

Integrating Motivational Interviewing and Other Treatment Modalities:

Moving At-Risk Adolescents Toward Change

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Adolescence is defined as the teenage years; that is, physical and mental transition from child to adult (Adolescence, 2008). During adolescence, the body changes in appearance, adult sexual needs emerge, hormonal shifts heighten irritability, and the capacity to reflect on the future and on the self expands (Broderick & Blewitt, 2006). Given the changes occurring at the physiological, psychic, and social levels, it is not surprising that the idea of crisis is present (Rayner et al., 1971). Further, this time period can be dangerous when typical developmental chaos is combined with risky, destructive behaviors such as drug and alcohol use. While risk taking is a healthy expression of autonomy to develop self identity in some ways (Broderick & Blewitt, 2006), some behaviors put youth more at risk than others.

There is a heightened awareness in the field of counseling to provide services to an underserved population of youth, who without healthy interventions can find themselves fighting a battle of substance use disorders. Treatment providers not specifically trained in substance use interventions may not always know useful ways to address substance use issues with an adolescent population. The purpose of this article is to (1) identify several variables that increase the risk of substance use in an adolescent population, (2) introduce the reader to concepts of interventions, and (3) demonstrate an

empirically supported way in which to incorporate motivational interviewing into a behavioral model of treatment.

Variables contributing to Substance Use in Adolescence

At-risk youth are defined as children under the age of 18 who meet at least one of the following three requirements: (1) absence from home for at least 72 consecutive hours without parental consent; (2) parental lack of control such that the child's behavior endangers the health, safety, or welfare of self or any other person, and/or (3) has a substance abuse problem for which there are no pending criminal charges relating to the substance abuse (At risk youth, 2008).

There are many contributing factors that lead to substance use in at-risk adolescents, thus it is impossible to provide an exhaustive list. For more information on factors affecting at-risk teens see Kilpatrick et al. 2000.

Parental substance use and trauma exposure. Two variables that are important to consider are *parental substance use* and *trauma exposure*.

According to Vimpani (2005), adolescents are a human illustration of the more universal phenomenon of 'homeostasis under threat'. At this point in an individual's life, external and internal challenges can threaten equilibrium, thus making the individual susceptible to substance misuse and risky behaviors.

Alarming statistics suggest that parental substance use and violence exposure are not only common, but also significantly affect adolescents' mental health. Of 4,023 adolescents, aged 12-17, surveyed in one study (Hanson, 2006), 8.2% reported sexual assault, 22.5% physical assault, 39.7% witnessed

violence at home or in the community, 50.6% experienced parental alcohol use and 19.1% reported parental drug use. Substance abuse by an adult caregiver put children at higher risk for abuse and neglect, but even in the absence of abuse or neglect, parental alcoholism put children at risk for being in relationships with alcoholics and for poor emotional and social adjustment. Hanson et al. (2006) also found that parental substance abuse and violence exposure were related to psychiatric disorders, including substance use disorders (SUD). Risk factors were measured to gather an understanding of how participants were affected. When adolescent alcohol and/or drug use was examined, the behavior was linked most significantly to parental drug use, physical assault, and sexual assault. Substance use in adolescents without parental drug use was much lower (Hanson et al., 2006).

Multiracial ethnicity. Cultural diversity is improving in today's culture; however, clinicians need to be prepared for the challenges *multiracial* adolescents bring to treatment, particularly when treating SUD. According to Choi et al. (2006), multiracial adolescents are at a much greater risk for substance use than monoracial groups. Adolescents who strongly identify with their ethnic community and culture are less vulnerable to risk factors for drug use; those who are not sure to which group they identify are at a higher risk. For example, European American youth were 38% less likely to smoke cigarettes than multiracial youth; African American youth, 32% less likely; and Asian American youth 51% less likely to have ever smoked. These monoracial groups were also less likely than multiracial youth to have ever drank alcohol; 45%, 30%, and 65%

less, respectively. European American youth were 48% less likely, and Asian American youth were 76% less likely than multiracial adolescents to initiate marijuana use. The rate of having ever gotten drunk or high on drugs were 41% and 65% less than the multiracial group, respectively. Asian American youth were 70% less likely to have ever used crack or cocaine compared to multiracial youth.

