

Family-based treatment development for adolescent alcohol abuse

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Abstract: A range of family-related risk factors have been linked to adolescent alcohol problems and predict escalation of use and alcohol dependence into adulthood. Family-based interventions have strong research and clinical traditions in the treatment of adult alcoholism and adolescent drug abuse, but have been infrequently applied to the unique problems of adolescent alcohol abuse and dependence. Researchers in the adolescent alcohol abuse specialty area have developed a robust developmentally oriented knowledge base about alcohol-specific risk and protective factors. Adolescent alcohol treatment researchers have made significant advances in recent years, including a deeper understanding of outcome trajectories. However youth relapse to alcohol use at high rates following standard community-based treatment, and few empirically supported treatments exist for adolescent alcohol abusers. Employing selected contemporary research findings, this article outlines specific areas of focus for a family-based intervention for alcohol abusing teens. We first review intervention-relevant research on the development of alcohol problems among adolescents with a focus on family risk and protective factors. Second, clinical research findings are presented supporting the use of family-based interventions with alcohol abusing population. Finally, areas of increased focus in an empirically supported family-based intervention for adolescent alcohol problems are outlined. By addressing these gaps, empirically supported family-based interventions for adolescent alcohol abuse have significant potential to advance the field of adolescent alcohol treatment.

Keywords: adolescents; alcohol abuse; family-based treatment, United States

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INTRODUCTION

Family-based treatments that intervene to alter risk factors in the multiple realms of the teen's functioning and social environment are recognized as among the most promising interventions for adolescent substance abusers (1). For instance, Multidimensional Family Therapy (MDFT)(2) significantly reduces substance use and related problem behaviors, and increases protective factors for youth and their families (3-5). However, alcohol abusing teens have generally not been the primary focus in MDFT or other family-based treatment outcome studies. Given recent advances in understanding the influence of family-related risk and protective factors for alcohol use disorders, the success of family-based interventions for adolescent drug abuse (6), and the efficacy of family-focused approaches for adult alcoholics (7), family-based models such as MDFT offer promise for treating alcohol abusing teens.

This article presents a framework for family-based treatment development with alcohol abusing teens. First, family risk and protective factors for adolescent alcohol problems are reviewed to provide justification for family-based interventions with these youth. Second, existing research findings supporting family-based treatment for alcohol abusing youth are presented. Next, intervention-relevant research is reviewed to lay a foundation for areas of increased clinical focus with this population. These areas are targeted to increase the applicability and effectiveness of family-based approaches with alcohol abusing adolescents.

RATIONALE

Despite increased primary school-based prevention efforts throughout the 1990's, alcohol use among teens has remained remarkably stable for over a decade, with a small percentage of teens developing alcohol dependence (3.5%)(8). These individuals are at high risk to experience chronic alcohol-related problems into adulthood. Only about 16% of youth in need receive treatment for alcohol problems (9), and those that receive standard treatment in the community relapse at high rates within the year following treatment (10). More effective interventions for adolescent alcohol abuse are clearly needed.

Alcohol problems are known to have multiple interacting precipitators, with family factors playing a central role in early alcohol use and the progression of alcohol problems (6). A range of family risk factors have been linked consistently to adolescent alcohol problems, including poor family functioning, parent and sibling substance use, ineffective parental monitoring, family conflict, and low levels of family support. Family factors are also among the strongest protective influences against adolescent alcohol problems. Parents protect teens from early alcohol initiation and alcohol abuse by setting clear standards against use and setting limits. Family factors also play an important mediational role in explaining other risk factors for drinking problems. While peers exert direct effects on teen drinking, parents mediate these influences through monitoring and maintaining close relationships with their adolescents. Family factors appear to operate both directly and indirectly to predict teen drinking, indicating the need for effective family-based interventions for alcohol problems (11).

Strong and consistent empirical support exists for the comparative efficacy of family-based therapy in reducing levels of adolescent drug use and increasing adaptive functioning in a number of well-controlled clinical trials (1). Family-based interventions have been found to have superior

effects on adolescent drug use compared to individual therapy, adolescent group therapy, and family psychoeducational counseling. The superior post-treatment effects of family-oriented treatments have been retained for up to 12 months after termination (3). Further, family-focused treatments improve family functioning, school performance, comorbid symptomatology, and delinquency (4,5,12). However, these models have generally not been developed specifically with alcohol abusing samples, and few investigators report effects on alcohol use. The following section describes the existing evidence in support of family-based interventions for adolescent alcohol abuse.

FAMILY-BASED INTERVENTION

Progress has been made in developing treatments for adolescent alcohol abuse and outlining the critical factors and processes in alcohol recovery and relapse among youth (13). However in the first year following standard community-based treatment, more than half of teens relapse (14) and over time (1-8 years), use of alcohol steadily rises in each consecutive year following treatment (15). Few empirically developed models for adolescent alcohol abuse exist, and we know very little about the intervention features that impact adolescent alcohol use following treatment. However, with new evidence about the multivariate nature of alcohol risk and protection, there is consensus that interventions for alcohol use disorders must simultaneously target the multiple factors and systems that create and maintain problems. Family-based approaches have potential in this regard, yet their promise with adolescent alcohol abusers has rarely been tested, and certainly has yet to be fully realized.

