Evidence-Based Family Treatment of Adolescent Substance-Related Disorders

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Introduction

Adolescence is an important period of individual development. It is a time wherein youth develop the ability to reason in more sophisticated ways than done previously. During this crucial period, youth often explore and shift their identity, behavior, and relationships (Arnett, 2013). Some degree of risk-taking and other externalizing problem behaviors are normal during this period of exploration and change. Although potentially dangerous, these behaviors help adolescents learn the importance of boundaries regarding their physical and emotional safety, as well as appropriate ways to assert their independence. Many adolescents discover these limits by experiencing punishments imposed by caregivers and authority figures, along with natural consequences when their behaviors are inappropriate. These repercussions often help to decrease problem behaviors by the time youth reach adulthood. However, the cessation of problem behaviors often is frustrated by adolescent substance abuse and addiction. Additionally, family, peer, and other contexts in which teens live have the potential to contribute to the development and continuation of their problem behaviors and substance abuse.

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Repetti, Taylor, and Seeman (2002) outlined the characteristics of both healthy and unhealthy family systems. These authors point to the increased risk of youth raised in unhealthy families to develop mental and physical problems in adolescence and later in life, including smoking, alcohol abuse, and drug abuse. To help youth exhibiting substance-related disorders, clinical interventions are crucial. Due to the interconnectedness of youth and their families, only treating the youth involved will be likely to result in failure because the family systems will not have adapted to support the individual's changes. Weidman (1987) recognized that the families of adolescent drug abusers can either help or hinder treatment, and proposed that families should be at least minimally involved in the treatment of adolescents and preferably engaged in family therapy.

Family systems researchers also assert that not only do individuals and families mutually influence one another, but individuals and families experience mutual influences with their surrounding systems as well (Bronfenbrenner, 1988). For instance, teens who engage in problem behavior, including substance use, often develop adversarial relationships with school officials, law enforcement, and others. When such teens begin to make changes aimed at eliminating problem behaviors, if their schools and law enforcement do not change the way they interact with the teens (i.e., continue to treat them as adversaries), the changes the teens are making will not be supported and may be jeopardized.

On the basis of a review of the clinical literature, Liddle (2004) concluded that family-based treatments of adolescent substance abuse have been shown to be more effective than alternative treatments in producing short-term and long-term change. To bring about lasting change, clinicians have proposed that treatments must not only intervene with the family system in which the adolescent develops, but also address extrafamilial systems. Sexton and Alexander (2005) identified several approaches that fulfill those criteria: multisystemic therapy (MST), multidimensional family therapy (MDFT), functional family therapy (FFT), and brief strategic family therapy (BSFT). After reviewing the recent clinical literature (i.e., the last 10 years) on family treatments of adolescent substance abuse, including two meta-analyses (Baldwin, Christian, Berkeljon, Shadish, & Bean, 2012; Tanner-Smith, Wilson, & Lipsey, 2013) published in the last 5 years, the authors of this chapter decided to include these four models in this chapter under the heading of "evidence-based family treatments." Other promising models will be discussed briefly, but MST, MDFT, FFT, and BSFT will receive the most attention.

Prevalence of Substance Use

Illicit Drugs

It is important to note two factors when considering rates of illicit drug use among adolescents: grade level of the child and type of drug use being reported (Johnston, O'Malley, Miech, Bachman, & Schulenberg, 2017). Grade level of the child often is

used instead of the child's age in reports of substance use rates because it better captures developmental context, particularly the peer context. Adolescents tend to share the peer context most often with peers in the same grade level, and drug use among adolescents is most likely to occur in peer contexts.

Children at higher grade levels are more likely than those in lower grade levels to use illicit drugs as they spend less time in the family context and more in the peer context (Johnston et al., 2017). The type of drug used also tends to vary by grade level of child. Children at lower grade levels are more likely than children at higher grade levels to use easily accessed substances (e.g., inhalants), while children in higher grade levels are more likely to use "harder" drugs (e.g., marijuana, cocaine, heroin). Finally, rates of illicit drug use are often impacted by the fact that marijuana, especially among older children, is the most frequently used illicit drug and tends to drive indices of illicit drug use; therefore, it is useful to consider rates of illicit drug use, excluding marijuana, to better detect trends in overall illicit drug use rates. This also should be in considered in the context of changing laws on recreational marijuana use; although it is still illegal for those under 21 to possess marijuana in states where recreational marijuana use has been legalized, the punishments may be less severe.

