

# Reducing Adolescent Substance Abuse and Delinquency: Pilot Research of a Family-Oriented Psychoeducation Curriculum

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**ABSTRACT.** Ninety-three parents and 102 adolescents were referred by juvenile court and treated for substance abuse and a co-morbid diagnosis of either oppositional defiant or conduct disorder using a parent education program over a six-week period. The goals of this study were to assess whether or not active parent involvement and the concurrent treatment of severe behavior problems would reduce teen substance as measured by the adolescent SASSI scale. In addition, if the SASSI scale indicated a significant reduction in substance abuse would these changes be maintained after a 12-month follow-up period as measured by re-arrest rates through juvenile court records? The results indicated that a parent's participation in their teen's treatment of substance abuse and

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other severe behavioral problems did have a major positive impact. Even though the adolescent's attitudes and defensiveness towards drugs or alcohol did not significantly change their substance abuse did. This was demonstrated by both the statistically significant changes on the adolescent's SASSI scores and the fact that 85% did not relapse over the course of an entire year after treatment was completed. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2006 by The Haworth Press, Inc. All rights reserved.]

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### INTRODUCTION

There is a growing concern in our society about the dramatic increase of adolescent drug and alcohol abuse and dependence. There is no shortage of reports describing these alarming trends (e.g., Muck, Zempolich, Titus, Fishman, Godley et al., 2001; Rowe & Liddle, 2003). Overall, drug abuse by teenagers has risen dramatically since 1996 while the overall use among adults has stayed the same or dropped (Department of Health and Human Services, 2002).

Increases in teen substance use have led to a greater need for theoretically based and empirically supported treatments (The Brown University Digest, 1999). Indeed the number of studies devoted to substance abuse and treatment in youth is continually growing (e.g., Coatsworth, Santisteran, McBride, & Szapocznik, 2001; Latimer & Newcomb, 2000; Liddle, Dakof, Parker, Diamond, Barrett et al., 2001). However, many agree that a gap still exists between research on adolescent substance abuse and the treatments currently being provided (Liddle, Rowe, Quille, Mills et al., 2002; Robbins, Bachrach, & Szapocznik, 2002; Rowe & Liddle, 2003).

Recent studies have pointed to three critical gaps in adolescent substance abuse research and treatment. First, there is a growing body of evidence that links adolescent substance abuse to dysfunctional family dynamics (e.g., Carr, 1998; Friedman, Terras, Glassman, 2000; Liddle & Schwartz, 2002; McGillicuddy, Rychtarik, Duquette, & Morsheimer, 2001; Public Health Reports, 1997; Tuttle, 1995). Brown, Monti, Myers, Waldron, and Wagner (1999) reported that "family support" was often cited by teens as being most helpful in quitting drugs and maintaining sobriety. Despite the growing support for the incorporation of family

therapy into adolescent substance abuse treatment (e.g., Berlin, 2002; Lambie & Rokutani, 2002; Rowe, Parker-Sloat, Schwartz, & Liddle, 2003; Wallace & Estroff, 2001), many programs still do not involve the family as an intricate part of their approaches. Instead, the primary emphasis is still on the individual teen through traditional treatment approaches (e.g., Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)) that are often designed for adults without taking into consideration the unique needs of adolescents (Berlin, 2002). Deas and Thomas (2001) agree that many tenets of twelve-step programs may be overly abstract and distasteful for developing adolescents (p. 187).

Second, the majority of substance abusing teens in treatment also exhibits other problems such as truancy, fighting, and defiance (Fisher & Harrison, 2000), running away (Slesnick, Myers, Meade, & Segelken, 2000), or other problem behaviors (Schmidt, Liddle, & Dakof, 1996). In these cases, family-based treatments were found to be highly effective not only in reducing substance use, but also in alleviating associated symptomatic behaviors. In 1999, the National Assembly on Drug and Alcohol Abuse and the Criminal Offenders concluded that addressing "adolescent drug addiction or substance abuse without also treating, for example, behavioral problems such as truancy, running away, or threats of violence reduced the likelihood of success" (p. 2). Yet, researchers at the National Assembly cited the failure of most treatment programs to address both substance abuse and severe behavioral problems concurrently.

