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Effects of a brief, parent-focused intervention for substance using adolescents and their sibling

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ABSTRACT

The purpose of this study was to evaluate the efficacy of the Family Check-up (FCU), a parent-focused brief motivational intervention, in families where parents were concerned about one adolescent's alcohol or marijuana use and the referred adolescent also had a sibling close in age. The primary goal of the FCU was to provide individualized feedback on specific parenting skills, including monitoring and supervision, limit setting, and alcohol-related communication. A total of 92 adolescents (37 female) between the ages of 12–19 years of age along with a sibling (48 female) between the ages of 11–21 years old, were randomized to the FCU or a psychoeducation (PE) comparison condition. Findings indicated that the FCU did not produce better effects on alcohol and other drug use outcomes than the PE condition, in either the adolescent or sibling. Brief interventions addressing parenting behaviors may not be sufficient to reduce alcohol use in adolescent drinkers not referred due to an alcohol-related incident. Future research might be conducted to explore whether brief parent interventions, such as those in the present study, could be useful as a preventive intervention for parents whose teens report low levels of substance use.

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1. Introduction

Multiple pathway, including developmentally normative experimentation (Masten, Faden, Zucker, & Spear, 2009), lead to alcohol use in adolescence but early and/or regular use have been associated with substance misuse in later adolescence (Chen, Storr, & Anthony, 2009; Lopez-Quintero et al., 2011). Over 26% of high school students report initiation of alcohol use and over 15% initiation of cannabis use by the 8th grade (Johnston, O'Malley, Miech, Bachman, & Schulenberg, 2016). By the time teens reach the 12th grade, 46.7% report having been drunk and 44.7% report cannabis use (Johnston et al., 2016). Youth who initiate alcohol and other drug (AOD) use early in adolescence are more likely to develop AOD diagnoses (Chen et al., 2009).

Furthermore, drinking to intoxication is highly associated with high-risk sexual behavior, high deviance, young adult arrests, and low educational attainment (McCambridge, McAlaney, & Rowe, 2011; Stueve & O'Donnell, 2005).

1.1. Parenting and AOD use

Adolescent AOD use can be directly and indirectly influenced by parental modeling, punishment for experimentation, and advice about peer selection (Johnson & Johnson, 2001). Other parenting behavior associated with the onset and maintenance of adolescent AOD misuse includes poor parental monitoring, poor family communication, low warmth and support, high parental criticism/hostility, and parent-adolescent conflict (McMorris, Catalano, Kim, Toumbourou, & Hemphill, 2011; Ryan, Roman, & Okwany, 2015). A number of studies have also found that low levels of parental monitoring are related to early AOD use (Blustein et al., 2015; Chilcoat & Anthony, 1996; Ryan et al., 2015).

Positive parent-child affective quality and effective parenting processes, including parent and teen communication, appear to have important protective influences on youth AOD use (Chilcoat & Anthony, 1996). It is not just positive communication in general which deters adolescent AOD use but also the content, context, style, and timing of the

Abbreviations: AOD, alcohol and other drugs; MI, Motivational Interviewing; FCU, Family Check-up; MET, Motivational Enhancement Treatment; PE, Psychoeducation.

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communication about drinking that deters adolescent alcohol use (Jaccard & Turrisi, 1999). Several studies suggest that influencing how parents talk to their adolescents about their attitudes toward drinking should be included in interventions with parents, along with advice to parents about monitoring strategies (Zhang, Welte, & Wieczorek, 1997). Kosterman, Hawkins, Guo, Catalano, and Abbott (2000) found that strong parental norms against teenage drinking tended to reduce the risk of initiation in early adolescence and suggest the need to assess and improve not only parent management, but also relationship qualities, when addressing adolescent AOD use.

1.2. Siblings and alcohol use

Multiple studies have demonstrated that siblings show significant levels of similarity for alcohol use in adolescence (Kokkevi, Richardson, Florescu, Kuzman, & Stergar, 2007; Kothari, Sorenson, Bank, & Snyder, 2014; Poelen, Engels, Van Der Vorst, Scholte, & Vermulst, 2007). Siblings close in age show the most synchronous levels of substance use (Kothari et al., 2014; Scholte, Poelen, Willemsen, Boomsma, & Engels, 2008; Trim, Leuthe, & Chassin, 2006) and co-sibling drinking has been shown to be more predictive of alcohol use in adolescence than parental drinking (Kothari et al., 2014; Scholte et al., 2008; Whiteman, Jensen, & Maggs, 2013), and heavy drinking by a sibling has been shown to convey a risk of similar magnitude to peer heavy drinking (Kokkevi et al., 2007b). Sibling collusion regarding deviant activities has also been shown to be related to AOD use (Stormshak, Comeau, & Shepard, 2004). Sibling drinking has emerged as a key predictor of heavy drinking in adolescence in several studies (Kokkevi et al., 2007a,b; Kothari et al., 2014), suggesting it is an important target for family interventions.

