Careful assessment of traumatic stress and substance abuse problems and their possible effects on youth functioning should be an integral part of the services provided by agencies and individuals working with adolescents. An individualized treatment plan should take into consideration that one of these problems can exacerbate the other, and that treatment services should be integrated and coordinated.

Although much progress has been made in the treatment of both youth substance abuse and child traumatic stress, these fields have grown independently of each other. Despite the clear link between the two clinical areas, very few attempts have been made to address service integration, and different methods and procedures for assessment for each have evolved.

Few treatment providers are proficient in the multiple areas of need among youth with co-occurring disorders. Substance abuse providers, for example, may not have the tools necessary to identify the impact of trauma exposure on adolescent functioning and its interaction with substance use; and they may not have experience or training in using trauma-informed interventions. Trauma treatment specialists, and mental health providers in general, may overlook signs of increasing substance use severity. They may not have a deep understanding of the process of addiction, or may not be familiar with effective strategies to strengthen youths’ abilities to reduce use or abstain from substances, and therefore do not target these problems as a central part of the intervention.

This toolkit is meant to help identify youth at risk and provide some guidance about integrated treatment approaches for youth afflicted with both traumatic stress and substance abuse problems.
The signs and symptoms of trauma and substance abuse can at times be hard to spot, especially amidst the turbulent lives of teenagers today.

Clarissa was only 5 years old when her stepfather started sexually abusing her. She lived in a rural town where everyone knew each other. Clarissa’s neighbors and classmates noticed that she always kept to herself and was usually “on edge.” She was very scared that her stepfather would hurt her or her mother if she told anyone about the things he did to her when they were alone. It wasn’t until Clarissa turned 11 that a school guidance counselor found out what she was going through. The Department of Social Services was notified, and Clarissa was removed from her parents’ home. She went through several foster placements before settling in with an aunt and uncle who lived in a big city in a crowded apartment with many other relatives.

Clarissa started to get into fights with her cousins and would often refuse to participate in activities with her relatives. When she was reprimanded for her failing grades, Clarissa told her aunt that she wished she didn’t exist. Her teachers noticed that Clarissa had trouble managing her emotions, often exhibiting deep sadness, irritability, agitation, and/or intense anger. The social worker assigned to the case told her caregivers that he noticed that Clarissa displayed a lack of regard for her own safety and well-being, as she was getting involved in several risky activities. She was introduced to marijuana at school when she was 13 and quickly progressed to alcohol use, and later to OxyContin.

When she turned 15, Clarissa told her friends that she felt worthless and unimportant. One of the ways she responded to conflict and tensions in the home was by going into her room and making superficial cuts on her arms with a razor blade. Her teachers wondered why she wore long sleeves all the time. Clarissa tried to stay away from home as much as possible, spending a lot of her time with peers in unsafe neighborhoods. On her way back from a party with friends late one night, Clarissa was attacked by a group of teens on the train, but none of her friends tried to help her because they were high at the time. She felt betrayed by her friends who she felt hadn’t stood up for her. Clarissa was already failing school, had lost trust in her friends and family, and did not feel that she had anyone to go to. She started considering the possibility of ending her life.

Throughout her life, Clarissa showed signs that she was in trouble. If the adults around her had noticed these signs, they would have had many opportunities to offer help. As you read the pages that follow, think about teens like Clarissa and consider the following questions:

- Are there different pathways that explain the link between traumatic stress and substance abuse?
- What are instruments and tools available to providers that can make it easier to identify youth at risk?
- Are there specific ways to provide integrated treatment for these adolescents?
- What are some treatment approaches and strategies that can be used to help adolescents with traumatic stress and substance abuse problems?

* “Clarissa’s story” was created by the authors as a composite representation of stories heard from real teenage clients struggling with these issues and provides examples of the challenges that clinicians face in providing care for youth with trauma and substance abuse problems. Models portrayed are not representative of cases described.
The Connection Between Trauma and Substance Abuse

Several pathways have been described explaining the temporal link between trauma exposure, posttraumatic stress disorder, and substance abuse among adolescents (Giaconia, Reinherz, Paradis, & Stashwick, 2003):