There is some evidence that family-based interventions reduce alcohol use and related problems among teens. For instance, the Purdue Brief Family Therapy model significantly reduced adolescent alcohol use in fewer sessions than drug education and individual treatment as usual (16). Behavioral family therapy was more effective than supportive counseling in reducing adolescent alcohol use up to nine months following treatment (17). Further, family-based preventive interventions were among the most promising approaches for reducing risk for adolescent alcohol abuse (18).

While controlled trials of Multidimensional Family Therapy (2) have generally targeted youth with marijuana and other illicit drug problems, these studies have also included adolescent alcohol users (approximately 20-40% of samples). The results of MDFT with teen drinkers are promising. For instance, MDFT was compared to two manualized treatments, Adolescent Group Therapy (AGT) and Multifamily Educational Intervention (MFI), for youth with combinational marijuana and alcohol abuse (3). At termination, youth assigned to MDFT showed a 54% reduction in alcohol and marijuana use (49% reduction 6 months after discharge) in comparison with an 18% reduction for group and a 24% reduction for multifamily therapy. Further, youth who received MDFT maintained treatment gains at the 12-month follow-up. A second controlled trial compared MDFT to individual Cognitive Behavior Therapy with an inner-city minority sample of juvenile justice-involved substance abusing youth (4). Both treatments decreased alcohol use from intake to discharge by 41%, and MDFT maintained these gains up to the 12-month follow-up. Finally, a third randomized trial compared MDFT with a manualized peer group therapy for substance abusing young adolescents (5). From intake to 12 month follow-up, MDFT was superior to group therapy in four major risk

domains: externalizing symptoms, family functioning, peer delinquency, and school behavior. In addition, MDFT participants showed a 71% decrease in alcohol use compared to a 39% increase in alcohol use among peer group treatment participants from intake to discharge, and youth in MDFT were more likely to be abstinent from alcohol at the 12 month follow-up.

In sum, MDFT has been validated as an effective treatment for adolescent substance abusers from diverse cultural backgrounds. It is included as an empirically supported therapy by various federal and private sources (e.g., NIDA, SAMHSA, Drug Strategies). A number of studies show that MDFT significantly reduces the target symptoms of substance abuse, internalizing and externalizing symptoms, delinquency, school performance, and family problems. There is also evidence to suggest that MDFT can reduce alcohol use and maintain these treatment gains up to 12 months after therapy. Although these initial results are promising, confidence in MDFT's effects with this population is limited by the small subset of primary alcohol abusers in these studies. In the remaining sections, we outline empirical guidelines and illustrate areas of increased focus in MDFT with adolescent alcohol abusers.

MULTIDIMENSIONAL FAMILY THERAPY

Efforts to intervene with youth at risk for alcohol problems must incorporate knowledge of developmental pathways to alcohol use disorders and their multiple risk factors. MDFT targets the major risk factors, established through longitudinal and cross sectional studies, known to be the precursors to substance abuse in adolescence and young adulthood. MDFT assumes that reductions in target symptoms and increases in prosocial target behaviors occur via multiple pathways, in differing contexts, and through different mechanisms.

The MDFT treatment system assesses and intervenes into four main areas: adolescent, parent, family, and extrafamilial systems. With the adolescent, the therapist seeks to transform the youth's substance using lifestyle into a developmentally normative one with improved functioning across domains (eg, peers, identity, school, and family relationships). Goals with the parent include increasing parental commitment, improving communication with the adolescent, and improving parenting practices (e.g., monitoring). In family sessions, MDFT therapists aim to promote supportive and effective communication among family members.

In our clinical work with alcohol abusing teens and families, we have used the treatment development framework (19) to identify and address risk factors specifically linked to alcohol problems. Below we outline three areas of additional focus and specification that have increased MDFT's applicability and efficacy with adolescent alcohol abusers: alcohol expectancies, parental substance abuse, and family-based relapse prevention and aftercare services.

Alcohol expectancies

Adolescents' alcohol expectancies are a significant predictor of problem drinking (20). Alcohol expectancies include beliefs about the positive social (eg, appearing more comfortable to others) and emotional (e.g., feeling more relaxed) effects of alcohol, as well as beliefs that alcohol is less harmful than it actually is. Adolescents' alcohol expectancies and attitudes are closely linked to the norms families communicate about drinking.

Children not only adopt their parents' drinking behaviors, but also the drinking coping strategies and motivations that are modeled by their parents (21). Thus interventions to change adolescents' expectancies must also involve a shift in parents' messages and behaviors (22).