1.3. The Family Check-up

The Family Check-up (FCU; Dishion, Nelson, & Kavanagh, 2003) is based on Motivational Interviewing (MI) principles (Miller & Rollnick, 1991) with the goal of being designed to enhance parental recognition of adolescent risk behaviors and to provide support and guidance on how to reduce these behaviors. In one study (Dishion et al., 2003), the FCU reduced the risk for future AOD use, among 6th grade students, three years later in the first year of high school; the prevention effect of the FCU was mediated by changes in parental monitoring. In another study (Spirito et al., 2011), parents of adolescents (ages 13–17) who were treated in an urban hospital emergency department for an alcohol-related event were randomized to receive either an individual adolescent Motivational Enhancement Treatment (MET) or the individual MET plus the FCU. Both conditions resulted in a reduction in all drinking outcomes (i.e., frequency, quantity, and frequency of high volume drinking) at 3 months with a gradual increase in all drinking outcomes across the 6 and 12 month follow-up points. The FCU in combination with the MET was found to be superior to the individual MET in reducing the frequency of high-volume drinking at 3 months following the intervention, but not at 6 or 12 months follow-up.

1.4. Current study

The purpose of the current study was to conduct a two-group randomized controlled trial to evaluate the efficacy of a sibling enhanced FCU, when focused on both an adolescent, whose parents were concerned about his/her alcohol or marijuana use, and a non-referred sibling close in age compared to psychoeducation (PE). Individualized feedback was tailored to specific parenting skills that pertained to both the referred teen and sibling in the family. Based on our prior studies in which brief interventions had short term effects (Spirito et al., 2011), it was hypothesized that the FCU condition would result in both fewer drinking days and heavy drinking days than PE at 3 and 6 months, but not 12 months, for both the teen and sibling. In addition,

based on the strong literature about the deterrent effects of parental monitoring on teen substance use, an a priori hypothesis stated that parental monitoring would result in fewer drinking days and heavier drinking days, for both teens and siblings, across all follow-up time points, regardless of treatment condition.

2. Material and methods

2.1. Participants

Participants included 92 “target” adolescents who were enrolled because their parents were concerned about their alcohol or marijuana use (herein referred to as “teens”) and 92 siblings, one from each family (herein referred to as “siblings”). Participants were recruited between January 2009 and May 2013 as part of a randomized controlled trial (see Table 1 for demographics). Eligibility criteria included: 1) between the ages of 12 and 19 years old; 2) living at home with a parent or legal guardian who is also willing to participate; 3) used alcohol or marijuana at least one time in the past 90 days; and 4) a sibling within 5 years of age of the target teen, living at home with the adolescent and participating parent(s), and between the ages of 11 and 21 years old. There were 7 adolescents, also included in these analyses, who reported during screening that they used alcohol or marijuana, but on the baseline assessment did not report any substance use.

2.2. Procedure

Participants were recruited from the community, including local high schools, family court and truancy courts, as well as through advertisements or referrals from emergency departments or mental health agencies. After expressing interest in participating, potential participants were screened by research staff either in person or over the phone to determine eligibility. Because two related trials for adolescent AOD use were being conducted simultaneously, a large number of families ($n = 930$) received information. Of the 930 families, 29% met the eligibility criteria stated above and were therefore invited to participate in this trial. The consort diagram (Fig. 1) provides an outline of the procedures as well as participant enrollment/retention. All study procedures were approved by the university and hospital Institutional Review Boards. The proposed sample size ($n = 150$) was derived in order to have a sufficiently large sample, after follow-up attrition, to detect a medium effect size (Cohen, 1992). Recruitment challenges, specifically recruiting both teens and a sibling for the same study, precluded reaching the proposed target sample size.

The baseline assessment was approximately 45 min long. Adolescent and sibling assessments were each administered by a separate research assistant. Parent assessments were self-administered, unless the parent needed assistance. Upon completion of the assessments, a treatment provider randomized the family into the experimental or comparison condition (see below for further detail). Approximately two weeks following the baseline appointment, families returned to complete the intervention. Three follow-up visits were scheduled after the baseline appointment, at 3, 6, and 12 months. Research assistants conducting follow-up assessments were masked with respect to participant treatment condition assignment.

2.3. Intervention conditions

Teens in both conditions received a computerized feedback program to satisfy referral sources and/or parents' request for the target teen's AOD use to be addressed individually. Depending on whether the adolescent identified a particular substance as more problematic than another, the teen received either the electronic-Check-up to Go for High School Youth for alcohol use (e-CHUG; <http://www.e-chug.com/hs/>) or the electronic THC Online Knowledge Experience for marijuana use (e-TOKE; <http://www.e-toke.com>). Both e-CHUG and e-TOKE draw

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