**High-Risk Hypothesis:**

**Adolescents having problems with substance use may be more likely to engage in risky activities that could potentially lead to experiencing trauma.** Several epidemiological studies have found that for some adolescents (45–66%) Substance Use Disorders (SUDs) precede the onset of trauma exposure (Clark, Lesnick, & Hagedus, 1997; Giaconia, Reinherz, Hauf, Paradis, Wasserman, & Langhammer, 2000; Perkonigg, Kessler, Storz, & Wittchen, 2000). Additionally, adolescents with SUDs are significantly more likely than are their peers with no SUDs to have experienced traumas that are more likely to result from engaging in risky behavior such as traumas involving harm to themselves and traumas that entail witnessing harm to others (Clark, et al., 1997; Giaconia, et al., 2000; Perkonigg, et al., 2000). Studies have also shown a direct link between alcohol use and engaging in risky behaviors in which adolescents may get hurt (Giaconia et al., 2000) such as hitchhiking, walking in unsafe neighborhoods, and driving after using alcohol or drugs (Centers for Disease Control, 2000).

**Susceptibility Hypothesis:**

**The presence of substance use disorders may decrease the youth’s ability to cope appropriately with distressing and traumatic events, thus leading to an increased likelihood of developing PTSD.** In a study by Giaconia, et al. (2000), investigators found that even after controlling for exposure to trauma, adolescents with SUDs were two times more likely to develop PTSD following trauma than were their peers without SUDs. Researchers suggested that the extensive psychosocial impairments found in adolescents with SUDs were in part because they lacked the skills necessary to cope with trauma exposure.

**Self-Medication Hypothesis:**

**Teenagers develop SUDs in an attempt to manage distress associated with the effects of traumatic stress.** Most clinicians are familiar with this pathway, which suggests that youth turn to alcohol and other drugs to manage the intense flood of negative emotions and traumatic reminders associated with PTSD. Several studies have found that substance use disorders developed following trauma exposure (25–76%) or the onset of PTSD (14–59%) for a proportion of the adolescent sample (Clark et al., 1997; Deykin & Buka, 1997; Giaconia et al., 2000; Perkonigg et al., 2000). More recently, research in this area suggests that substance use craving increases among populations with co-occurring trauma and substance abuse when exposed to cues of the traumatic event (Coffey, Saladin, Drobes, Brady, Dansky, & Kilpatrick, 2002; Saladin, Drobes, Coffey, Dansky, Brady, & Kilpatrick, 2003).

Regardless of the pathway describing the onset of trauma exposure or PTSD and the development of substance abuse problems, it is evident that youth with this co-occurrence experience difficulties with emotional and behavioral regulation, and thus find it hard to stop using. A successful treatment approach should be flexible enough to accommodate for the multiple ways in which trauma and substance abuse may be related.
Screening and Assessment of Trauma and Substance Abuse

Many of the signs of both trauma and substance abuse are similar to problem behaviors that are part of the natural developmental course of adolescence. For this reason, it may be hard to recognize these problems early. What is evident about this group of teenagers, is that they often experience a great deal of distress and need considerable help. Proper assessment of trauma and substance abuse is critical in order to provide adequate care. Service providers having regular contact with adolescents should incorporate screening and assessment instruments that address trauma and substance use into their general intake process.

The following table provides information about some assessment resources:

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<th>Resource</th>
<th>Brief Description</th>
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<tr>
<td><strong>Adquest</strong></td>
<td>This self-report measure allows adolescents to identify various issues of concern, which the therapist can then use to engage adolescents in discussion on a variety of topics including health, sexuality, safety, substance abuse and friends.</td>
<td>Peake, K., Epstein, I., &amp; Medeiros, D. (Eds.). (2005). Clinical and research uses of an adolescent mental health intake questionnaire: What kids need to talk about. Binghamton, NY: The Haworth Press, Inc.</td>
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<tr>
<td><strong>CANS-TEA</strong></td>
<td>This clinician-report instrument assesses a variety of domains including trauma history, traumatic stress symptoms, emotional and behavioral regulation (e.g., anxiety, depression, self-harm, substance abuse), environmental stability, caregiver functioning, attachment, child strengths and child functioning.</td>
<td>For information on the guidelines for use and development contact Cassandra Kisiel: (312) 503-0459 <a href="mailto:c-kisiel@northwestern.edu">c-kisiel@northwestern.edu</a></td>
</tr>
<tr>
<td><strong>TSCC</strong></td>
<td>The Trauma Symptom Checklist for Children is a self-rating measure used to evaluate both acute and chronic posttraumatic stress symptoms.</td>
<td>John Briere, Ph.D. Psychological Assessment Services <a href="http://www3.parinc.com/products/product.aspx?Productid=TSCC">http://www3.parinc.com/products/product.aspx?Productid=TSCC</a></td>
</tr>
<tr>
<td><strong>UCLA PTSD RI for DSM-IV</strong></td>
<td>This scale is used to screen for exposure to traumatic events and DSM-IV PTSD symptoms. Three versions exist: a self-report for school-age children, a self-report for adolescents, and a parent report. An abbreviated version of the UCLA PTSD RI is also available. This 9-item measure provides a quick screen for PTSD symptoms.</td>
<td>UCLA Trauma Psychiatry Service 300 UCLA Medical Plaza, Ste 2232 Los Angeles, CA 90095-6968 <a href="mailto:rpynoos@mednet.ucla.edu">rpynoos@mednet.ucla.edu</a></td>
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Linking trauma & substance abuse: treatment IV. – 60
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<th>Resource</th>
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<tr>
<td><strong>POSIT</strong> Problem Oriented Screening Instrument for Teenagers</td>
<td>This scale was designed to identify potential problems in need of further assessment and potential treatment or service needs in 10 areas including substance abuse, mental health, physical health, family relations, peer relations, educational status, vocational status, social skills, recreation, and aggressive behavior/delinquency.</td>
<td>National Institute on Drug Abuse (NIDA), National Institutes of Health Elizabeth Rahdert, Ph.D., 6001 Executive Blvd, Bethesda, MD, 20892 Email: <a href="mailto:Elizabeth_Rahdert@nih.gov">Elizabeth_Rahdert@nih.gov</a></td>
</tr>
<tr>
<td><strong>CPSS</strong> Child Posttraumatic Stress Disorder Symptom Scale</td>
<td>The CPSS was adapted from the adult Posttraumatic Diagnostic Scale (PTDS). The CPSS is a self-report measure that assesses the frequency of all DSM-IV-defined PTSD symptoms and was also designed to assess PTSD diagnosis. The measure yields a total Symptom Severity score as well as a daily functioning and impairment score.</td>
<td>To obtain the CPSS, contact: Edna Foa, Ph.D. Center for the Treatment and Study of Anxiety University of Penn. School of Medicine Department of Psychiatry 3535 Market Street, Sixth Floor Philadelphia, PA 19104</td>
</tr>
<tr>
<td><strong>CRAFFT</strong></td>
<td>The CRAFFT is a six-item measure that assesses adolescent substance use. The measure assesses reasons for drinking or other substance use, risky behavior associated with substance use, peer and family behavior surrounding substance use, as well as whether the adolescent has ever been in trouble as a result of his or her substance use.</td>
<td>The CRAFFT Questions were developed by The Center for Adolescent Substance Use Research (CeASAR). To get permission to make copies of the CRAFFT test, email <a href="mailto:info@CRAFFT.org">info@CRAFFT.org</a>.</td>
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Several fact sheets in this toolkit provide specific information about the multiple emotional problems and maladaptive behaviors that can result from traumatic stress (II. Understanding Traumatic Stress and Adolescents) and substance use problems (III. Understanding Substance Abuse in Adolescents). Providers should incorporate information from multiple sources to generate a treatment plan that will work including a complete evaluation of the signs and symptoms of trauma and substance abuse as well as the adolescent’s degree of functional impairment caused by these problems.

For a more comprehensive list of trauma assessment and screening tools, please visit the National Child Traumatic Stress Network’s online Measures Review database at [www.NCTCSNet.org/measures](http://www.NCTCSNet.org/measures).
There is a dearth of research evaluating integrated treatment approaches for youth with substance abuse and traumatic stress problems. However, a review of the adolescent substance abuse treatment literature suggests that traumatized youth do not do well in treatment focusing only on substance use.

- In a study comparing inpatient and outpatient treatment outcomes, there was no difference in treatment outcome between the two groups for adolescents with low victimization. However, adolescents with high levels of victimization in the inpatient treatment program had fewer substance-abuse problems at follow-up than did those in the outpatient programs—suggesting that traumatized youth with co-occurring substance abuse problems do not respond well to available outpatient treatments (Funk, McDermeit, Godley, & Adams, 2003).

- Titus, Dennis, White, Scott, & Funk (2003) illustrated that, along with gender, severity of victimization was a significant predictor of treatment outcome for substance abuse treatment.

