependence*. Several key clinical areas associated with addressing substance use have been identified for practitioners.

Creating a Therapeutic Alliance

It is important for the practitioner to develop a therapeutic relationship with adolescents in drug treatment (Hawke, Hennen, & Gallione, 2005). A working alliance between the youth and the practitioner needs to be sought. It is important for the practitioner to be authentic and realistic. A respectful, collaborative alliance with families to motivate family change is also an important ingredient (Madsen, 2009).

Assessment of Severity of Substance Abuse

It is important to assess where the youth's substance behaviors fall along the problem severity continuum, as discussed earlier in the chapter.

Assessment of Comorbid Disorders

The practitioner should assess for the presence of mental health issues such as ADHD, BPD, CD, OCD, anxiety, and depression. Additionally, the practitioner should assess for PTSD and a history of child abuse.

Clinical Interventions for Addiction

It should be remembered that addiction is a chronic disease that can be controlled but never cured. More recently, it has been found that outpatient rehabilitative (rehab) therapy is more successful than inpatient rehab therapy because the youth has to negotiate “real-life” issues while he or she is involved in therapy. Additionally, if the substance abuse has been long in duration or marked by heavy use, there may be damage to the brain that cannot be reversed by talk therapy alone (Urschel, 2009). It may be necessary for the client to be under the care of a psychiatrist to prescribe medications to help improve brain functioning or help with cravings. The practitioner should utilize a treatment approach that is strengths based, gender specific, and culturally congruent when working with recovering addicts. First, it is important to understand in which *stage of change* the client is currently situated.

The Stages of Change

Prochaska, Norcross, and DiClemente (1994) found that permanent change only happens when the individual is actually ready to change. This seems obvious, but many who enter rehab treatment are not yet ready to create change in their lives and thus fail to remain clean and sober, thereby creating another failure in their lives. By assessing what stage of change the client is in, the practitioner can determine whether the client is ready to do the work to be successful in his or her sobriety. There are six stages of change. The first stage is called *precontemplation*; friends or family may have suggested the addict get help, but the addict responds with anger or denial that there is a problem. The second stage is *contemplation*; the addict realizes that he or she has a problem, but is not quite ready to commit to making changes in his or her life. The third stage is *action*; the addict has chosen to be involved in rehab and is willing to do the work that is required of him or her to maintain sobriety. The fourth stage is *maintenance*; the recovering addict realizes that he or she has made important positive changes in his or her life and is also aware that there continues to be temptations and triggers that could put his or her sobriety at risk. The final stage is *termination*; sobriety is effortless and is simply a way of life. If the client is not in the action stage or moving from the contemplation to the action stage, real change may not yet be possible.

Fostering Prosocial Interactions for Youth

The practitioner should help the adolescent identify social support networks of youth, family members, and adults who can support him or her

in being clean and sober. It is important that youth who have abused substances do not return to the same companions that they used to drink or do drugs with. An adage from the rehab world is that to remain clean and sober “you need to change your playmates and playhouses.” Intervention strategies that foster the development of interpersonal skills, prosocial skills, and academic skills help youth develop attachments to positive role models and increase their self-esteem and self-efficacy.

Activities that help the addict feel good about him- or herself and the direction of his or her life are important. The early stages of sobriety are not fun, and some youth may feel that their current desire to be clean and sober is nothing but drudgery. Therefore, activities that support athleticism, problem solving, and cooperation are beneficial for recovering addicts. In many communities, organized activities for recovering addicts such as biking, hiking, climbing, or training for a distance-running race or a triathlon have been created to help them in their sobriety.

Exploring the Youth's Feelings of Guilt and Shame

The youth who has chosen to enter treatment often feels very guilty about some of the activities that he or she participated in when he or she was under the influence. Some youth have put themselves at risk or their friends or family at risk through their involvement with substances. Some youth may have told lies and undermined the trust of the people important to him or her. They may have spent a great deal of energy hiding behaviors, substances, and paraphernalia from their family or friends, and lived a dual life, which is both physically and emotionally draining. Others have stolen money or have stolen items from their friends or family to support their habit and now feel very guilty about their actions. Some youth have said hurtful things or acted in hurtful ways to friends or family and now in their sobriety they feel embarrassed. As youth continue in their sobriety, it is important for them to be able to confront their own feelings of guilt and shame. When possible and appropriate, it may be freeing for the recovering addict to take responsibility for his or her past behavior, apologize to those he or she has hurt, make amends, and move forward.