MDFT attends to the social cognitive aspects of substance use, the meaning and motivation for substance use, and the development of motivation for abstinence. Addressing expectancies, beliefs, and attitudes about alcohol is consistent with the MDFT therapist's work with teens to examine their motivations for using and help them become aware of the health compromising aspects that are associated with alcohol use. Individual sessions with the adolescent focus on highlighting discrepancies between stated personal goals or outcomes and current lifestyle choices, including beliefs about alcohol and its consequences. Continued use of substances is acknowledged as being incompatible with a non-drinking lifestyle and the benefits of these changes (e.g., doing better in school, having less conflict at home). The pathways to achieve these changes also involve parents and other social systems. Therapists work with parents to examine their messages and norms about drinking. Individual work with adolescents and parents provides a platform for families to talk together about drinking and help the adolescent develop more realistic beliefs about alcohol and new skills to avoid drinking.

Parental alcoholism

One of the strongest and most consistent family risk factors for teen alcohol problems is parental alcoholism (23), with increased risk even when the parent's alcoholism is in remission (24). Parental alcoholism increases young adolescents' risk of alcohol abuse through specific mechanisms that can be addressed in family interventions (25), such as family conflict and lack of cohesion, decreased monitoring, and alcohol expectancies (26-28).

Directly and systematically addressing parental alcoholism is consistent with core parent work in MDFT (29). MDFT targets the functioning of the parent as an individual adult, apart from their role as a parent or caregiver (30). Since parenting practices are correlated with the parent's functioning, parental substance abuse is critical to address in therapy. The therapist motivates the parent to take steps to change their own lives by resuscitating their love and commitment for the child, and by highlighting the links between the parent's own functioning and the child's problems. The therapist helps parents see how their drinking and other substance use has impacted the teen (often by having the adolescent share some of these experiences and feelings in family sessions), and how the parent's recovery is a necessary part of the youth's ability to stay sober. MDFT therapists also link parents' alcohol and substance use to their parenting, highlighting how alcohol use impairs their ability to be consistent, firm, and available to their child. Therapists also help parents access mental health and substance abuse services to address their own needs.

Family-based relapse prevention and aftercare

The most common precipitators of relapse following treatment are social pressures and negative affect (11). Protective factors against alcohol relapse include aftercare participation, better alcohol coping skills, and positive supports for recovery (31,32). Family functioning has also been found to play a primary role in helping teens achieve and maintain abstinence (33).

These findings underscore the importance of bolstering coping and relapse prevention skills during treatment and providing continued support and aftercare services following treatment (34).

In MDFT, primary family interventions are aimed at promoting new interactional patterns among family members. Since the family environment is an important context of adolescent functioning, one of the goals of MDFT is to create a new family environment in which the family becomes the therapeutic agent long after the MDFT therapist has completed work with the teen and parents. Thus MDFT family sessions use the technique of enactment to elicit and shape discussions of important topics, including alcohol use and ways to cope with drinking urges. These interventions provide opportunities for the therapist to take an active and directive stance toward the prompting of new responses and supportive behaviors from family members. Issues raised in the individual sessions with the parents and with the teenager are brought into the family meetings, with the encouragement, support, and facilitation of the therapist.

A complementary component of work that helps to maintain the teen's recovery during and following treatment is in the extrafamilial realm. MDFT therapists aim to improve the parents' and adolescent's functioning relative to important and influential social systems outside of the family and to promote the adolescent's involvement in prosocial activities. Added support during and following treatment is also facilitated by encouraging adolescents' participation in teen-focused AA meetings (35). Youths' attendance at AA and other 12 step meetings has been shown to increase motivation for abstinence and predict better outcomes in the three months following treatment (36). Multiple-systems oriented approaches such as MDFT have the advantage of addressing intrapersonal, social, familial, and extrafamilial relapse risk factors.

CONCLUSIONS

Increasingly, experts are recommending further development and application of family-based interventions like MDFT that are comprehensive and multisystemic in scope (37). MDFT's success in treating diverse samples has been based on its strong treatment development framework. The model has evolved over 20 years in response to the unique clinical needs of different clinical populations and empirical advances in our understanding of the clinical phenomenon of adolescent substance abuse. Consistent with treatment development guidelines, the model has undergone rigorous tests of therapeutic process and outcome (3,38,39). Variations of the approach have been designed to more effectively target the needs of different groups of adolescent substance abusers, such as adolescent girls and teens from different cultural groups. These efforts have been fruitful in that they have illustrated core mechanisms in MDFT (38), as well as developing more effective methods of intervention for specific target groups (39).

Similar work has been done in our clinical work to adapt family-based interventions for alcohol abusing teens. In this article, we have identified core areas based on etiological and treatment research that are potential targets of intervention. As we have done in previous treatment development efforts, we have worked from a detailed and deep understanding of the clinical phenomena of adolescent alcohol abuse, as we know it through the empirical literature, to identify areas for further

development. Rigorous empirical tests of family-based models for adolescent alcohol abuse are an obvious next step to advance this specialty.

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