Multidimensional Family Therapy for Adolescent Alcohol Abusers

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SUMMARY. Multidimensional Family Therapy (MDFT) has been empirically supported in a series of randomized clinical trials over 20 years. These studies have demonstrated the potency of MDFT in achieving outcomes across functional areas of the teen's life, including reductions in alcohol-other drug use, behavioral problems, emotional symptoms, negative peer associations, school failure, and deficits within the family. This article describes our approach to refining and testing MDFT with teens who abuse alcohol. Drawing from the research base on risk and protective factors for teen alcohol abuse and relapse patterns, a strong case can be made for using a family-based approach for adolescent alcohol problems. MDFT shows promising preliminary results with teens who have alcohol and marijuana use disorders. Specific change targets within

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INTRODUCTION

The last decade has seen significant advances in the empirical development and testing of treatments for adolescent alcohol abuse (Lowman, 2004). Individual and group interventions for adolescent alcohol problems are gaining empirical support, and researchers have made important discoveries outlining the critical factors and processes in alcohol relapse. Several studies have documented that standard community treatment can decrease adolescent alcohol use and ameliorate alcohol use disorders. However, in the first year following standard community-based treatment, up to 64% of teens continue, resume or increase their alcohol use (Maisto et al., 2001). Longer outcome studies show that over time (1-8 years), use of alcohol steadily rises in each consecutive year following standard, inpatient alcohol and drug treatment (Tapert et al., 2003). There is strong evidence that adolescents with alcohol use disorders are an underserved population at risk for chronic problems without effective treatment (Grant et al., 2006).

Risk and Protective Factors for Adolescent Alcohol Use Disorders

Alcohol problems are understood within a "biopsychosocial matrix of risk" (Zucker, 1994), which considers the multiple interacting influences that make individuals vulnerable for alcohol problems throughout the life span. Alcohol use in adolescence is generally embedded within a constellation of other deviant behaviors, including school failure, conduct problems, and drug use, which operate together to increase vulnerability for alcohol dependence in young adulthood and beyond (Guo et al., 2001). However, the risk factors for alcohol and other drug problems may be somewhat different (Zhou et al., 2006) and alcohol problems are known to have multiple interacting precipitating contributors, as well as different developmental trajectories. Generally, the earlier these problems develop and the greater the number of risk

factors in the absence of protective factors, the poorer the prognosis for long-term development. Thus, contemporary research supports multi-component interventions for adolescent alcohol abuse that are developmentally oriented and capable of addressing these interrelated factors (IOM, 1990).

Family factors play a central role in early alcohol use and the progression of alcohol problems. A range of family risk factors have been consistently linked to adolescent alcohol problems, including parent and sibling substance use (Sher et al., 1991), poor parental monitoring (Kuperman, 1999), family conflict (Dishion & Medici-Skaggs, 2000), parents' alcohol norms (Brody et al., 2000), and low family support and control (Windle, 1996). Negative parenting behaviors not only predict initial levels of drinking, but also influence increases in drinking over time. Family factors are also among the strongest protective influences against adolescent alcohol problems. Longitudinal research suggests that firm parental rules against drinking at ages 10 and 16 reduce the likelihood of alcohol abuse and dependence at age 21 (Guo, 2001). Parental control also predicts de-escalation of drinking among high school teens who have initiated alcohol use (Stice et al., 1998). Even among high-risk families, protective factors still operate; young adolescents with alcoholic parents are protected from later alcohol problems through high levels of family organization and behavioral coping (Hussong & Chassin, 1997). A recent study suggests that the strength of the bond between the teen and parent may be more powerful in predicting teen drinking than family structure or parental drinking (Kuntsche & Kuendig, 2006).

Family factors also play an important mediational role in explaining the impact of other risk factors for problem drinking among adolescents. One of the most important protective functions of parents during adolescence is reducing the teen's association with drug using peers. Family risk factors predict the teen's migration toward drinking peers, which directly influences alcohol use (Blanton et al., 1997). Parent-child conflict also predicts increases in adolescents' and their friends' substance use over time. An 18-year longitudinal study uncovered strong direct effects of peer antisociality on adolescents' substance use, but showed that peer relationships were determined by a range of family factors in early childhood (Garnier & Stein, 2002). While peers exert direct effects on teen drinking, parents mediate these influences through several different mechanisms. Family factors appear to operate both directly and indirectly to contribute to teen drinking, indicating the need for effective family-based interventions.