Understanding the Youth's Developmental Stage

As stated throughout this book, developmental issues are always evolving and subject to change in youth. Consequently, intervention should consider the physical, social, cognitive, emotional, and moral issues that may evolve during the course of the practitioner's relationship with the adolescent. Since the recovering addict is discovering who he or she is without

the substances, his or her identity may also go through a transformation. The addict may have to get to know who he or she is without the substance, including how he or she thinks, feels and interacts with others when not high or not seeking his or her preferred substance. Often, the addict had a very intimate relationship with his or her preferred substance. It may be helpful to frame the ending of this relationship as a “break up” between the addict and the substance. Since most teens have experienced the ending of a relationship, they can effectively use this metaphor.

Cognitive-Behavioral Therapy

The recovering addict must change his or her thoughts from proaddiction to prorecovery (Urschel, 2009). The practitioner should address and dispel thoughts that previously supported the client’s substance abuse. These thoughts may include an inability to see consequences for his or her behavior, irrational thinking, inaccurate thoughts, jumping to conclusions, inability to think through cause to effect, inability to take another’s perspective, inability to reframe a situation, paranoia, or rage directed at particular individuals or situations. Cognitive-behavioral therapy (CBT) conceptualizes substance abuse as learned behaviors reinforced by environmental contexts. It can be utilized in a group or individual format that can enhance problem solving, self-efficacy, communication, and anger management. It can help the adolescent identify *triggers* for substance use. Triggers are ideas, persons, places, music, memories, or emotional states that stimulate the desire to use substances (Urschel, 2009). Knowing what triggers drive the desire to use can help youth avoid the trigger or brainstorm in advance options of how to deal with the trigger when it occurs. Core to the notion of CBT is that the recovering addict is incapable of fully extinguishing all thoughts about the substance of choice. However, through CBT the recovering addict can change what he or she does about those thoughts. The recovering addict has the power to decide to act on those thoughts or not. A full discussion of CBT is presented in Chapter 12.

Motivational Enhancement Therapy

Motivational enhancement therapy (MET) uses *intrinsic motivation* to change behavior. Intrinsic motivation is the belief that one has the necessary attributes to complete the task and that the completion of the task is the reward itself; there are no external rewards or “carrots.” The use of intrinsic motivation leads the client to initiate, persist in, and comply with behavior change efforts (Miller & Rollnick, 1991). There are five basic motivational principles:

1. *Express empathy.* This means that the practitioner needs to use *reflective listening skills*. Reflective listening skills combine respect for the client, acceptance of where he or she currently is, and supporting the process of change (Miller, 1995).

2. *Develop discrepancy.* The practitioner helps the client see the discrepancy between where he or she is and where he or she wants to be. This allows the client to begin honest discussion of the negative affects of his or her drug use and create motivation for change (Miller, 1995).

3. *Avoid argumentation.* The practitioner avoids moralizing or attacking the client about his or her drug use. The practitioner helps the client accurately see the consequences of his or her drug use. It is the client who comes to the realization that change is necessary and what he or she wants (Miller, 1995).

4. *Roll with resistance.* The practitioner helps the client understand that resistance to change is normal. The practitioner asks the client to brainstorm ideas of how to move past resistance (Miller, 1995).

5. *Support self-efficacy.* The practitioner helps the client come to know that he or she has the requisite skills to make a permanent change. The belief in him- or herself, in his or her own strength and skills, allows the client to have hope that change is possible. It also helps the client have optimism about the future (Miller, 1995).

Group Work

Though a great deal of substance abuse treatment is done in a group setting, practitioners should keep in mind that peer group interactions may occasionally increase adolescent problem behavior by providing recovering addicts an opportunity to learn and model deviant behavior from other youth who are not serious about change (Dodge, Dishion, & Lansford, 2006). However, when the group is motivated to work, groups can be extremely effective. Groups can help support positive change and buoy group members when they are feeling weak or discouraged. Psychoeducational groups can be extremely effective in helping youth understand the steps to recovery and the impediments to change.

Setting Realistic Goals and Expectations for Yourself as the Practitioner

Practitioners must acknowledge that their client may return to using substances. This can be disheartening. Some youth may not be ready to remain clean and sober. The practitioner must acknowledge the potential

for relapse and not take the client's inability to stay sober as a personal affront on his or her clinical abilities (Burrow-Sanchez, 2006).

Family-Based Treatments

Most family-based models are based on family systems theory. By addressing protective and risk factors, the practitioner works to promote family engagement and increase motivation for change. The practitioner can help the family improve parenting skills, communication between family members, and better connect the family to seek supportive members in their peer, neighborhood, and school microsystems.

