

Strengths-Oriented Family Therapy for Adolescents with Substance Abuse Problems

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Adolescent substance abuse continues to be a societal problem for which we need high quality, cost-effective treatments. That is, substance use and abuse by adolescents is associated with a more rapid progression into addiction, delayed entry into adult roles (that is, adult relationships, employment, and so forth), and high societal costs (Chambers, Taylor, & Potenza, 2003; Kandel, Davies, Karus, & Yamaguchi, 1986; Miller, Levy, Spicer, & Taylor, 2006). Thus, we need to expand treatment options for adolescents with substance abuse problems. This article describes a new treatment program, developed by social workers, called Strengths-Oriented Family Therapy (SOFT). Specifically, we describe the rationale for SOFT, intervention techniques, and the linkages with social work values.

OVERVIEW OF STRENGTHS-ORIENTED FAMILY THERAPY (SOFT)

SOFT is a manualized treatment developed for a five-year project to expand and enhance adolescent drug treatment in two counties in rural and semi-rural Iowa (SAMHSA TI 13354). Although SOFT shares many components with other prominent models of family treatment (Hamilton, Brantley, Tims, Angelovich, & McDougall, 2001; Liddle, 2001), this model has three unique features: (1) a pretreatment family motivational enhancement session called the Strengths-Oriented Referral for Teens (SORT) (Smith & Hall, 2007), (2) a foundation in solution-focused language and treatment techniques, and (3) a formal strengths and resources assessment in the early stages of treatment. Overall, the SOFT approach contains four main activities: (1) family-based assessment and motivational feedback (that is, SORT), (2) work with individual families that progresses through three stages, (3) multifamily groups, and (4) SOFT case management, as needed.

Rationale for SOFT

We have a strong rationale for why SOFT should be an efficacious treatment model for adolescents who abuse substances. First, the quality of family relationships and parenting predict adolescent drug use (Steinberg, Lamborn, Darling, Mounts, & Dornbusch, 1994). Second, family-based treatment approaches are efficacious for treating adolescents with substance abuse problems (Austin, Macgowan, & Wagner, 2005; Szapocznik & Williams, 2000; Williams & Chang, 2000). Third, we identify and amplify client strengths, use solution-focused language, and employ motivational interviewing techniques. These strategies foster increases in client perceptions of self-efficacy, change talk, and commitment to treatment, which are known predictors of treatment success (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). Fourth, adolescents presenting for substance abuse treatment have multiple clinical and psychosocial needs and many barriers to receiving treatment, which forms the rationale for providing case management services (Mensing, Diamond, Kaminer, & Wintersteen, 2006). In summary, the SOFT model is grounded in research on how to treat adolescents with substance abuse problems.

SOFT ACTIVITIES

SOFT blends a pretreatment family referral session (SORT), solution-focused family therapy, parent-teenager communication skills training in multifamily groups, and case management services to comprise a multimodal intervention for adolescents who abuse substances.

SORT

We developed SORT, a specialized module, to engage parents and teenagers into SOFT. During SORT sessions, we use the major principles of motivational interviewing and solution-focused counseling to give results to teenagers and parents

from a structured substance abuse and mental health assessment (Berg & Miller, 1992; deShazer, 1988; Miller & Rollnick, 2002). We engage adolescents and parents in a discussion of the adolescent's strengths and problems. We integrate the four core principles of motivational interviewing in the SORT session: being empathic, supporting self-efficacy, rolling with resistance, and raising awareness (Miller & Rollnick, 2002). We use solution-focused techniques to elicit examples of successful coping efforts, allowing us to frame treatment recommendations as supplemental to the family's existing problem-solving efforts. We end the session by discussing multiple treatment options, emphasizing the family's choice in determining which are most appropriate.

Stages of Treatment

In the SORT session, we refer clients into treatment and to other appropriate resources. Following this session, adolescents and parents progress through the three stages of SOFT treatment: (1) engagement and initial strengths assessment, (2) development and implementation of a solution plan, and (3) monitoring and refining of goals until termination. Adolescents and parents usually attend sessions together, but we use clinical discretion and hold separate parent and adolescent sessions when high conflict precludes productive family sessions. In addition to the conjoint family and individual sessions, youths and parents attend weekly, multifamily group sessions to improve communication skills.

After completion of the assessment and the SORT feedback session, the first stage of treatment starts. In this stage, we engage clients in treatment by completing a structured adolescent (and family) strengths and resources assessment. The purpose of the strengths assessment is to begin treatment on a positive note, send a clear message to the family that we focus on competencies as well as current problems, bond with the adolescent, and emphasize to clients that when difficulties occur it is important not to lose sight of the teenager's and family's strengths. We build alliances with both teenagers and parents by using family therapy techniques common to many models—for example, listening to and empathizing with both parties (Cunningham & Henggeler, 1999; Diamond, Liddle, Hogue, & Dakof, 1999). We also help the family manage crises.

Initially, we manage crises and conflicts by completing an immediate concerns checklist that asks adolescents and parents to rate several com-

mon clinical issues (that is, family communication, truancy, ongoing substance use) on a Likert-scale ranging from "We can table this concern temporarily" to "This is life or death." We use the immediate concerns checklist to rapidly assess whether there are pressing clinical issues families would prefer to address before completing the strengths and resources assessment. That is, some families find it strange that SOFT begins by focusing on adolescent and family strengths, and this exercise helps demonstrate that the treatment is responsive to their specific concerns. After we review immediate concerns and complete the strengths assessment, we usually have built enough rapport with the family to consider them to be engaged in treatment. The family then moves into the next phase of treatment which is the development and implementation of a solution plan.