- Grella & Joshi (2003) looked at treatment processes and outcomes among adolescents with a history of abuse who were in drug treatment and found that, in general, youths with a history of physical abuse had a lower likelihood of posttreatment abstinence.

- Research in adults with co-occurring trauma and substance abuse supports the same conclusion. Studies of adults receiving substance abuse treatment indicate that individuals with co-occurring PTSD and substance abuse have higher relapse rates than do those with substance abuse problems alone, and that initial PTSD severity is a significant predictor of both alcohol/drug relapse and PTSD status (Brown, 2000; Ouimette, Brown, & Najavits, 1998).
Treatment Recommendations

Adolescents who have experienced trauma and adversity often turn to alcohol and drug use in order to cope with painful emotions. Youth with both substance abuse and trauma exposure show more severe and diverse clinical problems than do youth who have been afflicted with only one of these types of problems. When these problems are treated separately, youth are more likely to relapse and revert to previous maladaptive coping strategies.

Although the importance of addressing these co-occurring conditions is evident, integrating these services is not as clear-cut. For example, some providers may feel that before being able to address underlying issues relating to trauma, it is important to treat substance-abusing symptoms and limit the potential harm and threat to the individual. Conversely, some providers may feel that unless the individual learns strategies to manage distress associated with trauma, the likelihood of substance abuse relapse remains high. The research on integrated treatment approaches for this population is limited; however, there are guidelines that providers can follow to better serve this population. Given the multiple and complex needs of youth with co-occurring traumatic stress and substance abuse problems, several investigators have proposed the recommendations listed below (Back, Dansky, Coffey, Saladin, Sonne, & Brady, 2000; Giaconia, et al., 2003; Ouimette & Brown, 2003):

- Providers in regular contact with adolescents should include assessments of substance abuse problems and traumatic stress as part of routine screening and assessment procedures.
- Youth and families should be provided with more intense treatment options to address the magnitude of difficulties often experienced by this population.
- An emphasis on management and reduction of both substance use and PTSD symptoms should happen early in the recovery process. Youth will need help in addressing the negative affect common to both Substance Use Disorders and PTSD in an effort to help prevent relapse of both types of symptoms.
- Relapse prevention efforts, targeting both substance and trauma-related cues, should be provided early in treatment.
- School-based treatment programs may represent an important means of reaching at-risk youth.

Cohen, Mannarino, Zhitova, & Capone (2003) suggest that treatment of youth with trauma and substance abuse should include the following components:

- Therapeutic relationship that is consistent, trusting, and collaborative
- Stress management skills such as relaxation and positive self-talk
- Emotion regulation skills such as the identification, expression, and modulation of negative affect
- Cognitive restructuring such as recognizing, challenging, and correcting negative cognitions
- Increasing problem-solving, drug refusal, and safety skills
- Social skills training
- Gradual exposure to achieve desensitization to trauma reminders
- Parental involvement in treatment with the goals of increasing parenting skills, communication, and conflict resolution
- Psychoeducation for both youth and their families about trauma and substance abuse problems
- Random urine drug screenings
- Adjunct psychopharmacologic treatments
- Possible referral to adolescent self-help groups
Considering Culture and Context

It is important for providers to remember that adolescents with co-occurring traumatic stress and substance abuse and their families could belong to any number of cultural communities. Providing services that are culturally competent lays the foundation for establishing a safe, respectful environment that communicates to adolescents and families that they are uniquely valued. Culturally competent service providers are specially trained in, and are aware and respectful of the values, beliefs, traditions, customs, and parenting styles of the youths and families they serve whose cultures are different from those of the majority of Americans. One’s cultural background goes beyond ethnicity and race, and can include identities associated with disability, socioeconomic status, sexual orientation, homelessness, immigration/refugee status, spiritual or religious groups, foster care, and others.

Providers who offer culturally competent care respect the community’s values. See box below for examples (Anderson, Scrimshaw, & Fullilove, 2003; Cross, Bazron, Dennis, & Isaccs, 1989):

- Staff and agency demonstration of understanding and respect for diverse worldviews
- Staff who reflect the cultural diversity of the community served
- Use of interpreter services or, preferably, bilingual providers for clients with limited English proficiency
- Ongoing staff cultural competency education, training, and requirements
- Use of linguistically and culturally appropriate educational materials
- Physical environment that reflects the diversity of communities served, including artwork, accessibility, and materials
- Culturally relevant assessments
- Working within the family’s defined structure (e.g., the family may include elders or other relatives)
- Understanding and respect for the social mores related to interactions by gender and age

Emphasizing Strengths

When dealing with youth of all cultural and social backgrounds, it will be important to adopt a “strength-based” approach that capitalizes on individual, family, and contextual factors that can serve to promote healthy coping and adjustment. These factors can include a family’s religious or spiritual beliefs; extended families and available social support networks; positive role models in the community; opportunities for participating in positive recreational, artistic, or academic activities; adolescent’s built-in capacity to grow and flourish in the midst of adversity.