Rationale for Family-Based Interventions for Adolescent Alcohol Abuse

A strong tradition exists for the use of family-based interventions for adult alcohol abusers (O'Farrell and Fals-Stewart, 2003). For instance, Behavioral Couples Therapy (BCT), recognized as one of the most promising interventions for alcoholism, helps alcoholics reduce their drinking and incidents of domestic violence with significant cost-savings up to 2 years post-treatment. By improving marital/couple interactions and reducing substance abuse, children's behavioral functioning also improves dramatically (Kelley and Fals-Stewart, 2002). Empirical support for both behavioral family therapy and family systems approaches in treating adult alcohol abusers has accumulated steadily (Stanton and Shadish, 1997). The success of these interventions serves as a solid platform for the application of family-based interventions for adolescent alcohol abusers.

Findings from several well-controlled clinical trials also support the comparative efficacy of family-based therapy in reducing levels of adolescent drug use and increasing adaptive functioning (Rowe and Liddle, 2003). Family-based interventions have been found to have superior pre–to post-treatment effects on levels of adolescent drug use compared to individual therapy, adolescent group therapy, and family psychoeducational counseling (Azrin et al., 1994; Henggeler et al., 1991; Liddle, 2002b; Liddle et al., 2001, 2004). These effects have been retained up to 12 months after termination (e.g., Liddle et al., 2001). Family-based interventions not only directly reduce drug use, but also consistently alter the multiple risk factors that predict progression into further dysfunction. However, these models have generally not been developed specifically with alcohol abusing samples, and few report effects on alcohol use.

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 individually-oriented treatment as usual (Trepper et al., 1993). Azrin and colleagues demonstrated the superiority of behavioral family therapy in comparison to supportive counseling in reducing adolescent alcohol use and increasing the length of abstinence up to 9 months following treatment (Azrin et al., 1994). Further, family-based preventive interventions are among the most promising approaches for reducing the risk of alcohol abuse among adolescents. By reducing risk and bolstering protective factors,

family-based interventions may be instrumental in reducing vulnerability for later alcohol problems. For instance, Project Northland, a multifaceted, multi-year community-based intervention with a strong family component, has been successful in reducing alcohol use among young adolescents, reducing peer risk and positive expectations about drinking, and improving parent-child communication relative to controls (Perry et al., 1996). Thus family-based interventions, which have the advantage of directly addressing the multiple interacting risk factors for alcohol abuse and bolstering protective mechanisms within the family and other systems, appear to hold promise in reducing teen drinking.

Multidimensional Family Therapy for Adolescent Substance Abuse

Multidimensional Family Therapy (Liddle, 2002a) is recognized as a "Best Practice" model for teen substance abuse and delinquency by federal and international agencies (Communities that Care, 2004; Drug Strategies, 2003; NIDA, 1999; CSAT, 1998; Rigter et al., 2004). It has demonstrated efficacy in several clinical trials over the past 20 years in reducing substance use and related problems, and in increasing the prosocial and protective functioning of teens and their families (Liddle, 2002b; Liddle et al., 2001; Liddle et al., 2004). There is also evidence of its potential as a prevention model to reverse adverse developmental trajectories among high-risk youth (Hogue et al., 2002). However, adolescents with primary alcohol use disorders have constituted only a small percentage of the samples studied in these clinical trials. Family-based models such as MDFT offer promise for treating alcohol abusing teens and their families (Lowman, 2004); however, more attention to the unique needs of alcohol abusing youth and their families is needed.

MDFT has been adapted for different clinical populations using a systematic, empirically-grounded treatment development framework. The model has evolved over the past 20 years in response to the unique clinical needs of different clinical populations, empirical advances in our understanding of the clinical phenomenon of adolescent substance abuse, and treatment outcome and process research findings that guide our clinical approach. Consistent with treatment development guidelines (Kazdin, 1994), the model has undergone rigorous tests of therapeutic process and outcome. Model developers have asked questions about the specific adolescent, parent, family, and environmental factors that influence treatment outcomes with each unique population. Specific intervention targets have been identified through careful examination of basic developmental and applied research, as well as exploration of key

MDFT processes linked to successful outcomes, and MDFT has been modified accordingly for unique populations. These different versions of the approach are designed to more effectively target the needs of different groups of adolescent substance abusers, such as adolescent girls, adolescents from different cultural backgrounds, and adolescents with multiple comorbid problems.

