



Skill training versus 12-step facilitation for parents of substance-abusing teens



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ABSTRACT

Distressed parents ($N = 85$) with a substance-abusing adolescent not receiving treatment were randomized to 12 weeks of coping skill training (CST), 12-step facilitation (TSF), or delayed treatment control (DTC). At the end of treatment/delay, CST showed greater coping skillfulness than TSF, and both CST and TSF were more skillful than DTC. The percentage of parent problem days (PPD)—days when the adolescent's substance use caused a problem—also was reduced in CST and TSF, relative to DTC. Both CST and TSF reported significantly reduced monthly PPD by the end of a 12-month follow-up. Skill training and TSF interventions appear equally effective for this underserved parent population.

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1. Introduction

Poor communication skills, excessive conflict, and low parental monitoring are often present in families affected by adolescent substance abuse (e.g., Barnes, Reifman, Farrell, & Dintcheff, 2000; Dishion, Patterson, & Reid, 1988; Tobler & Komro, 2010; van der Vorst, Engels, Meeus, Dekovic, & Vermulst, 2006; Walden, McGue, Iocano, Burt, & Elkins, 2004). Although parenting deficits may lead to adolescent substance use (e.g., Steinglass, Bennett, Wolin, & Reiss, 1987), poor parenting can also be the result of stress brought on by the adolescent's use, itself (e.g., Hobfoll & Spielberger, 1992; Kerr & Stattin, 2002; McGillicuddy, Rychtarik, & Morsheimer, 2004; Stice & Barrera, 1995). Parent skills training to deal more effectively with teen substance use may help reduce parental distress, and improve parenting.

Few studies have examined the impact of teaching new skills to parents of substance-abusing adolescents; the typical focus of this research has been to teach them skills to support teen abstinence during and following treatment (e.g., Toumbourou, 1994; Williams & Chang, 2000). These efforts have helped reduce relapse (e.g., Bry, 1988; Stanton & Shadish, 1997; Williams & Chang, 2000), with adolescents citing family support as instrumental in their success at abstaining (e.g., Brown, Monti, Myers, Waldron, & Wagner, 1999). However, there has been little emphasis on teaching skills to improve the parents' own functioning,

or to assess parent outcomes (e.g., Joanning, Quinn, Thomas, & Mullen, 1992; Smith, Sells, Rodman, & Reynolds, 2006). In addition, few studies monitor parent behavior change from pretreatment to posttreatment, or utilize a comparison or control group (e.g., Schmidt, Liddle, & Dakof, 1996). Overall, these studies have been limited with regard to the precise skills parents are learning, the measurement of these skills, and how they are incorporated into parent training programs.

Even fewer studies have focused on parents of substance-abusing teens not in treatment, an important group as fewer than 10% of teens in need of substance abuse treatment receive it (Substance Abuse and Mental Health Services Administration (SAMHSA), 2013). Toumbourou, Blyth, Bamberg, and Forer (2001) in a small, unrandomized study, developed and examined a parent-only intervention, designed to increase parenting assertiveness, and to reduce focus on the adolescent. Compared to those on a waitlist, recipients of the intervention demonstrated improved mental health, and increased use of assertive parenting. McGillicuddy, Rychtarik, Duquette, and Morsheimer (2001) conducted a pilot ($n = 22$) examining the efficacy of coping skill training (CST) for parents of a substance-abusing adolescent not receiving treatment. At pretreatment assessment, parents were administered the Parent Situation Inventory (PSI; see McGillicuddy et al., 2004), a roleplay measure of coping in parents of adolescent substance abusers, and randomly assigned to CST or delayed treatment. At the end of the 8-week treatment/delay, participants were administered the alternate PSI form. Parents receiving CST improved significantly from pretreatment to posttreatment on PSI skill relative to parents whose treatment was delayed. In addition, moderate-to-large between group effects favoring CST were found on measures of parent functioning and teen marijuana

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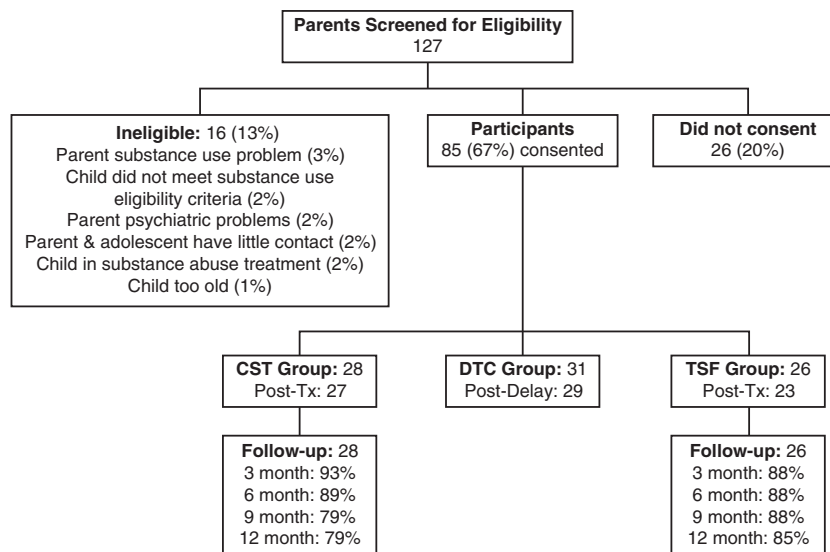