MULTISYSTEMIC THERAPY

Multisystemic therapy (MST) goals include improving family parenting disciplinary practices, decreasing association with negative peers, increasing involvement with prosocial youth, and developing support systems that include extended family, schools, and neighborhoods (Henggeler et al., 2002). MST practitioners generally have small caseloads and spend a considerable amount of time with the family to restructure its interactions with its various environments.

MULTIDIMENSIONAL FAMILY THERAPY

There are four domains of multidimensional family therapy (MDFT): (1) the adolescent as a member of a family and a member of a peer group, (2) the parents in their role as mother and father, (3) the family environment, and (4) the extrafamilial environments of positive and negative influence such as the school and the neighborhood (Liddle, Rodriguez, Dakof, Kanzki, & Marvel, 2005). As part of MDFT, random urine drug screens are required for the youth throughout treatment. The results of these screens make youth responsible for their behavior rather than keeping their behavior a secret from their family. MDFT employs intervention strategies in three stages within each of the four domains:

- *Stage 1: Build the foundation.* The goal of the first stage is to create engagement. Examples of work during this stage include developing a collaborative process between family members, encouraging youth to voice concerns, eliciting the family story, understanding the parents' previous attempts to develop an emotional connection to the adolescent, and investigating possible past traumatic experiences and mental health issues.

- *Stage 2: Work the themes/request change.* The work during the second stage includes working with the adolescent about ambivalence to change, addressing drug abuse directly, addressing difficulties in other environments such as school failure and delinquency, helping the adolescent imagine alternative behaviors, helping the adolescent plan to make changes, instilling hope in all family members, improving communication, working with the parents around their own drug abuse history, and emphasizing self-care strategies for all members of the family.

- *Stage 3: Progress in treatment.* In the third stage, work from stage 2 is strengthened and solidified. During the termination process, a new family story is created about the family's successes in therapy.

Case Study

Jerry is an athletic 16-year-old European American male. He was on his high school's ski team. Unfortunately, Jerry had a bad accident skiing, which left him with a broken right arm and leg. He had two surgeries that were painful and his recovery was slow. He was given Vicodin as a painkiller. Jerry at first was scared of the Vicodin because it made him feel like he was floating and made him feel nauseous, but after several doses he enjoyed the pain being taken away and the feeling of euphoria it gave him. He continued to use the Vicodin, even when he no longer experienced pain, but told his doctor he continued to have pain so that his prescription was renewed. As he healed, Jerry realized he would miss the following competitive ski season and that made him feel sad, he would miss both friends who skied with him, and he would miss the sport he loved. Jerry's identity had been centered on his being a competitive skier. Jerry was not sure who he was if he was not a skier.

Jerry felt lonely and sad and began to use marijuana to soothe those feelings. As Jerry smoked more marijuana, he felt more relaxed about his lack of skiing and began to make friends with others who used marijuana and other drugs. Jerry began to skip school with his new friends to get high or get stoned at lunch. Jerry had moved from being in the jock group at school to the stoner group. Jerry was gaining a reputation for being a wild partier and he dabbled in selling weed as well. Jerry had always done relatively well at school with minimum effort, but he was now in danger of failing a class.

When Jerry missed an entire day of classes without an excuse, the school social worker called Jerry's dad, Edward, at work. Edward had dropped off Jerry at school that morning and was dumbstruck. Edward called his wife, Margaret, who had just returned home from work. Margaret went through

Jerry's bedroom and found a small pipe and some weed in a plastic bag at the bottom of his sock drawer. Margaret called her family physician, who referred the family to a local substance abuse treatment center. That night at dinner, Margaret showed Jerry what she found in his room. At first, Jerry denied that the pipe and the marijuana were his. When he realized that his secret was out, he began telling his parents about his marijuana use and how it had gotten out of control. Jerry agreed to attend the intake appointment at the substance abuse treatment center.

Jerry is currently in outpatient rehab treatment. He attends a weekly psychoeducational group, as well as individual and family counseling with his mother and father.

QUESTIONS FOR THE REFLECTIVE PRACTITIONER

1. What risk factors does Jerry have?
2. What protective factors does Jerry have?
3. If you were Jerry's practitioner, how would you begin working with him?
4. How could you help Jerry maintain sobriety?
5. How would you work with Jerry's family to support his sobriety?
6. How would you create a more supportive social network to improve Jerry's functioning?
7. Do you think Jerry will maintain sobriety?

Chapter Summary

The chapter discussed the protective and risk factors related to adolescent substance abuse. The various pathways to adolescence substance abuse were also investigated. Additionally, the rates of substance abuse and the current drugs of choice by youth were explored. Interventions for addicts were discussed, which included both individual interventions and family interventions. In the next chapter, sexual orientation is discussed.