Previous studies have tested the impact of systematic variations of the MDFT model. For instance, in applying the model with young African-American urban male drug abusers, we explored the cultural themes being expressed in therapy, studied the literature on the risk and protective forces at work in the lives of urban African American teens, and adapted the approach to integrate this content (Jackson-Gilfort et al., 2001). More recently, a similar process has been undertaken to identify salient cultural themes that are critical for successful engagement and productive work with Hispanic youth and families. In another study, examination of alliance building interventions with adolescents who initially demonstrated poor therapeutic relationships enabled us to develop early stage interventions necessary to succeed in engaging teens in MDFT (Diamond et al., 2000). Similarly, this systematic empirically-driven treatment development approach has guided our efforts to refine the model for young adolescents (Rowe et al., 2003). These efforts have identified core mechanisms of change in family-based treatment, as well as helping to develop more effective methods of intervention for these specific groups and others.

Similar work has been done to adapt MDFT specifically for alcohol abusing teens. 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 of further development. The following sections describe this treatment development process and change targets within MDFT.

MULTIDIMENSIONAL FAMILY THERAPY FOR ADOLESCENT ALCOHOL ABUSERS

The MDFT theory of change follows directly and logically from a multidimensional theory of dysfunction. Understanding that the teen's drinking and related problems have been caused by a complex set of interrelated and mutually reinforcing risk factors, MDFT targets

change in each of these core areas of functioning. The model posits that reductions in target symptoms and increases in prosocial behaviors occur via multiple pathways, in differing contexts, and through different mechanisms. With the adolescent, the therapist seeks to transform the youth's substance using lifestyle into a developmentally normative one with improved functioning across domains, including promoting positive peer relations, healthy identity formation, bonding to school and other prosocial institutions, and autonomy within the parent-adolescent relationship. Goals with the parent include increasing parental commitment and preventing parental abdication, improving communication with the adolescent, and increasing knowledge and skills in the realm of parenting practices (e.g., limit-setting, monitoring). In family sessions, MDFT therapists aim to transform negative interactional patterns into more positive relationships and to promote supportive and effective communication among family members. The therapy is phasically organized, and it relies on success in one phase of the therapy before moving on to the next. Knowledge of normal development and developmental psychopathology guides the overall therapeutic strategy and specific interventions.

The format of MDFT has been modified to suit the clinical needs of different clinical populations. A full course of MDFT is delivered in several sessions each week over four to six months. Sessions may be held in a variety of contexts including in the home, clinic, other community settings (e.g., school), or by phone. The MDFT treatment system assesses and intervenes into four main areas: the adolescent as an individual, the parent/parents as a subsystem, the family interactional system, and the extrafamilial system (the family and adolescent's interactions and relationships with influential systems outside of the family). Assessment of functioning in each of these areas is followed by interventions into these same domains. The core interventions of MDFT are organized according to the particular subsystem targeted and the stage of treatment.

Treatment development efforts with MDFT have focused on addressing the risk factors specifically linked to teen alcohol problems and bolstering protective processes that have been shown to facilitate resiliency among teens at risk. These specific areas of focus are discussed below: alcohol expectancies, parental substance abuse, and family-based relapse prevention.

Alcohol Expectancies

Research has shown that adolescents' alcohol expectancies are a significant predictor of heavy and problem drinking (Colder and Chassin, 1999). Alcohol expectancies include beliefs about the positive social (e.g., appearing more comfortable) and emotional (e.g., feeling more relaxed) effects of alcohol, as well as beliefs that alcohol is less harmful and more normative than it actually is. Adolescents' alcohol expectancies and attitudes are closely linked to the norms families communicate about drinking and by parents' drinking patterns (Martino et al., 2006). Positive alcohol expectancies predict early initiation of alcohol use and determine progressive increases in alcohol use after initiation. Alcohol expectancies also predict relapse to alcohol use up to 8 years following treatment (Tapert et al., 2003).