Special Treatment Considerations for Homeless Youth

Given the high rates of trauma exposure and substance use among homeless youth (Gwadz, Nish & Leonard, 2007; Johnson, Whitbeck, & Hoyt, 2005), it is particularly important to be aware of treatment considerations specific to this population (NCTSN, 2007; Thompson, McManus, & Voss, 2006). The lives of homeless youth are often characterized by high levels of personal and environmental instability, including uncertainty about basic needs such as having access to a meal or a place to sleep. Even the most elemental therapeutic processes such as engaging youth in treatment and attempting to develop a trusting relationship between the adolescent and service providers can be quite challenging. In addition, it might also be difficult to safely conduct more involved therapeutic strategies such as exposure-based treatment, particularly when access to environmental supports and the possibility of regular attendance is limited.

For this reason, it will be important to prioritize homeless youths’ immediate and primary needs, and to provide access to complimentary services that address additional psychosocial needs (NCTSN, 2007). Brief interventions employing motivational interviewing (Baer, Peterson, & Wells, 2004) as well as skill-based cognitive-behavioral approaches appear to better suited for this population. These approaches are described in the sections that follow.
Several successful treatment programs have been developed or adapted from adult models that help adolescents process traumatic memories and manage distressing feelings, thoughts, and behaviors. These empirically supported manuals are described in detail below.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT):

TF-CBT is a short-term individual treatment that involves sessions with the youth and parents as well as parent-only sessions. TF-CBT is for youth (aged 4–18) who have significant behavioral or emotional problems related to traumatic life events, even if they do not meet full diagnostic criteria for PTSD (Cohen, Mannarino, Berliner, & Deblinger, 2000). Utilizing weekly, clinic-based, individual treatment, TF-CBT helps youth process traumatic memories, and manage distressing feelings, thoughts, and behaviors. TF-CBT also uses joint parent and youth sessions to provide parenting and family communication skills training. When compared to a nondirective supportive therapy, sexually abused youth aged 8–15 treated with TF-CBT demonstrated significantly greater improvement on levels of anxiety, depression, and dissociation at 6-month follow up. Youth treated with TF-CBT also showed a significant improvement in PTSD symptoms and dissociation at 12-month follow-up (Cohen, Mannarino, & Knudsen, 2005). Online training for TF-CBT is currently available at http://tfcbt.musc.edu.

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS):

CBITS is an intervention program for youth exposed to traumatic events that can be delivered on school campuses by school-based clinicians. It was developed in collaboration with the Los Angeles Unified School District for students and their families. CBITS utilizes individual and group sessions to teach youth relaxation techniques and social problem-solving skills, as well as how to challenge upsetting thoughts and process traumatic memories. CBITS also includes a parent and teacher psychoeducation component. In a randomized controlled trial comparing this intervention with a 3-month wait-list condition, those receiving CBITS reported lower PTSD, depression, and psychological dysfunction symptom scores after 3 months (Stein, Jaycox, Kataoka, Wong, Tu, Elliott, et al., 2003).
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS):

SPARCS is a group intervention specifically designed to address the needs of chronically traumatized adolescents who may still be living with ongoing stress, are currently experiencing stress, and are experiencing problems in areas of functioning such as impulsivity, affect regulation, self-perception, dissociation, relations with others, somatization, and struggles with their own purpose and meaning in life. The 16-session program can be provided in a variety of settings, including school, outpatient, and residential, and incorporates components of three existing interventions. These components include mindfulness, interpersonal, and emotion regulation skills derived from Dialectical Behavior Therapy for Adolescents (Wagner, Rathus & Miller, 2006); problem-solving skills from Trauma Adaptive Recovery Group Education and Therapy (TARGET), Ford, Mahoney & Russo (2004); and social support enhancement and skills regarding planning for the future from the School Based Trauma/Grief Group Psychotherapy (Layne, Saltzman, Pynoos, et al. 2001).