A significant change to the United States Census survey was made in 2000 to allow respondents to select one or more racial categories. The 2000 Census showed that the US population on April 1, 2000 was 281.4 million, and of this number, 6.8 million or 2.4% self-reported more than one racial category (United States Census Bureau, 2001). Unfortunately, there is a scarcity of literature about multiracial clients, as well as specific strategies that can be used with this population. It is important for therapists to recognize that models designed for monoracial individuals may not be appropriate for use with multiracial clients. Clinicians can benefit from recognizing the richness of heritages that multiracial clients can present with; for example, multiracial clients have the ability to be competent in more than one culture without necessarily relinquishing one's sense of cultural identity which has been highlighted as an asset by acculturation researchers (Pedrotti et al., 2008).

Parental monitoring. *Parental monitoring* is another important factor in adolescent's opportunities to experiment with substance use. The term parental monitoring is utilized verses "supervision" because monitoring encompasses a larger set of critical parent activities to include: relationship quality, limit setting,

positive reinforcement, problem solving, and involvement. One of the appealing features of the parental monitoring construct is that it is a “common denominator” across diverse interventions and developmental theories that focus on parenting practices. Methods and foci of monitoring change throughout the developmental process, but the function of these activities are essentially the same: to facilitate parental awareness of the child’s activities and to communicate to the child that the parent is concerned about, and aware of the child’s activities (Dishion & McMahon, 1998).

Literature supports the correlation between low levels of parental monitoring, early substance use, and other risky behaviors among adolescents. According to Dishion et al. (1995), parental monitoring, adolescent-onset substance use, and deviant peer involvement at ages 15-16 were so highly correlated that they were difficult to disentangle in multivariate analyses. High rates of single-parent households and low rates of structured activity scheduling for adolescents in these homes has also been linked with adolescent substance use, especially among youth with overall low levels of parental monitoring (Tebes et al., 2007). The correlation between the lack of parental monitoring and youths’ problem behaviors has been replicated and appears robust to diverse samples, definitions, community settings, and measurement techniques (Brown et al., 1993; Griffin et al., 2000; and Dishion et al., 1995).

Interventions for working with at-risk adolescents

During adolescence, youth become increasingly concerned with developing coherence and consistency among their beliefs, values, and

behavior. This can serve as a significant incentive to change behavior, particularly if current behavior is in conflict with adolescents' self-identified goals. To this end, adolescents are almost exclusively included as equal participants in their treatment efforts (Erickson et al., 2005).

Screening tools are essential in assessing SUD among adolescents. The screening instrument should be simple enough that a wide range of health professionals can administer it, should take no more than 30 minutes to administer, and should focus on the adolescent's alcohol and other drug (AOD) use severity, including negative consequences associated with use and consumption pattern (i.e., onset and frequency). The content may also briefly screen other critical problems often associated with adolescent AOD abuse, such as legal problems, suicidality, living situation, sexual/physical abuse, and HIV/STD risk (Winters et al., 2002).

The CRAFFT test is a brief screening tool designed to be developmentally appropriate for teenagers. It is verbally administered, uses a mnemonic device for easy remembering, and is simple to score with each "yes" response equaling 1 point:

- C Have you ever ridden in a *car* driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
- R Do you ever use alcohol or drugs to *relax*, feel better about yourself, or fit in?
- A Do you ever use alcohol or drugs while you are by yourself, or *alone*?
- F Do you ever *forget* things you did while using alcohol or drugs?

- F Do your family or *friends* ever tell you that you should cut down on your drinking or drug use?
- T Have you ever gotten into *trouble* while you were using alcohol or drugs?

It is important to note that the CRAFFT test is designed to be a screening tool, with a score of 4 or higher indicating a need for further assessment.