Expectancies about the positive social effects of alcohol play an important role in adolescent alcohol problems but are explained at least partially by family factors. Alcohol expectancies are shaped not only by the teen's drinking experience, but also by parents' drinking. Children not only adopt their parents' drinking behaviors, but also the drinking coping strategies and motivations that are modeled by their parents (Windle, 1996). Children tend to internalize their parents' norms about drinking by early adolescence, and, once internalized, directly influence their drinking behaviors (Brody et al., 2000). Protective factors that are facilitated in healthy family environments, such as good decision making skills, self efficacy and positive coping, as well as social competence, reduce risk for adolescent alcohol problems. Clinical research shows that one prevention approach that intervened with parents (Project Northland) was successful in decreasing adolescents' positive alcohol expectancies (Perry et al., 1996).

MDFT attends to the social cognitive aspects of substance use, the meaning and motivation for substance use, the teen's developmental challenges, and motivation to improve one's life. Addressing expectancies, beliefs, and attitudes about alcohol is consistent with the MDFT therapist's work with the individual adolescent in that therapists challenge teens to examine their motivations for using and help them become aware of the health compromising aspects that are associated with substance use. Individual sessions with the adolescent focus on highlighting discrepancies between stated personal goals or outcomes and current lifestyle choices, including beliefs about substances. Continued use of substances is acknowledged as being incompatible with a non-substance using lifestyle and the benefits of this new lifestyle and the changes associated

with it. Doing better in school, having less conflict at home, resolving one's legal problems, and having more fulfilling peer relations are elements of the non-substance using lifestyle that are developed and sought in MDFT.

The pathways to achieve a shift in alcohol expectancies and accompanying reductions in drinking come through individual work with the youth in ways that motivate him or her individually, but also in ways that involve parents and other systems. Work with the parents to examine their messages about alcohol use and norms about drinking are critical, in part because most parents underestimate their own teen's drinking (Guilamo-Ramos et al., 2006). The MDFT therapist helps parents in these individual sessions to commit to taking a firm stand against drinking and communicating a clear and consistent message that drinking is not safe for teens and is not acceptable. Individual work with both adolescents and parents provides a platform for families to talk together about drinking and other drug use. The therapist uses the core family therapy technique of enactment to shape productive and positive conversations between parents and teens that demonstrate the parents' love and concern for the adolescent in setting clear limits about drinking. These family sessions help the adolescent develop more realistic beliefs about alcohol and its consequences and hone new skills to avoid drinking.

Parental Alcoholism

One of the strongest and most consistent family risk factors for teen alcohol problems is parental alcoholism (Sher et al., 1991), with increased risk even when the parent's alcoholism is in remission. Lifetime risk of alcohol dependence is substantially elevated among children of alcoholics, particularly among those who initiate drinking during adolescence (Guo et al., 2001). Children with alcoholic parents show increased risk in the form of behavioral problems as young as age 3 (Fitzgerald et al., 1993), with high levels of drinking by either mother or father predicting heavy alcohol use as early as 5th and 6th grade (Weinberg et al., 1994). While genetics probably determines much of the liability for transition of alcoholism, environmental factors increase alcohol risk among children of alcoholics. Ellis et al. (1997) argue that it is the aggregation of numerous alcohol-specific (e.g., parental modeling) and alcohol-nonspecific factors (e.g., family disorganization) that increase risk for children of alcoholics. Parental alcoholism increases young adolescents' risk of alcohol abuse through specific mechanisms that can be addressed in family interventions, such as family conflict and lack of cohesion

(Havey & Dodd, 1995); decreased monitoring (Chassin et al., 1996); and behavior problems (Hussong et al., 1998). Parental alcohol use is an important determinant of alcohol-specific rules and alcohol availability in the home, which both predict teen drinking (Van Zundert et al., 2006). Thus, the genetic transmission of alcohol problems from parent to child is most likely mediated in part by factors that can be altered through intervention (Sher, 1994).