Finally, researchers have found the psychoeducational component of family substance abuse treatment to be successful in reducing the teen's drug use as well as heightening parents' functioning. Studies have highlighted the utility of psychoeducation in adolescent substance abuse treatment, including parent training (Bamberg et al., 2001; Schmidt et al., 1996) and skills training (McGillicuddy et al., 2001; Wagner, Brown, Monty, & Waldron, 1999). One problem with traditional parenting groups, however, is the significant dropout rate of parents and teens. Parents are often resistant to acceptability for their children's substance abuse. Not surprisingly, they state that adolescents are responsible for their own difficulties. Thus, they resent coming to a parent education group to learn new skills because their teen "got caught" abusing drugs or alcohol. As a result, parents are resistant in helping their teen overcome their substance abuse. However, a systemic approach to teen substance abuse treatment has been shown to result in a higher level of engagement in treatment and to lower dropout rates than other routine procedures (Cormack & Carr, 2000).

To address these deficits, a parent education program was used to treat teens that were diagnosed with substance abuse as well as oppositional defiant or conduct disorders (DSM-IV; American Psychiatric Association [APA], 1994) and their parents. Ninety-three parents and 102 adolescents were referred by juvenile court and treated using the parent education program over a six-week period. Research studies have shown that teen substance abuse and conduct disorder relapse rates are typically extremely high with some as high as 75% (Long, 1999; Sholevar & Schworer, 2003).

The goals of this study were to assess whether or not active parent involvement and the concurrent treatment of severe behavior problems would reduce teen substance as measured by the adolescent SASSI scale and if these changes would be maintained after treatment ended over a 12-month period.

### **Research Questions**

Three questions were examined in this study. First, would active parent involvement and the concurrent treatment of severe behavior problems reduce teen substance abuse as measured by the adolescent SASSI subscales? Second, would reductions in substance abuse behavior as measured by the SASSI subscales be maintained at the 12-month follow-up? Third, would adolescents relapse within a 12-month period as measured by re-arrest rates through juvenile court records?

## **METHODS**

The sample consisted of 102 adolescents and 93 parents who together attended a six-week *Parenting with Love and Limits*<sup>TM</sup> substance abuse prevention program. The adolescents ranged in age from 9 to 18, with the average participant being 15 years old. Each participant was diagnosed with substance abuse and a co-morbid diagnosis of either oppositional defiant or conduct disorder. The study was conducted within an opportunistic window of opportunity. This required that the study be non-reactive in terms of measurement. As a result, we were unable to track demographic variables such as socioeconomic data and severity of offense.

The majority of the adolescents were White (82.4%). The remaining participants were African-American (11.8%) and Mexican-American (1.0%). Both males and females were present in the sample, with males

substance abuse, extreme disrespectful behaviors, and so on. At the end of this module, parents and teens form respective breakout groups to vent their feelings and frustrations.

In the second module, presentations are made on how adolescents engage in provocative behavior (e.g., swearing, argumentative discussions). Presentations are also made on how parents engage in activities that are ineffective (e.g., lecturing, criticizing, acrimonious comments about past conflict).

In the third module, effective behavioral contracting methods are presented. Parents are taught to critique their contingency management contracts to ensure that adolescents will be apprised on the consequences of violating provisions of a behavioral contract. Parents and adolescents retire into separate breakout groups to critique and write new contracts.

In the fourth module, presentations are made on how adolescents creatively circumvent seemingly well-designed behavioral contracts.

In the fifth module, parents choose from a recipe menu of creative consequences to respond to adolescents' provocative behaviors. Such behaviors include skipping school, drug/alcohol abuse, sexual promiscuity, violence, and threats of suicide.

In the sixth module, parents and children are taught about the necessity to recreate a positive climate within a household and specific methods of doing so.