Nevertheless, the CRAFFT score's discriminant properties can help clinicians estimate not only the presence, but also the magnitude of risk of substance-related problems (Knight et al., 2002).

Prevention of Substance Use Through Education

Within behaviorally oriented interventions, monitoring is considered to be central to the behavior change process (Dishion & McMahon, 1998). Adolescents who spend afternoons in settings where no adult is present are more likely to engage in problem behaviors, and these behaviors increase as parental knowledge of the adolescents' whereabouts decrease (Richardson et al., 1993). At-risk adolescents, who engage in positive after school activities, can learn healthy behaviors to prevent and or minimize substance use and risky behaviors. Individuals who work with at-risk youth in a Positive Youth Development program (PYD) emphasize youths' resilience and value to others, rather than viewing them as troublesome and in need of fixing (Tebes et al., 2007). An example of this type of intervention is the Positive Youth Development Collaborative which teaches substance use prevention skills and encourages participation in health education and cultural heritage activities through an evidence-based, comprehensive, after-school program.

Other empirically supported interventions are the Yale Adolescent Decision-Making Program and the Adolescent Decision-Making for the Positive Youth Development Collaborative (ADM-PYDC) which is an adaptation of curricula from both the Yale Adolescent Decision-Making Program and the Positive Youth Development Collaborative. ADM-PYDC aims to prevent adolescent substance use by facilitating an eighteen session curriculum in a school-based setting. The program includes psychoeducation about drugs and alcohol, stress management and effective decision-making, followed by the application of this information in order to cope with daily stressors and set positive goals (Tebes et al., 2007). According to a study examining the effectiveness of the ADM-PYDC collaborative (Tebes et al., 2007), the program was effective in preventing adolescent substance use, and adolescents receiving the intervention were significantly more likely to view drugs as harmful at program exit. Within the intervention group, participants exhibited significantly lower increases in alcohol, marijuana, and other drug use one year after beginning the program. In addition, 77% of those in the intervention group remained in the study until the exit interview. At a one year follow-up, the odds that the intervention group would use alcohol was 63% less than the control group. These are promising statistics that suggest that adolescents' energy can be directed towards a positive pathway.

Motivational Interviewing

There is a unified frustration among health professionals, teachers, counselors, parents, and those who work in social service and judicial systems

when it comes to unchanging behavior. When working in these capacities, it is often easy to see that a person's behaviors and decisions are not working. As professionals, we can see a better way.

Motivational interviewing (MI) is a client-centered, collaborative, and directive treatment that can be particularly effective with adolescents who may be ambivalent to change. Centered on support of the client's autonomy and the notion that validation and support of a client is critical to change. MI supports a client's inherent and natural potential to move themselves toward change (Erickson et al., 2005; Miller & Rollnick, 2002). MI focuses on evoking client's own ideas regarding change, as opposed to traditional medical approaches that rely on confrontation, education, and authority. MI offers an efficient means of targeting behavioral, developmental, and social problems, and it is efficacious when working with adolescents because this approach addresses the ambivalence and discrepancies between a person's current values, behaviors, and their future goals (Erickson et al., 2005).

There are four underlying principles of MI:

- Express empathy—acceptance facilitates change: skillful reflective listening is fundamental and ambivalence is normal.
- Develop discrepancy—the client rather than the counselor should present the arguments for change because change is motivated by a perceived discrepancy between present behavior and important goals or values.

- Roll with resistance—avoid arguing for change because resistance is not directly opposed. New perspectives are invited but not imposed.
- Support self efficacy—a person’s belief in the possibility of change is an important motivator. The client, not the counselor, is responsible for choosing and carrying out change. The counselor’s own belief in the person’s ability to change becomes a self-fulfilling prophecy (Miller & Rollnick, 2002).