Directly and systematically addressing parental alcoholism is consistent with core parent work in MDFT. MDFT targets the functioning of the parent as an individual adult, apart from his or her role as a parent or caregiver. Since parenting practices are correlated with functioning in other domains of a parent's life, these other aspects of a parent's day-to-day functioning (e.g., mental health issues, drug or alcohol abuse, marital disharmony) are germane to address in therapy. The therapist motivates parents 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, their parenting deficits, and the child's problems. The therapist helps parents see how their drinking and other substance use has impacted the teen and how the parents' recovery is a necessary part of the youth's ability to get sober and stay abstinent. MDFT therapists link parents' alcohol and substance use to their parenting deficits, highlighting how alcohol use impairs their ability to be consistent, firm, and available to their child. Therapists help parents access mental health and substance abuse services to address their own needs. Individual sessions with the parent(s) include discussion of parenting philosophy and practices, assessing skills in implementing core parenting skills such as monitoring, limit setting, and communicating to the adolescent age appropriate maturity demands.

With this foundation in place, productive work can be done in family sessions to heal past hurts related to the parents' drinking and commit to helping each other achieve and maintain sobriety. As a result of individual work with the adolescent to explore his or her disappointment, shame, and anger related to the parents' drinking, many youth are prepared to share some of these experiences and feelings in family sessions. These family sessions can be very powerful motivators for parents to take steps toward their own recovery. These discussions are often empowering for teens as well, in that years of pent-up emotions can be shared and families can move toward forgiveness and a commitment to help each other in the recovery process.

Family-Based Relapse Prevention

The study of relapse trajectories following alcohol treatment has shed light on the different patterns of alcohol use and predictors and consequences of relapse after treatment (Chung and Maisto, 2006). Research shows that following standard outpatient treatment in the community, the medium time to relapse with alcohol is only 26 days, using the most stringent criteria for defining relapse, and between one-half and two-thirds of youth relapse by the 6 month follow-up (Cornelius et al., 2003). Alcohol use plays an important role in relapse among teens following treatment, even among those who do not report alcohol use as their substance of choice at intake (Brown et al., 2002). Protective factors against relapse include aftercare participation, better alcohol coping skills, and positive supports for recovery (Chung et al., 2004). Understanding different relapse trajectories has helped identify those youth who may need more intensive treatment and follow-up services. Taken together, these studies underscore the importance of bolstering coping and relapse prevention skills during treatment and providing continued support for abstinence and following the formal treatment phase.

Family functioning has been found to play a primary role in helping teens achieve and maintain abstinence. For instance, parental participation in youth substance abuse treatment predicts positive outcomes at both 6 and 12 months (Hsieh et al., 1998). Improvements in family relationships are strongly related to long-term maintenance of treatment goals following adolescent substance abuse treatment (Brown et al., 1994), whereas family drug use is linked to poorer treatment retention and more alcohol use among teens after treatment (Galaif et al., 2001). Further, firm family rules and consequences about drinking both related to initial motivation to stop drinking and predicted taking action to change drinking behaviors 3 months following adolescents' alcohol-related medical emergencies (Barnett et al., 2002). Families are clearly important in maintaining post-treatment gains.

In MDFT, individual sessions with teens focus on the context, meaning, and consequences of drinking so that positive alternatives can be generated and adopted. In contrast to more traditional family therapy models, MDFT directly and systematically targets the drinking and related cognitions and behaviors, rather than assuming drinking will abate when family conflict reduces and parents become more effective in implementing positive parenting strategies. The MDFT therapist helps teens recognize the emotional, behavioral, and cognitive antecedents to

drinking, and to identify the consequences of drinking in relation to problems with family members, peers, school, and the legal system (as well as longer-term ramifications if the use continues). Drinking is considered a problem not from a moralistic or legalistic standpoint, but because excessive drinking keeps adolescents from reaching the goals they have set for themselves. Regular drinking keeps teens from being available to themselves to make good decisions about their lives. Progress in avoiding friends and situations where they will be tempted to drink and using coping skills generated in individual sessions is continually linked back to the teens' stated hopes and dreams for themselves. In this way, motivation is elicited for long-term abstinence beyond the completion of therapy.