Although researchers have observed declines in adolescent drug abuse with regard to specific classes of drugs since 2014 (Johnston et al., 2017), the rate of drug use still is high. According to Johnston et al., (2017), the average lifetime rate of any illicit drug use 8th, 10th, and 12th graders combined was 32.6% in 2016. The average lifetime rate of illicit drug use for drugs other than marijuana was 14.3% in 2016. By grade level, the rates of lifetime use of any illicit drug are as follows: 17.2% for 8th graders, 33.7% for 10th graders, and 48.3% for 12th graders. A notable difference exists between these rates and those that exclude use of marijuana, which are significantly lower: 8.9% for 8th graders, 14% for 10th graders, and 20.7% for 12th graders.

Alcohol Abuse

The Monitoring the Future survey (Johnston et al., 2017) also revealed that statistics varied widely by grade level for alcohol use. Among 8th graders, 22.8% had ever used alcohol, followed by 43.4% of 10th graders, and 61.2% of 12th graders. In terms of those who had been drunk, 8.6% of 8th graders, 26% of 10th graders, and 46.3% of 12th graders reported ever being intoxicated.

Long-Term Impacts of Adolescent Substance Use

Substance abuse that begins in adolescence can have long-term consequences. The National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration, 2013) found that adults who first used marijuana at age 14

or younger were over four times more likely to be classified with substance use or dependence as those who first used marijuana at or after age 18 (11.5% vs. 2.6% respectively). Adults who first consumed alcohol at age 14 or younger also were over four times more likely to be classified at any point in their lives with alcohol abuse or dependence compared with those who first consumed alcohol at or after age 18 (15.4% vs. 3.8% respectively).

Treatment Gaps

The Substance Abuse and Mental Health Services Administration (2013) estimates that 1.5% of teens in the US population at or above age 12 received treatment for either illicit drug use or alcohol use in 2013. This remained stable from the previous year and is comparable to 2002. According to the Substance Abuse and Mental Health Services Administration (2013) the percentage of adolescents currently dependent on or abusing illicit drugs in 2013 was 5.2% (2.8% for alcohol); comparison of these statistics indicates that there may be a significant gap between the number of adolescents who need treatment and those who actually receive it.

Evidence-Based Family Treatments

Family-based treatments are clinical approaches wherein the adolescent battling with a substance-related disorder is treated with members of his or her family system. Considerable research supports the importance of including more than just the adolescent in treatment, as the adolescents' families are often affected by the adolescents' substance abuse and the adolescents' substance abuse is also influenced by family interactions in a bidirectional manner (Alexander, Waldron, Robbins, & Neeb, 2013).

Several family-based treatments have displayed varying, yet promising, levels of success in treating adolescent substance abuse. Some of the treatments considered in this chapter (e.g., MST, MDFT, FFT, and a combination of FFT and cognitive-behavioral therapy) are integrative therapy models because they employ the use of multiple therapeutic models. Other family treatments (e.g., BSFT) are more narrowly focused family interventions, and adhere more closely to traditional family therapy models. In addition to providing treatment to the family system, MDFT, MST, and FFT also qualify as ecological models in that they include other external systems in treatment (e.g., law enforcement, schools, religious groups) to encourage change in those systems that would support changes in the family and individual who are the focus of treatment.

MST (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009), MDFT (Liddle, 2002), FFT (Alexander & Parsons, 1982), and BSFT (Szapocznik, Hervis, & Schwartz, 2003) are four family treatments that have shown, through multiple and rigorous studies, effectiveness in treating adolescent substance abuse

(Baldwin et al., 2012; Tanner-Smith et al., 2013). Descriptions of each family-based treatment model and its respective empirical evidence will be elucidated hereafter.

Multisystemic Therapy

MST (Henggeler et al., 2009) is based on the ecological theory of human development (Bronfenbrenner, 1979) and early family therapy approaches including structural (Minuchin, 1974) and strategic family therapy (Haley, 1976). Bronfenbrenner's ecological theory posits that human beings develop in the context of multiple nested systems. Beyond the developing individual, the most basic and important of these systems is the family. Other systems include the community, school, work, and larger society in general. These systems shape the individual both directly (through interaction with the individual) and indirectly (through interaction with other systems). In addition, the individual and the systems interact with each other in a reciprocal manner; individuals shape the systems just as the systems shape individuals. Bronfenbrenner's theory is central to the practice of MST because the MST therapist acts as an advocate for and intervention specialist within the adolescent, family, and the extrafamilial systems (Schoenwald & Henggeler, 2005).