To achieve these goals, MI encourages open-ended questions, reflective listening, affirmations, summary statements, and talk of change versus talk of ability or importance. *Open-ended questions* provide an avenue for clients to do most of the talking during a session. When MI is done skillfully, the atmosphere of acceptance and trust within a session allows the client to explore their concerns (Miller & Rollnick, 2002). Although this phenomenon is important when working with all populations, it is particularly necessary when building a healthy therapeutic relationship with adolescents to move them toward change.

One of the most important and most challenging skills required in MI is *reflective listening*. The fundamental element of reflective listening includes not only staying quiet and hearing what a client has to say, but also how a counselor responds to what the client says. A well formed reflective statement is less likely to evoke resistance from a client. Ideally the counselor’s reflections move the session forward rather than repeating what the client has said; for example:

CLIENT: I worry sometimes that I won't fit in with the "cool" kids, so I use drugs and alcohol at times.

INTERVIEWER: Is it important to you to fit in?

CLIENT: Not always sometimes I tell my "home boys" that "I'm good."

INTERVIEWER: "I'm good." What does that mean?

CLIENT: You know; I don't want anything right now because I am "okay."

INTERVIEWER: What does an okay day look like for you?

CLIENT: Well, not getting into trouble at home, and not getting caught stealing to keep smoking and drinking, and just doing what kids do. Now I'm always craving marijuana and when I smoke I drink, so I'm hung over most mornings.

INTERVIEWER: And that bothers you?

CLIENT: Sometimes I guess. No one has ever asked me this question, so I haven't given it much thought. I know I don't want to crave for "blunts" (marijuana) everyday, I hate that I keep forgetting stuff, and I am so over waking up to hangovers.

INTERVIEWER: Just to recap what you have said so far; you think that you have a problem with smoking "blunts" and drinking which makes you forget things, and do things you normally wouldn't do, and the "home boys" you are hanging out with are using as well, but you are not sure if you want to change these behaviors.

CLIENT: It sounds crazy doesn't it?

INTERVIEWER: I understand how you might be having a difficult time making a decision at this time.

Affirming is a process by which the clinician can continue to build rapport and encourage open exploration with clients. Direct affirmations certainly have a place in counseling, especially when working with adolescents. Statements such as, "I appreciate that you took a big step in coming here today," "You enjoy being happy with your friends and making them laugh," and "I look forward to working

with you throughout this process,” engage the adolescent by demonstrating that they are heard and understood.

The fourth method to use early and continuously throughout motivational interviewing is *summarization*. Summaries can combine several change talk themes, link positives and negatives in an effort to acknowledge their coexistence, and/or transition the focus from one idea to another. These various types of summarization can be useful throughout the therapeutic session.

Lastly, the fifth method which is consciously directive, *eliciting change talk* is a strategy for resolving ambivalence and to “tip the balance” in the direction of change. Change talk falls into four general categories: (1) recognizing disadvantages of the status quo—“Maybe I have been taking foolish risks;” (2) recognizing advantages of change—“Probably I would feel a lot better if I stopped drinking;” (3) expressing optimism about change—“I think I could probably do it if I decided to;” and finally, (4) expressing intention to change—“I don’t know how I am going to do it, but I am going to stop.”

Motivational interviewing lends itself nicely to the concept of two partners; clinician and client, bringing aspirations to the dance floor; both have hopes for what will happen. MI is a shared process of decision making, exploration, and negotiation. Simply shaped and complicated by the opinions, investment, and relative power of the two partners (Miller & Rollnick, 2002)

Conclusion

Parental substance use, trauma exposure, multiracial ethnicity, and low parental monitoring are among the variables that can contribute to the use and abuse of substances within the adolescent population. Exposure serves as a catalyst for adolescents to emulate and react to what they deal with on a day-to-day basis. Counselors must intervene therapeutically early in the process to help facilitate healing, guidance, and hope to this under-served population. After-school prevention programs and motivational interviewing have been effective in moving adolescents toward change. This article demonstrates ways in which clinicians can reach those adolescents at risk for developing problems with substance use and intervene to assist those who are already struggling with drugs and alcohol.

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