Fig. 1. Subject flow and attrition.

use. Though results of these interventions appear promising, additional research is needed to compare them with alternate treatment models, and to address methodological limitations noted above.

1.1. Study goals

The current study begins to address the above needs by comparing the CST developed in McGillicuddy et al. (2001), with a conceptually distinct Twelve-Step Facilitation (TSF) condition, and a Delayed Treatment Control (DTC). Both CST and TSF were group-based, and had the common goals of improving the parent's adolescent-related stress, and reducing the frequency of problems experienced by the parents due to the adolescent's substance use. The study addressed the following specific questions: (a) What is the relative efficacy of the treatment conditions on parental coping skills, parent treatment/self-help meeting attendance, parental stress, and adolescent substance abuse-related problems experienced by the parent at the end of a 12-week treatment/delay period?; and (b) What is the relative effectiveness of CST and TSF on parental stress and adolescent substance abuse-related problems across a 12-month posttreatment followup?

2. Materials and methods

2.1. Participants

Participants were 85 parents of substance-abusing adolescents recruited over a 32-month period in response to media advertisements offering a free program for parents experiencing stress due to their adolescent's use of alcohol and/or illicit drugs. To be eligible, individuals had to (a) be a parent or guardian of a substance-abusing adolescent (ages 12–21), (b) have lived with the adolescent for at least 28 of the previous 90 days, (c) be free of a substance use disorder of their own as defined by a score <8 on the *Alcohol Use Disorders Identification Test (AUDIT; Babor, de la Fuente, Saunders, & Grant, 1989)* and <4 on the *Drug Abuse Screening Test (DAST; Skinner, 1982)*, (d) report that the adolescent had used alcohol or illicit drugs within the past 3 months, and had not attended formal treatment, Alcoholics Anonymous (AA), or Narcotics Anonymous (NA) within the past month, and (f) report that the adolescent had used substances ten or more times in the past year, scored >30 on a parent-administered version of the problem severity subscale of the Personal Experience Screen Questionnaire (PESQ; Winters, 1992), or scored >7 on the substance abuse subscale of

the Problem Oriented Screening Instrument for Parents (POSIP; Rahdert, 1991).^a See Fig. 1 for participant flow and followup. In 66 (78%) families, one parent participated; two parents participated in the remainder of families. Among the latter families, both parents received treatment together, but were interviewed separately during clinical screen and research assessments. Analyses presented in this report were conducted only on scores of the parent who reported spending more time with the teen.^b Participating parents were predominantly female (85% of sample); on average, the substance-abusing adolescent was 16.51 (1.65) years of age. Additional characteristics of the final sample are presented in Table 1.

2.2. Design and procedure

A 3-group (coping skill training [CST], twelve step facilitation [TSF], or delayed treatment control [DTC]) design was used.^c On consenting to participate, and completing a pretreatment assessment, individuals meeting eligibility criteria were assigned to the next available cohort (i.e., therapy group). Once 3–6 participants were assigned to a cohort, it was deemed full. To avoid lengthy delays waiting for the start of treatment, cohort size varied depending on the availability of eligible participants. Once full, a cohort was randomized to treatment condition, with the provision that each condition occur twice within a consecutive set of 6 cohorts. The cohort then participated in 12 weeks of the assigned condition. Overall, 21 cohorts were randomized (seven cohorts in each treatment condition). Following completion of the initial 12-week period, participants were administered a set of measures similar to that administered at pretreatment. Participants also received telephone assessments at 3 and 9 months, and in-person

^a 100% of the participants reported the adolescent used substances on at least 10 occasions over the past year, 91% achieved a PESQ score >30, and 77% achieved a POSIP score >7. PESQ scores and POSIP scores were highly correlated (Pearson $r = .72$). Only one parent failed to meet study eligibility based on either PESQ or POSIP score. Analyses conducted without the data of this one parent did not change any of the study's findings.

^b The mother's data were used for 13 families; the father's data were used for six families.

^c A second factor, Parent Situation Inventory (PSI) form (McGillicuddy et al. 2004), to which cohorts were randomized and on which they were initially assessed and exposed during treatment, also was included in the design. However, preliminary analyses found no significant PSI form or PSI form X Treatment interaction on any variables. Thus, to simplify analyses and reporting, we collapse across PSI form.

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