The rationale behind the use of this program is twofold. First, *Parenting with Love and Limits*<sup>TM</sup> is one of the first parent education programs of its kind to specifically address both substance abuse and oppositional and conduct disorder behaviors concurrently. Traditional psychoeducation group programs are not based on a lengthy period of process and qualitative research with adolescents and their families. Further, they are not designed to address a range of extreme behavior problems in adolescents. Finally, teens are not typically active participants in the parenting group process. Traditional groups are either for the parents only or the teens as passive observers and not active participants.

The high completion rate (i.e., 85% completion rate by adolescents and a 94% completion rate by parents of all six weeks of the *Parenting with Love and Limits*<sup>TM</sup> program) ensured that the study was a credible investigation into the programmatic effects.

### **Measures**

The Adolescent SASSI questionnaire was administered to the 93 adolescents before they began the first *Parenting with Love and*

2.06, whereas the post-test mean was .73. The pretest mean for the FVOD was 2.83, whereas the post-test mean was .95.

The adolescent's attitudes about their drug or alcohol use were measured through the OAT and SAT. On the OAT subscale, the average respondent changed only slightly. The pretest mean for the OAT subscale was 6.19, whereas the post-test mean was 5.85. A similar pattern is seen in the SAT subscale, with the exception of direction. The average respondent had a pretest SAT score of 1.90 and a post-test SAT score of 2.08. The difference between these scores was not statistically significant.

The last subscale (DEF) measured defensiveness concerning substance use. The primary purpose of the DEF scale is to identify defensive clients who are trying to conceal evidence of personal problems and limitations. Whether it is due to life events or to personality characteristics, excessive defensiveness can be problematic, and it must be taken into account in treatment planning.

On this subscale, the average respondent's score increased slightly (6.60-7.05). This indicates that the average program participant increased slightly in defensiveness. However, this change was very small and did not reach statistical significance. In addition, the average respondent was in the normal range at the time of pretest, so high levels of change were not expected on this subscale. Only six (15%) of the 93 adolescents who completed the *Parenting with Love and Limits*<sup>TM</sup> program relapsed or re-offended over a 12-month period as indicated by juvenile court arrest records that tracked each of the 93 adolescents. Re-offenses included both substance abuse behaviors (e.g., illegal possession of alcohol or drugs like marijuana) and conduct disorders behaviors (e.g., shoplifting, violence, running away, etc.).

## DISCUSSION

The results indicate that parents' participation in adolescents' treatment of substance abuse and severe behavioral problems can have a major positive impact on program effectiveness. One key indicator was adolescents' self-reported substance use dropped significantly. This finding was juxtaposed by the finding that adolescents' attitudes and defensiveness toward drugs or alcohol did not significantly change. The significant change in subscales on perceived alcohol and drug use showed that adolescents believed that they misused these substances. This was demonstrated by both the statistically significant changes on

the adolescent's SASSI scores and the fact that 85% did not relapse over the course of an entire year after treatment ended.

The low OAT and SAT scores among adolescents were not unexpected because while they may judge themselves as misusing or using drugs or alcohol, they do not see themselves as having a drug or alcohol problem. That is, adolescents often do not see themselves as chemically dependent or having personality characteristics that are associated with society's stereotypical alcoholic or drug abuser on skid row (SASSI Manual, 2000). Thus, a high score and level of change on these subscales was not wholly unexpected.

This evidence suggests that a group-oriented, family therapy informed psychoeducation is effective in helping parents reassert their authority and reduce if not curtail adolescents, their teen's severe behavior problems and substance abuse. Additionally, attitudes toward alcohol and drug abuse may well change following behavioral changes. Notwithstanding this optimistic viewpoint, there are potential problems with the lack of congruence between attitudes and behavior. Without understanding why adolescents changed their behavior, the possibility of recidivism is elevated. The lack of recidivism in this study suggests that that this process needs to be further studied.