Bronfenbrenner's ecological theory is central to the MST theory of change (Henggeler et al., 2009), which posits that adolescent antisocial behavior, which includes substance abuse, develops in the context of intersecting risk factors whose origins are in the multiple systems with which the adolescents interact, either directly or indirectly. For therapy to be effective, MST interventions must address these risk factors and develop protective factors in their place. These protective factors are important because they support the changes made by the individuals and families through the course of treatment; without such supports, changes made are likely to break down. In addition, MST assumes that caregivers play a central role in change, and need the resources and skills to make changes to become more effective caregivers (Henggeler et al., 2009). The development of protective factors in systems external to the family is accomplished in partnership with caregivers.

MST is a home-based therapy. A primary therapist, who is part of a larger treatment team, implements MST by providing therapy to the adolescent, family, and other systems in their environments (Henggeler et al., 2009; Schoenwald & Henggeler, 2005). The prescribed use of a treatment team is the most unique aspect of MST, and one that is necessary due to the intensive nature of MST. The treatment team consists of the primary therapist, a supervisor, and one to three other MST therapists. Although the primary therapist is ultimately responsible for carrying out the treatment interventions, the treatment team helps in assessment and provides feedback on the therapist's conceptualization of the case. Assessment is constantly occurring in MST, so the treatment team monitors and makes changes to the treatment plan based on whether targeted changes are taking place. In addition, the treatment team makes it possible for an MST therapist to be available to clients 24 h a day, 7 days a week by making a treatment team member available as a therapist in

the absence of the primary therapist. The supervisor's role is to ensure treatment fidelity. The treatment team is essential to the successful implementation of MST.

MST has a well-defined analytical process known as the "Do Loop" (Henggeler et al., 2009; Swenson, Henggeler, Taylor, & Addison, 2005). The "Do Loop" is a series of steps that guide the MST treatment team in assessment and intervention. First, the therapist assesses what problems brought about the family's referral to MST. Next, the therapist assesses the goals of the key players involved in the process (e.g., adolescent, parents, school officials, coworkers, or work supervisors). Once those goals are decided upon, the treatment team formulates overarching goals for the family. The therapist then begins to determine the fit between the referral problems and the ecology of the youth (Henggeler et al., 2009; Swenson et al., 2005). To do so, the therapist observes the strengths of the family and the surrounding systems, and refines the assessment as information is discovered. Next, the therapist formulates short-term treatment goals that are linked to the overarching goals.

When all the goals are formulated, the therapist begins to implement interventions meant to help the family and extrafamilial systems accomplish those goals (Henggeler et al., 2009; Schoenwald & Henggeler, 2005). During this period, the therapist monitors the success of the interventions. When a barrier to success appears (whether at the family, extrafamilial, or therapeutic level), the treatment team formulates strategies to overcome those barriers. The therapist implements those strategies and reevaluates. Another unique aspect of MST is that, at any point in the therapeutic process, MST prescribes a self-reflexive process for the therapists and treatment teams. Success and failure of treatment are evaluated by both the therapist and the treatment team. The therapist, treatment team, and supervisor monitor their own behavior in relation to the therapeutic process. The self-reflexive process is unique because many other therapies do not prescribe it as a crucial part of therapy, and because a treatment team plays an integral role in the process. Although other therapies, in theory, can function without such a process, MST requires it as a part of a faithful adherence to the treatment model.

MST has been evaluated as an effective treatment for youth violence, delinquency, and substance use (Curtis, Ronan, & Borduin, 2004; Henggeler, Clingempeel, Brondino, & Pickrel, 2002; Henggeler, Melton, Brondino, Scherer, & Hanley, 1997; Henggeler, Melton, & Smith, 1992; Henggeler, Pickrel, & Brondino, 1999; Liddle, 2004; Liddle & Dakof, 1995). Henggeler et al. (1991) reported that 4% of all juvenile offenders in the MST condition had a substance-related arrest in a 4-year follow-up, compared to 15% of those in individual therapy. In a 14 year follow-up to this study, Schaeffer and Borduin (2005) found that juvenile offenders who received MST were less than half as likely as those who received individual therapy (13% vs. 33.3% respectively) to be arrested for a later substance-related offense. In another 4-year follow-up study, Henggeler et al. (2002) found that adolescents in the MST condition abstained from marijuana significantly more frequently than did adolescents in the treatment-as-usual condition (55% vs. 28%, respectively). Finally, in a

study of substance abusing juvenile offenders (Henggeler et al., 2006), researchers found that MST was more effective than other treatments at decreasing substance use over a one year period.

