Reducing Adolescent Substance Abuse and Delinquency:

Pilot Research of a Family-Oriented Psychoeducation Curriculum

Thomas Edward Smith
Florida State University

Scott P. Sells
Savannah State University

Jeffrey Rodman
Warren Coalition

Lisa Rene Reynolds
Nova Southeastern University

Thomas E. Smith, Ph.D., is a Professor in Social Work at Florida State University; Scott P. Sells, Ph.D., is a Professor in Social Work at Savannah State University; Lisa Rene Reynolds, LMFT, PhD Candidate Nova Southeastern University.

All Correspondence should be addressed to Scott P. Sells, Ph.D. Savannah State University, Department of Social Work, Savannah, GA 31404. E-mail: spsells@aol.com Phone: (912) 224-3999 Fax: (912) 897-5959

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

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 lead 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 et. al. (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 approach. 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 the adolescent (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 exhibit 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 parental functioning. Studies have highlighted the utility of psychoeducation in adolescent substance abuse treatment, including parent training (Bamberg, et. al.,
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2001; Schmidt, et. al., 1996) and skills training (McGillicuddy, et.al., 2001; Wagner, Brown, Monty, & Waldron, 1999). However, one problem with traditional parenting groups is the significant dropout rates of both parents and teens. Parents are often too accepting of their children’s substance abuse. Not surprisingly, they state that their adolescents are solely responsible for their own difficulties. Hence, they resent coming to parent education groups to learn new skills because their teen “got caught” abusing drugs or alcohol. Parents are subsequently resistant in helping their teen overcome their substance abuse. Studies are therefore needed that demonstrate higher parent attendance, increased parent engagement, and lower parent and teen dropout rates (Cormack & Carr, 2000).

To address these deficits, a parent education program was implemented to treat teens who were diagnosed with substance abuse as well as oppositional defiant or conduct disorder (DSM-IV; American Psychiatric Association [APA], 1994) that actively involved 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.

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 follow-up period. The follow-up piece was critical because research studies have shown that teen substance abuse and conduct disorder relapse rates are typically high with some as high as 75% (Long, 1999; Sholevar & Schwoeri, 2003).
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™ 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 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 accounting for the majority of the participants (56.9%). All adolescents were court ordered and drug tested to determine a baseline rate of substance abuse. In addition, these adolescents committed a wide variety of concurrent offenses, with the most commonly occurring offense being shoplifting (22.5%). Once the cases that were missing data related to the SASSI subscales were deleted, 93 adolescents remained in the sample.
Parenting with Love and Limits™

The six-week Parenting with Love and Limits psychoeducational program was developed from a three-year process-outcome research study (Sells, 1998; Sells, 2000, Sells, Smith & Sprenkle, 1995) and integrated the best principles of a structural family therapy approach. Structural Family Therapy was rated a Model Program in the United States Department of Education’s *Applying Effective Strategies to Prevent or Reduce Substance Abuse, Violence, and Disruptive Behavior Among Youth* (Scattergood, Dash, Epstein, & Adler, M, 1998). Programs using the framework of structural family therapy have consistently demonstrated success in reducing or eliminating substance abuse in adolescents (Labia & Rokutani, 2002; Springer & Orsbon, 2002; Rowe, Parker-Sloat, Schwartz & Liddle, 2003).

Two group facilitators led a small group of parents, caregivers, and their teenagers (no more than 4-6 families with no more than 15 people total in the group) in six classes, each two hours long. Two co-facilitators are needed because breakout groups were an essential piece of the program. Parents and teens meet together collectively as a group but there are times in which each group meets separately in breakout groups. The rationale for these breakouts was that often times both parents and teens need to meet separately to address issues that collectively they cannot.

The Parenting With Love and Limits Program provided parents with a detailed six-module treatment manual on curtailing their teenagers’ substance abuse and other behavior problems. To assist in intervention delivery, workbooks were available for parents, their children, and group facilitators. In addition, a final workbook was available on how to train group facilitators to implement the program.
The Parenting With Love and Limits Program is designed to provide the parents with a step-by-step roadmap on how to stop both their teenagers substance abuse and other behavior problems using the following six class modules:

- **Class One: Understanding Why Your Teen Misbehaves.** Parents learn why their teen creatively uses things like substance abuse, disrespect, running away, or violence to commit acts of parent abuse to defeat parents each and every time they try to regain control of their household. Parents and teens go into their respective breakout groups to vent their feelings and frustrations.

- **Class Two: Button Pushing:** Parents learn how their teen skillfully pushes their hot buttons (whining, disgusted look, swearing, etc.) and teens learn about how parents push their (lecturing, criticizing, talking in chapters, etc.).

- **Class Three: Ironclad Contracting** Parents learn how and why their old methods of contracting failed and the five micro steps to put together an ironclad contract that actually works with the use of both rewards and consequences. Teens meet in their breakout groups to help write their own contract.

- **Class Four: Troubleshooting:** Parents learn how teens have a special ability called “enhanced social perception” to think two steps ahead and derail even the best-laid contract.

- **Class Six: Stopping the 7 Aces:** Parents choose from a recipe menu of creative consequences to stop the teen’s 7 aces or “big guns” of disrespect, ditching or failing school, running away, drugs or alcohol, sexual promiscuity, violence, or threats of suicide.
Class Seven Reclaiming Lost Love: Understand how years of conflict have drained the softness out of the parent child relationship and the six strategies needed to reclaim this lost love.