One key ingredient in the current study may be parental involvement and providing them with the proper skills to address their adolescents' behavioral problems. The parental involvement may explain the 94% completion rate by parents and the 84% completion rate by adolescents of all six two-hour parenting classes. One intuitive explanation for adolescents' high rate of attendance was that they were ordered into treatment. However, that does not explain why parents' involvement was so elevated. High parent attendance in this six-week course contradicts research findings that this population of parents is resistant to treatment and shows a lack of participation in the overall therapeutic process. Therefore, the 94% completion rate shows promise that programs with the right curriculum can engage a population of parents who are traditionally highly resistant to participation.

Future studies that use qualitative research methods are needed to discover what particular concepts or techniques within the Parenting with Love and Limits program are reducing parental resistance and increasing their readiness to change. The identified key concepts can then be refined and modified to increase both parent and teen participation and readiness to change.

## REFERENCES

- Bamberg, J., Toumbourou, J.W., Blyth, A., & Forer, D. (2001) Change for the BEST: Family changes for parents coping with youth substance abuse. *Australian and New Zealand Journal of Family Therapy*, 22(4), 189-198.
- Berlin, M. (2002). Adolescent substance abuse treatment: A unified model. *Dissertation Abstracts International: Section B: The Sciences & Engineering*, 63 (6-B), pp. 2999.
- Brown, S.A., Monti, P.M., Myers, M. G., Waldron, H. B., & Wagner, E.F. (1999). More resources, treatment needed for adolescent substance abuse. *The Brown University Digest of Addiction Theory and Application*, 18 (11), 6-7.
- Carr, A. (1998). The inclusion of fathers in family therapy: A research based perspective. *Contemporary Family Therapy*, 20 (3), 371-383.
- Coatsworth, J.D., Dsanisteban, D.A., McBride, C.K., & Szapocznik, J. (2001). Brief strategic family therapy versus community control: Engagement, retention, and an exploration of the moderating role of adolescent symptom severity. *Family Process*, 40 (3), 313-333.
- Cormack, C., & Carr, A. (2000). Drug abuse. In A. Carr (Ed.), *What works with children and adolescents?: A critical review of psychological interventions with children, adolescents, and their families*.
- Deas, D., & Thomas, S.E. (2001). An overview of controlled studies of adolescent substance abuse treatment. *The American Journal on Addictions*, 10: 178-189.
- Fisher, G.L., & Harrison, T.C. (2000). Substance abuse: Information for school counselors, social workers, therapists, and counselors. Needham Heights, MA: Allyn & Bacon.
- Friedman, A. S., Terras, A., & Glassman, K. (2000). Family structure versus family relationships for predicting to substance use/abuse and illegal behavior. *Journal of Child & Adolescent Substance Abuse*, 10(1), 1-16.
- Lambie, G.W., & Rokutani, J. (2002). A systems approach to substance abuse identification and intervention for school counselors. *Professional School Counseling*, 5(5), 353-360.
- Latimer, W.W., & Newcomb, M. (2000). Adolescent substance abuse treatment outcome: The role of substance abuse problem severity. *Journal of Consulting and Clinical Psychology*, 68 (4), 684-697.
- Liddle, H.A., Dakof, G.A., Parker, K., Diamond, G.S., Barrett, K., & Tejada, M. (2001). Multidimensional family therapy for adolescent drug abuse: Results of a randomized clinical trial. *American Journal of Drug and Alcohol Abuse*, 27(4), 651-688.
- Liddle, H.A., Rowe, C.L., Quille, T.J., Dakof, G.A., Mills, D.S., Sakran, E., & Biaggi, H. (2002). Transporting a research-based adolescent drug treatment into practice. *Journal of Substance Abuse treatment*, 22 (4), 231-243.
- Liddle, H.A., & Schwartz, S.J. (2002). Attachment and family therapy: The clinical utility of adolescent-family attachment research. *Family Process*, 41 (3), 455-476.
- Long, W.C. (1999). The dilemma of addiction and recovery during adolescence. *Dissertation Abstracts International Section A: Humanities and Social Sciences*, 59 (7-A), pp. 2440.