Multidimensional Family Therapy

MDFT (Liddle, 2002) is based on several frameworks: risk and protective factors, developmental perspectives, and ecological theory (Liddle, 2016). The risk and protective factors framework provides information to clinicians about various factors that facilitate or hinder healthy development (e.g., peer networks, early physical maturation, community resources, neighborhood violence). Developmental perspectives provide information to clinicians about normative developmental transitions and youths' ability to cope with the developmental tasks associated with such transitions (Rohde et al., 2007). Ecological perspectives provide a framework for understanding not only the individual and family, but interacting social influences (e.g., mesosystems; Bronfenbrenner, 1979) that form unique and whole systems of influence on individual development (e.g., peer and school, school and home). Such systems need to be a focus of intervention (Liddle, 2016) because it helps to reinforce longer lasting systemic change for individuals and families if the systems surrounding them are supportive of changes made at the individual and family level.

One of the primary guiding principles of how change occurs in MDFT is that "adolescent problems are multidimensional phenomena" (Liddle, 2016, p. 233). In other words, substance abuse problems in adolescents are associated with a myriad of interconnected factors that are biological, psychological, and social in nature. Therefore, the MDFT therapist must intervene with not only the individual, but also family, peers, school, and other social systems, to name a few. In addition, MDFT assumes that "family functioning is instrumental in creating developmentally healthy lifestyle alternatives for adolescents" (Liddle, 2016, p. 233). In MDFT, the family is a target in assessment and intervention because of its direct influence on adolescents. It is the therapist's role to create individual therapeutic alliances with the family and other multiple systems in which the adolescent is embedded.

MDFT is a manualized treatment system, which is published online (Liddle, 2002; Liddle, Rodriguez, Dakof, Kanzki, & Marvel, 2005). MDFT is designed to tailor the treatment to the characteristics of the adolescent, family, and their involvement with extrafamilial systems. For that reason, MDFT has been modified into several formats to account for varying individual and family circumstances (Liddle, 2004). MDFT is similar to MST in its goals and some of its concepts, but MDFT takes a different approach to the process of therapy, mainly in its prescription for individual sessions and meetings with the adolescent and with the family, and the lack of a dedicated treatment team that is available 24/7 as in MST.

MDFT is implemented in stages with modules within each stage (Liddle, 2002, 2016). Initially, the therapist meets with the entire family to begin assessing family interactions, and then the therapist moves on to the first stage. The first stage is

engagement. Within this stage, the MDFT therapist usually meets with the adolescent (module 1) and parents (module 2) separately for a few sessions to allow for engagement and to gain information about the unique perspectives of each individual. In individual sessions with the adolescent, therapists focus on current pressures the adolescent is experiencing, motivation for substance use, identity, and future dreams and goals (Liddle, 2016). In individual sessions with parents, therapists focus on environmental challenges parents experience in their parenting, along with gaining information about parenting practices and their relationship with their child (Liddle, 2016). Some interventions take place in the engagement stage as well. After the individual sessions are complete, the therapist brings the family together (module 3) to further assess family interactions and history, as well as to begin to define the therapeutic process. The therapist also begins to shape family interactions on a smaller scale (e.g., the therapist may ask family members to use I-statements or may have family members explore one another's perspectives or emotions). Larger scale, and more stress-inducing, changes and interventions (e.g., enactments, prescribed changes to interactions outside of therapy) are accomplished in later stages. In module 4, the therapist makes contact with representatives from the extrafamilial systems that have an interest in the adolescent's well-being. The therapist assesses the needs of the extrafamilial systems in relation to the adolescent and establishes a working relationship with them. Of course, as with MST, the therapist receives the parents' permission to contact those systems.

The second stage is the *primary intervention* stage (Liddle et al., 2005). Module 1 is insight-oriented, skill-oriented, and solution-focused. The therapist encourages self-examination in the adolescent, helps to improve functioning in critical areas (e.g., anger management), and focuses on solutions and alternatives for living. The therapist also collaborates with other treatment systems (e.g., psychiatrists) with which the adolescent is involved. In module 2, the therapist helps the parents to learn how to engage in self-care activities (e.g., stress-reduction, and assessing needs and desires), employs parenting training, and helps solve interparental conflict (i.e., help them work as a team). In module 3, the therapist facilitates discussion among family members to bring conflict into the open and to deal with it directly. The therapist also encourages the discussion of past hurts and emotions surrounding the problem and parental attempts to solve the problem.

In the third stage, the therapist acknowledges changes that have been made by the family, making them overt and visible to the family (Liddle et al., 2005). MDFT emphasizes that treatment is not perfect, and that all changes, whether desirable or imperfect, are part of the family's narrative about a future that includes those changes. In this stage, the therapist also explores termination of therapy with the family.