In addition to individual work, family interventions are aimed at promoting new interactional patterns among family members. Since the family environment is an important context of adolescent functioning, and communication and interactions are generally compromised in substance abusing families, the family interactional realm is generally in need of significant attention during treatment and following the initial treatment phase. 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 substance use and ways to cope with drinking urges. These interventions provide *in vivo* 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. For instance, therapists contact school and arrange meetings, coaching the parents and adolescents about what is required in these situations to facilitate the best possible outcomes, and how to maintain good outcomes after treatment. The fundamental premise of extrafamilial interventions is that changes in parents, adolescents, and in family interactions are insufficient unless social environment factors and realities are taken into account. Extrafamilial interventions facilitate a

new kind of mindset and competence of parents and adolescents vis a vis these developmentally influential social systems, promoting additional supports for abstinence following the end of treatment. For example, added support during and following treatment is facilitated by encouraging adolescents' participation in teen-focused AA meetings. Multiple-systems oriented approaches such as MDFT have the advantage of addressing intrapersonal, social, familial, and extrafamilial relapse risk factors.

EMPIRICAL SUPPORT FOR MDFT WITH ADOLESCENT ALCOHOL ABUSERS

Examining results of Multidimensional Family Therapy with adolescent drug abusers who also reported alcohol use suggests that the model has promise with teen drinkers. For instance, in the first trial of MDFT, the model was compared to two other standard, once-a-week (14-16 sessions), office-based therapies (adolescent group therapy and multifamily education) with a sample of youth who were almost all combinational users of both alcohol and marijuana (Liddle et al., 2001). At termination, youth assigned to MDFT showed a 54% reduction in combinational alcohol and marijuana use in comparison with only an 18% reduction for group therapy and a 24% reduction for multifamily therapy. The general pattern of results shows the greatest improvement among youth in MDFT, with gains maintained at 6 and 12-mth follow-ups.

Another controlled trial compared MDFT to individual Cognitive Behavior Therapy (CBT) with a primarily male, African American sample with marijuana use disorders (Liddle, 2002b). Examining only those teens who reported drinking at intake (40%) revealed a significant decrease from intake to 12 months following discharge for both the individual (CBT) and family-based (MDFT) treatment conditions. Overall, both treatments reduced symptoms from intake to termination across all three target domains of functioning: substance use, externalizing symptoms, and internalizing symptoms; however, only MDFT was able to maintain treatment gains in these areas after termination and up to the 12-month follow-up.

A third randomized trial compared MDFT with a manualized peer group therapy for drug abusing young adolescents (ages 11-15) who were predominantly male and minority (Liddle et al., 2004). Significant treatment effects (pre-post treatment) were found to favor MDFT in four major risk domains: externalizing symptoms, family cohesion, peer delinquency, and school behavior. In addition, MDFT was more

effective than group treatment in decreasing alcohol use in the subset of adolescents who reported drinking at intake (20% of the sample). MDFT participants showed a 71% decrease in alcohol use compared to a 39% *increase* in alcohol use among youth in group treatment from intake to discharge. Youth in MDFT were also more likely to be abstinent from alcohol at the 12 month follow-up than teens in group treatment.

In a series of clinical trials, MDFT has demonstrated more significant reductions in the target symptoms of substance abuse, internalizing and externalizing symptoms, delinquency, school performance, and family problems than comparison treatments. There is also evidence that MDFT can reduce alcohol use and maintain these gains up to 12 months after therapy.

CONCLUSIONS

We have presented an empirically based justification and outline for new areas of treatment development for MDFT with adolescent alcohol abusers. The treatment development work that has been done in the family-based specialty generally and in MDFT specifically has focused mainly on drug abusing samples. This specialty area is poised for breakthroughs with alcohol abusing teens if careful theoretically and empirically based treatment development work is done. The theory that guides this work is based on a thorough understanding of the known determinants, ingredients, and contextual factors that predict alcohol problems among teens.

With sound theory, preliminary outcomes, and a vast empirical base on risk factors to guide the implementation of family-based alcohol-specific interventions for teens, rigorous study of these approaches with drinking samples is an important next step. Many questions remain unresolved regarding differences among teens with comorbid drug and alcohol use disorders versus those with primary abuse of alcohol. As noted above, the etiological pathways to different substance use disorders may be different, suggesting that interventions may need to be alcohol-specific. This article outlines promising targets of change with teen drinkers and their families.

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