In the second stage of SOFT, families develop and implement a *solution plan*, which highlights the influence of solution-focused therapy in the SOFT intervention. We use solution-focused language to develop and identify appropriate client-selected treatment goals. Specific solution-focused techniques we use include exception-finding questions (that is, identifying past successful solutions when the current problems did not exist), coping questions (that is, asking what family members are currently doing so that things are not worse), scaling questions, and questions specifically designed to help clients to define what they consider a successful treatment (Walter & Peller, 1992). For example, we may ask, "When you leave here and treatment has been successful, what will you be doing differently?" All questions emphasize actions and behaviors that are within the client's control. The end product, the solution plan, is a compilation of small measurable tasks defining the specific actions the client will take as part of problem resolution. For example, we may develop a homework assignment with the adolescent and parent to plan one specific fun activity together that week. After we implement the solution plan, we move to the third stage of SOFT.

During the third and final stage of the SOFT model, we monitor treatment goals from the initial solution plan and modify these goals and plans as appropriate. We continue to use solution-focused language to praise client-produced accomplishments, identify new goals, and maintain the task-orientation associated with this therapy approach.

Treatment is considered complete when the family meets its goals.

SOFT treatment usually lasts for about 12 weeks, with adolescent clients attending approximately five biweekly two-hour family sessions. Families also attend 10 weekly two-hour multifamily groups. Thus, each client receives approximately 30 hours of SOFT treatment. In our preliminary report, families, on average, received 24.8 hours of treatment ($SD = 16.3$). Approximately 57 percent of clients completed SOFT treatment, which was 12 percent higher than the comparison group (Smith, Hall, Williams, An, & Gotman, 2006).

Multifamily Group

The SOFT multifamily group blends solution-focused group interaction, family communications skills training, and cognitive-behavioral therapy specific to substance abuse treatment. Group topics include the following: giving and receiving positive feedback, listening assertively, giving and receiving constructive criticism, coping with substance-using peers, solving problems, solving family problems, building healthy relationships and fighting fairly, managing stress, managing anger, and preventing future use.

The groups are structured and task-oriented. During group we facilitate a brief check-in by using a set of weekly questions (that is, solution-focused questions presuming change, scaling questions), give a brief didactic lecture and facilitate discussion about the topic (that is, discuss rationale for activities, describe topic), and role-play the skills we discussed. Participants complete feedback forms after each group session and submit them to group facilitators to both comment on usefulness of the groups and to reinforce learning.

Case Management

We provide SOFT case management activities on an as-needed basis to augment family and group therapy services. We adapted services from the comprehensive Iowa Case Management model to be appropriate for adolescents in the SOFT model (Hall, Carswell, Walsh, Huber, & Jampoler, 2002). Examples of SOFT case management services include the following: helping a client with job hunting, transporting clients to sessions, making home visits, facilitating meetings between the family and other professionals, and meeting with school officials to advocate for school reentry after suspensions.

SOFT AND SOCIAL WORK VALUES

The SOFT model is consistent with the core social work values of service, social justice, cultural competence, dignity and worth of the person, the importance of human relationships, integrity, and competence (NASW, 2000). First, initial assessments and SORT sessions are provided free of charge, which is consistent with the notion that social workers should provide some pro bono service. Second, SOFT addresses social justice concepts through use of solution-focused questioning and case management, as both these SOFT techniques emphasize client-driven goal setting and eliminating barriers to needed services. Case management may be especially salient to underserved and vulnerable clients, including minority clients, who drop out of treatment services at higher rates when compared with majority clients (Schmidt, Greenfield, & Mulia, 2006). To further address cultural competence, we hire therapists who are racially representative of the clients we serve, which is important as ethnic minority clients drop out of treatment at lower rates when matched to a therapist with a similar racial background (Wintersteen, Mensinger, & Diamond, 2005). Third, we focus on client strengths during all phases of SOFT treatment, which highlights each client's dignity and worth as a person. Fourth, we restore strained parent-teenager relationships by improving family trust and communication, which conveys the importance of these relationships in the recovery process. Fifth, SOFT therapists practice with integrity and process ethical dilemmas with their supervisors about many topics, such as adolescent confidentiality rights, communication with other professionals, and potential dual relationships arising from practicing in a small community. Finally, SOFT therapists maintain competence by adhering to a therapy manual and receiving ongoing supervision involving audiotape reviews. In short, SOFT is highly consistent with the core social work values in NASW's *Code of Ethics*.

EMPIRICAL SUPPORT

In a longitudinal randomized trial ($n = 98$), we compared SOFT to another promising treatment called the Seven Challenges (7C) (Schwebel, 1995, 2004; Smith et al., 2006). We randomly assigned adolescents (24 percent ethnic minority; 29 percent female, 42 percent working class or below) and their families to these two treatments and interviewed them every three months for one year following intake into the

study. At six months, adolescents in both SOFT and 7C had significantly lower substance use frequency and substance-related problems. Neither treatment was significantly more efficacious, which we believe is due to our high-quality implementation of these two treatments. We are currently studying SOFT's long-term effects and impact on mental health and family functioning.

CONCLUSION

SOFT is a promising new family-based treatment for adolescents with substance abuse problems that is consistent with social work values. Although SOFT has undergone initial empirical testing, additional research is needed to further establish the efficacy of this intervention. **SW**

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