MDFT has been effective in reducing substance abuse in adolescent client populations (Liddle et al., 2001; Liddle, Rowe, Dakof, Ungaro, & Henderson, 2004). In a randomized clinical trial, MDFT, compared to adolescent group therapy and a multifamily educational intervention, yielded clinically significant and greater reductions in substance abuse and improved family functioning between pretreatment and posttreatment, and at 6- and 12-month follow-ups (Liddle et al., 2001). Clinically significant reductions were judged to be a reduction in substance abuse

below the threshold set for entry into the study (i.e., marijuana use at least three times per week over a period of a month, or an instance of using "hard drugs"). Liddle et al. (2004) found that MDFT led to greater maintenance of treatment gains when compared to peer group treatment.

Comparison of MDFT and MST

On the surface, MDFT and MST are very similar therapeutic models. Although the overarching goals and targets of treatment are quite similar, there are noticeable treatment process differences. Similarly to MST, in the treatment of adolescent substance abuse, MDFT targets the adolescent, family, and extrafamilial systems. MDFT emphasizes that adolescent substance abuse develops along various contextual pathways that sometimes intersect (Liddle et al., 2005). In other words, the MDFT therapist assumes that adolescent substance abuse develops along pathways involving peer relationships, family relationships, individual psychological issues, and interactions between those systems and educational and justice systems (i.e., mesosystemic interactions; Bronfenbrenner, 1988). For example, MDFT may target an adolescent's peer relationships in the context of the school setting or examine how relationships with peers are affecting interactions with parents.

Despite their similarities, MST and MDFT take different approaches to the therapeutic process. While MST permits individual sessions, it is preferred that the therapist intervene with the entire family; MDFT prescribes individual sessions. In addition, unlike MST, there is no prescription for a treatment team to be involved in each case for MDFT. The therapists in MST and MDFT are self-reflexive, but MST therapists have the added advantage of a treatment team that is available to be actively involved in the therapeutic process as both observers and actors (i.e., meeting with extrafmailial systems, providing back-up to the lead therapist in case of absence). Finally, MDFT seems to emphasize the role of the therapist in creating therapeutic alliances between and among involved systems, where MST emphasizes the family as the active agent in setting up therapeutic alliances with the coaching of the therapist.

Functional Family Therapy

FFT (Alexander et al., 2013; Alexander & Parsons, 1982) follows many of the same theoretical principles and therapy models as Multisystemic Therapy and Brief Strategic Family Therapy (e.g., family systems theory, structural family therapy, and strategic family therapy). In addition, as is often the case with other therapeutic approaches, FFT explicitly emphasizes that the therapist is an integral part of the therapeutic system. Because of FFT's assumption that every family is different, the therapist must be creative in the treatment of the family (Sexton & Alexander, 2005).

However, the need for creativity does not preclude the need for structure in the therapeutic process. The FFT therapist must be attuned to the dialectic tension between creativity and structure, and be able to balance the two (Sexton & Alexander, 2005).

FFT developed out of the earlier family therapy models of structural and strategic family therapy (Sexton & Alexander, 2005). Those two models, as with other therapies discussed in this chapter, emphasize assessing repeated patterns of interactions in families and intervening in an active and purposeful manner by targeting the problems that are most amenable to change. FFT has more recently included social constructionist and ecological theories to provide (1) an approach that is open to therapist creativity and (2) a comprehensive approach that considers the multiple systemic interactions that difficult client populations (such as substance abusing adolescents) experience (Sexton & Alexander, 2005). Additionally, FFT is a short-term, intensive, strength-based model, which is usually completed over an average of 12 sessions spanning 3–4 months (Alexander et al., 2013).

To provide the structure needed for sound therapy, the creators of FFT developed a clinical model that consists of five treatment phases: Engagement, Motivation, Relational Assessment, Behavior Change, and Generalization (Alexander et al., 2013). The goal of the Engagement Phase is "to enhance family members' perceptions of responsiveness and credibility" (Alexander et al., 2013, p. 8). This phase is completed in a culturally sensitive manner, wherein the therapist attends to the myriad needs of the family and meets them where they are. Families may have transportation issues or speak a different language. Therefore, therapy may need to be performed in the families' homes and the therapist may need to arrange for a translator or for another therapist who is fluent in the families' native tongue (Alexander et al., 2013).

FFT involves as many family members in treatment as possible and, whereas other treatment models focus much more on individual behavior change in the adolescent (and sometimes the parents), FFT emphasizes that the family's interactions are central to problem development (Alexander et al., 2013). Therefore, the overarching goal of the Motivation Phase is to help engage all family members, thus helping to increase their motivation for change as a result of treatment. Specifically, "The goals of this phase include creating a positive motivational context, minimizing hopelessness and low self-efficacy, and changing the meaning of family relationships to emphasize possible hopeful experiences" (Alexander et al., 2013, p. 12).