The rationale behind the use of this program was twofold. First, *Parenting with Love and Limits™* is one of the first parent education programs of its kind to specifically address both substance abuse and oppositional and conduct disorder behaviors concurrently. Second, teens and parents together were active participants in the entire six-week group. Many traditional groups are either for the parents only or for the teens only.

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™* program) indicated that the study was a credible investigation into the programmatic effects.

Treatment fidelity was demonstrated through a manualized Leader's Guide that was used by each group facilitator. The Leader's Guide had the same script that each group facilitator applied in exactly the same way. Each group facilitator also went through the same intensive two-day training on how to conduct the program with consistent live observation “spot checks” once a week throughout the six- week program.

**Measures**

The Adolescent SASSI questionnaire was administered to the 93 adolescents before they began the first *Parenting with Love and Limits™* class and again after the last parenting class was completed. It has five subscales: The FVA subscale measured
self-perception of alcohol abuse. The FVOD subscale measured self-perception of other drug abuse (i.e., marijuana). The OAT (overt measure of attitudes toward drug use) and SAT (subtle measure of attitudes toward drug use) together measured adolescents’ overt and covert willingness to admit that they have personality characteristics that are commonly and stereotypically associated with substance abusers (e.g., impatience, low frustration tolerance, grandiosity, etc). The fifth subcale was the DEF that measured defensiveness toward drug use.

The Adolescent SASSI has a high reliability co-efficient of .91 and high face validity for each of its five subscales (SASSI Manual, 2000). To assess for change following program participation, paired sample t-tests were conducted for each subscale of the SASSI.

Recidivism or relapse rates for all 93 adolescents who completed the program were measured through juvenile court records for each adolescent. Re-arrest records for substance abuse or conduct related problems such as shoplifting were obtained for all 93 adolescents six months after the completion of the parenting program and then again after twelve months of completing the program.

Results

As Table 1 indicates both the FVA and FVOD subscale scores were significantly lower following the adolescent’s participation in the Parenting With Love and Limits six week program. These two subscales measure adolescent’s judgements on whether or not they have substance abuse with Alcohol (FVA) and other drugs like marijuana (FVOD). The pretest mean for the FVA was 2.06 whereas the posttest mean was .73. The pretest mean for the FVOD was 2.83 whereas the posttest mean was .95.
Table 1

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Pretest Mean (Standard Deviation)</th>
<th>Posttest Mean (Standard Deviation)</th>
<th>T</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>FVA</td>
<td>2.06 (2.79)</td>
<td>.73 (1.41)</td>
<td>4.532</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>FVOD</td>
<td>2.83 (4.94)</td>
<td>.95 (2.05)</td>
<td>3.732</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

The adolescent’s attitudes about their drug or alcohol use were measured through the OAT (Obvious Attitudes) and SAT (Subtle Attitudes). The OAT and SAT scales measured the adolescents willingness to admit that they have personality characteristics that are commonly and stereotypically associated with substance abusers (e.g., impatience, low frustration tolerance, grandiosity, etc).

On the OAT subscale, the average respondent changed only slightly. The pretest mean for the OAT subscale was 6.19 whereas the posttest 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 posttest SAT score of 2.08. The difference between these scores was not statistically significant.

Low OAT and SAT scores among adolescents are common because while adolescents may judge themselves as misusing or using drugs or alcohol, they do not often see themselves as having a drug or alcohol problem. 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). Therefore, a high score and level of change was not expected on these subscales.
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 to 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.

As Figure 1 indicates out of the 93 adolescents who completed the Parenting with Love and Limits™ program only 15% or six adolescents out of 93 relapsed or re-offended as indicated by juvenile court arrest records that tracked each of the 93 adolescents over a 12-month period. Re-offenses included both substance abuse behaviors (e.g., illegal possession of alcohol or drugs like marijuana) and conduct disorder behaviors.
There was an 85% completion rate by adolescents and a 94% completion rate by parents of all six weeks of the Parenting with Love and Limits™ program. Even though the teens were court ordered into the parenting program, the parents were not.

**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. 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 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 was not expected on these subscales was not wholly unexpected.

This evidence suggests that a group-oriented, family therapy informed psychoeducation can be 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 this process needs to be further studied.

It appears that key ingredient in the current study was parental involvement and providing parents with the proper skills to address their adolescents’ behavioral problems. In turn, the reduced stress of alleviating these severe behavioral problems may have led to a less stressful home environment, which in turn could have lead to a reduction in substance abuse as indicated by the SASSI.

The high level parental involvement is indicated by the 94% parent completion rate 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 because they were not court-ordered into treatment.

High parent attendance in this six-week course contradicts research findings that this population of parents are traditionally resistant to treatment and show a lack of participation in the overall therapeutic process (Bamberg, et. al., 2001; Schmidt, et. al., 1996; Springer & Orsbon, 2002). 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 micro-step 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 with substance abusing adolescents. In addition, future outcome studies that involve random assignment and control groups are also needed to isolate key variables that contributed to higher parental involvement, lower recidivism rates, and lower rates of adolescent substance abuse.

References


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