In the Relational Assessment phase, the therapist attends to whether each family member's statements or behaviors seek to build connection or to distance within the family system, as well as to establish hierarchy (Alexander et al., 2013). In the Behavior Change phase, change occurs through family-based interventions such as skill building, changing habitual problematic interactions, and other coping skills being taught at both the individual and relational levels. Other creative interventions and skills aimed at changing negative behavioral and cognitive patterns are utilized during this phase (Alexander et al., 2013; Sexton & Alexander, 2005). FFT therapists work with family risk and protective factors to activate change. For example, the FFT therapist may target a particular family strength (e.g., positive regard for one another) to reduce negative affect or poor communication in interactions.

Lastly, the Generalization Phase is used to help individuals and families maintain the changes they have made or are in the process of making on multiple systemic levels (Alexander et al., 2013). This involves the therapist linking changes in the family to other areas of family functioning peripheral to the original presenting problem, with the goal of transferring treatment gains into multiple areas of family functioning. The FFT therapist also makes connections between the family and other community resources. For example, the FFT therapist may link the family with support groups or community recreation centers (Alexander et al., 2013).

Although all the therapies mentioned in this chapter are attuned to the same guiding principles of family therapy as FFT, there are notable differences among them. For example, FFT does not prescribe individual sessions with the adolescent or other family members as in MDFT. According to FFT, individual behavior change is best accomplished in the context of the family; therefore, the preferred tool is relational interventions.

Another difference among FFT, MST, and MDFT is in the level of focus on extrafamilial systems. While FFT considers extrafamilial systems (e.g., relationships with peers, the family's support network) in the generalization phase, there is no direct consultation or intervention with those systems during the first two stages of therapy. Both MST and MDFT therapists interact directly with extrafamilial systems during the entire course of therapy.

According to several clinical trials, FFT has demonstrated effectiveness in reducing delinquency and substance abuse (Liddle, 2004; Waldron, 1997; Waldron, Slesnick, Brody, Turner, & Peterson, 2001). Liddle cited FFT as one of the more effective models of family therapy for adolescent drug abuse. Friedman (1989) found that FFT significantly reduced substance use and improved psychiatric and family functioning, but the effects were not significantly greater than those in the other treatment condition (i.e., parent training group). However, in a randomized clinical trial, FFT demonstrated significantly greater effectiveness in reducing heavy to minimal adolescent marijuana use at 7 months posttreatment than did cognitive-behavioral therapy (CBT) alone and group interventions (Waldron et al., 2001). Another study demonstrated that FFT (office based) was more effective than treatment as usual in reducing alcohol and other drug use among runaway youth (Slesnick & Prestopnik, 2009). However, the same authors found that families took part in and completed more treatment sessions when they received a home-based ecologically based family therapy approach versus FFT. The authors point to the likelihood that the setting (i.e., office-based versus home-based) in which the therapy is provided influences the number of sessions families complete (Slesnick & Prestopnik, 2009).

Brief Strategic Family Therapy

Another family-based treatment that has demonstrated effectiveness is BSFT (Szapocznik et al., 2003). Like the other approaches reviewed in this chapter, BSFT adheres to family systems theory, as well as structural and strategic family therapy

models (Horigian et al., 2005). BSFT is different than the others in that it is a short-term therapy alternative. BSFT is intended to be completed within 12–16 sessions, with booster sessions after termination as needed (Horigian et al., 2005). BSFT subscribes to the same theories as FFT, but it has different emphases within its process. BSFT has three main stages: joining, diagnosing, and restructuring (Horigian et al., 2005). During the joining phase, the therapist focuses on engaging the adolescent and family in therapy. The therapist attempts to form a new system with the family—the therapeutic system. The therapeutic system includes all members of the family and the therapist, with the therapist acting as both an observer and a change agent. As both an observer and a change agent, the BSFT therapist is very active. Joining is crucial to the therapist becoming a change agent because the therapist must gain the family's trust in order to direct change in an active way. Joining involves simultaneously attending to the individuals within the family and patterns of family interaction. Because the therapist must assess family functioning as it typically and naturally occurs during the joining phase, substantive interventions are not implemented during this stage.

At the diagnosing stage, the therapist begins to more actively assess the family. Part of the diagnosing stage involves creating enactments (Horigian et al., 2005). Enactments should fulfill two purposes: (1) create an atmosphere in which family members can interact as they normally do and (2) provide the therapist with an assessment opportunity to passively observe the family. The therapist should intervene in early enactments to redirect the family members to interact with each other during the enactment rather than to talk to the therapist.

The therapist attends to several factors during assessment (Horigian et al., 2005). Paying attention to family hierarchy, subsystem organization, and the communication flow enable the therapist to understand how the family organizes itself around interactions. The therapist also focuses on the connections and responsiveness among family members. It is important for the therapist to assess the family's developmental stage, especially when children are in adolescence. One of the family interactional patterns most closely associated with adolescent behavior problems occurs when one or both parents do not allow for developmentally appropriate autonomy (Micucci, 1998). Finally, the therapist attends to family interactions organized around maintaining the adolescent as the identified patient. In doing so, the therapist identifies who blames the adolescent for family problems, and who contributes to the adolescent maintaining that role (Horigian et al., 2005).

The final stage before termination of treatment is restructuring (Szapocznik et al., 2003). Once the therapist has assessed the family, clinical goals are formulated and interventions are assigned to each goal. Interventions focus on reshaping present interactions. That is, therapists work to pinpoint what is happening in the therapy room and use those interactions as the basis for change (Horigian et al., 2005). Families in therapy often want to focus on the content of their past interactions ("he said/she said"), but it is the therapist's responsibility to redirect the family to process-oriented interactions in the here-and-now.

The therapist uses reframing to motivate change. When reframing, the therapist helps the family create alternative meanings behind interactions. Reframing is not meant to change individual cognitions, but to create an alternate frame of reality in which the family can successfully operate (Worden, 2003). For instance, in the context of exploring what parents term as an adolescent's "rebellion," the therapist may reframe the rebellion as an attempt by the adolescent to become more independent from the parents so that he or she can one day live without the parents' assistance. If the parents buy into the reframe, then they can set up a system in which they feel less need to control the adolescent and will be able to help develop that autonomy in more adaptive ways.

The BSFT therapist also works to change the family's boundaries to de-emphasize alliances that are maintaining maladaptive behavior in the adolescent (Horigian et al., 2005). For instance, if the adolescent has an overinvolved relationship with one parent, the therapist might assign tasks designed to increase the frequency of positive interactions with the other parent. The BSFT therapist also assigns tasks to the family to be completed outside of sessions (Horigian et al., 2005). Assigning tasks accomplishes two goals: (1) it maintains the family's effort outside of therapy sessions, and (2) it helps the family continue its success following treatment. The belief is that if the family members can successfully complete tasks while outside of the therapy room, then they will continue to carry their success and new tools after treatment.

BSFT differs from the other therapies mentioned in this chapter in several ways. First, it is a brief therapy option, and is less intensive than MST and MDFT. It is a viable alternative when a therapist does not have the resources to be available to clients 24 h a day, 7 days a week (as MST requires), or to engage in prolonged treatment. It is meant to be completed within a relatively brief time period; MST, MDFT, and FFT do not have a set number of sessions. BSFT also differs in that there is no prescription for intervention with extrafamilial systems.

BSFT has been shown to be effective in treating adolescent drug abuse (Santisteban et al., 2003; Szapocznik et al., 1988; Szapocznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1986). Santisteban et al. (2003) found that 60% of BSFT participants reliably decreased marijuana usage, compared to 17% in the group therapy condition. In a recent clinical trial comparing BSFT to treatment-as-usual conditions (e.g., group therapy, parent education, case management), Robbins et al. (2011) found that BSFT resulted in a significant reduction in number of days of self-reported drug use among adolescents compared to the treatment-as-usual, as well as higher success in engaging adolescents and their families in treatment, and improvements in family functioning.

Promising Family Treatments

Certainly, treatments with strong empirical support are the best options for clinicians who wish to ensure they are utilizing the best available treatments. However, there are alternative approaches that show promise. Some treatments have not been developed fully into a treatment model or have not yet been shown to be effective, yet they show promise as viable treatment alternatives. The most promising of these is described below.

Cognitive-Behavioral Therapy and FFT (Integrative Treatment)

Integrative treatment has shown promise in recent research, but has not been institutionalized in the form of a manual or developed beyond being a treatment condition in clinical trials. Waldron et al. (2001) combined CBT and FFT to serve as a treatment condition in testing the effectiveness of FFT as a treatment for adolescent substance abuse. Waldron et al. (2001) also tested CBT by itself in the study. The CBT model used in the study focused on developing self-control and coping skills to help the adolescents avoid substance abuse. When combined with a family therapy model such as FFT, this rendition of CBT adds an additional skill-based component that is not always present in traditional family therapy.

When combined, FFT and CBT offered an integrative treatment that (1) identifies and intervenes in family interactions that maintain adolescent substance abuse and (2) initiates behavioral change in the adolescent and helps the adolescent gain skills to avoid the use of substances. Waldron et al. (2001) found that the condition that combined FFT and CBT outperformed both component treatments. The FFT/CBT combination resulted in a greater reduction in heavy to minimal marijuana usage from pretreatment to 7 months posttreatment (89.7% vs. 55.6%) than did the FFT condition (86.6% vs. 62.1%).

Family Treatments for Specific Abused Substances

There are no family treatment approaches to our knowledge that are *designed* to target a specific drug. However, some treatment models have shown effectiveness in decreasing use of specific substances. For instance, Santisteban et al. (2003) found that BSFT was more effective than adolescent group therapy in the treatment of adolescents who abused marijuana. At posttreatment, 60% of the adolescents in the BSFT condition improved (i.e., decreased use) and 15% deteriorated (i.e., increased use), while 17% of those in the group therapy condition improved and 50% deteriorated.

Parental substance abuse can also be a target of family therapy interventions with adolescent substance users. Parental substance abuse is a systemic issue that needs to be addressed when it occurs in the home of an adolescent. It is not uncommon for adolescents to abuse drugs or alcohol that they witness their parents using. It is somewhat less common, but possibly more therapeutically significant, that some parents abuse drugs *with* their children. It may be helpful for the therapist to target those specific drugs that the parents abuse, whether alone or with their children, when facilitating family therapy.

Conclusion: Treatment Recommendations

Our overarching treatment recommendation is that clinicians treating substance abusing adolescents or their families should strive to use those treatment strategies that have been shown to be empirically effective. Researchers testing the effectiveness of MST, MDFT, FFT, and BSFT have demonstrated their ability to produce both short-term and long-term reductions in substance misuse of adolescents, above and beyond the effects of other treatments popular in treatment communities (Curtis et al., 2004; Henggeler et al., 1991, 2002; Liddle et al., 2001, 2004). Many available treatment options have shown some effectiveness in treating other disorders and family problems. It is a natural tendency of treatment professionals to gravitate toward the treatment models under which they trained, and with which they have experienced some success in other contexts. However, it should be the goal of every clinician to utilize treatment approaches that are effective for the specific populations and problems with which the clinician works (e.g., adolescent substance abuse).

There are specific aspects of evidence-based family treatments that have been connected with treatment success with substance abusing adolescent populations. The following aspects of evidence-based treatments could be used as criteria for discerning effective treatment protocols from ineffective ones.

- *Engagement*. Researchers examining evidence-based treatments have demonstrated the effectiveness of family-based treatments in engaging adolescents and their families in treatment (Curtis et al., 2004; Liddle, 2016; Liddle et al., 2001, 2005; Schoenwald & Henggeler, 2005). The engagement process is also referred to as joining (Horigian et al., 2005). Engaging adolescents and their families in treatment is important to keeping them in treatment long enough for treatment to have a significant effect on the identified problems. Family-based treatments emphasize engaging the entire family, not just the adolescent with the identified problem.
- *A present- and problem-focused approach.* Evidence-based treatments emphasize the use of both present- and problem-focused approaches to therapy (Horigian et al., 2005; Schoenwald & Henggeler, 2005; Sexton & Alexander, 2005). Present-focused approaches rely on family interaction patterns that take place during and between therapy sessions for both assessment and intervention.

MDFT therapists encourage clients to talk about past hurts, but they make sure that clients talk to each other about such things rather than to the therapist in order to maintain a process focus (Liddle et al., 2005).

- *A multisystemic (ecological systems) orientation*. Most evidence-based treatments for adolescent substance abuse incorporate multisystemic interactions and how they are related in a reciprocal manner to the identified problem (Liddle et al., 2005; Schoenwald & Henggeler, 2005; Sexton & Alexander, 2005). Interventions with the systems surrounding the adolescent and family (e.g., work, school, legal system, and peers) produce changes in the systems, beyond the family, that maintain the adolescent's substance misuse.

Our recommendation for the treatment of adolescents battling with substance-related disorders is a family-based approach that encompasses all of the above criteria. MST, MDFT, and FFT all meet these criteria. BSFT includes the first two criteria listed above, but does not explicitly focus on multisystemic processes early in therapy. However, BSFT is a brief therapy option; a multisystemic orientation requires more long-term and intensive therapy. However, even with a short intervention, it might be advisable for BSFT therapists to consider multisystemic influences on the family in assessment and intervention.

A final recommendation is that clinicians should choose a therapy approach geared toward the context within which each client/family operates. MST, MDFT, and FFT have been validated with juvenile-justice populations, and are more appropriate for them. BSFT, as a brief therapy option, may be more appropriate for adolescents and families who are not or are minimally involved with the legal system due to its less intense focus on extrafamilial systems.

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