Trauma Systems Therapy (TST):

Developed at the Center for Medical and Refugee Trauma at Boston Medical Center (Saxe, Ellis, Fogler, Hansen, & Sorkin, 2005), TST acknowledges the complexity of the social environment that surrounds an individual and the ways in which disruptions in one area of the social ecology may create problems in another. The social ecological model of human behavior—in which the contexts of family, school, peer group, neighborhood, and culture all interact with an individual’s development (Bronfenbrenner, 1979)—is applied to youth exposed to traumatic stress, who often live in environments characterized by child maltreatment, parental illness and substance abuse, and domestic violence. TST interventions are designed to work in two dimensions: strategies that operate through and within the social environment to promote change, and strategies that enhance the individual’s capacity to self-regulate their emotions.

The TST model involves choosing a series of interventions that correspond to the fit between the traumatized youth’s own emotional regulation capacities and the ability of the youth’s social environment and system-of-care to help him/her manage emotions or to protect him/her from threat. TST begins with an assessment of both the youth’s level of emotional regulation and the degree of environmental stability in the youth’s world. Preliminary data from an open trial of TST demonstrate a significant reduction of trauma symptoms and increased emotional regulation skills among youth, as well as a more stable social environment after three months of treatment (Saxe, et al., 2005). A controlled trial of TST is currently in progress.
Several successful treatment programs have been developed or adapted from adult models in order to focus on the unique cognitive changes, developmental transitions, and peer and family issues that typically occur during adolescence. Treatments for adolescents incorporate these developmental considerations in different ways. Described below are the current approaches utilized within various types of interventions, as well as empirically supported treatment manuals available for substance-abusing adolescents in an outpatient setting.

**Brief Interventions**

Interventions that are of shorter duration and less extensive than more traditional substance abuse treatments can be appealing to consumers, service providers, and managed care providers. These treatments have the overarching goal of addressing and enhancing motivation to change problem behaviors as well as providing skills to meet these goals. Generally, brief interventions contain between one and five sessions and can be delivered virtually anywhere by a variety of professionals. Two of the most widely used brief intervention approaches include cognitive-behavioral therapy and motivational interviewing.

**Cognitive-Behavioral Therapy (CBT):**

Cognitive-behavioral models, based on social learning theory, conceptualize substance use and related problems as learned behaviors that are initiated and maintained in the context of environmental factors. This treatment approach incorporates the principle that unwanted behavior can be changed by clear demonstration of the desired behavior and consistent reward of incremental steps toward achieving it. CBT may incorporate emotional exposure to internal cues in order to inoculate individuals against future relapse. Therapeutic activities include completing specific assignments, rehearsing desired behaviors, experiencing imagined and real exposures to emotions and situations to enhance emotional tolerance, and recording and reviewing progress. Praise and privileges are given for meeting assigned goals. This model can be implemented via individual sessions as well as within a group treatment approach. According to research studies, individual and group CBT can help adolescents become drug free and increase their ability to remain drug free after treatment ends.
Motivational Interviewing (MI):
This treatment approach involves using specific interviewing and discussion techniques to enhance the individual’s motivation to change their problematic behavior. MI pertains to both a style of relating to the client as well as therapeutic techniques that facilitate the process. Its main tenets include: 1) taking an empathic, nonjudgmental stance while listening reflectively, 2) developing discrepancy, rolling with the client’s resistance, and avoiding argumentation, and 3) supporting self-efficacy for change. Motivational interviewing has been found to significantly reduce drinking and driving in teens with initial low motivation to change.

Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Cannabis Users:
The Cannabis Youth Treatment Collaborative developed an empirically tested 5-session treatment manual that combines the motivational interviewing treatment approach and cognitive behavioral therapy. The treatment consists of two initial individual sessions designed to increase the adolescent’s motivation to deal with their drug use, followed by three group CBT sessions designed to help adolescents develop skills useful for stopping or reducing marijuana use. This brief therapy has been proven effective in reducing marijuana use in adolescents. The option also exists for therapists to utilize an additional 7-session CBT component to provide additional skills training. The complete manuals for both the brief 5-session treatment as well as the extended treatment with 12 CBT sessions are available at: http://www.chestnut.org/LI/cyt/products/.

Family-Based Therapies
Family-based treatment is the most thoroughly studied treatment modality for adolescent substance use. Considerable research underscores the influential role played by family relationships and family environments in the development of adolescent alcohol and drug problems. The more thoroughly researched family approaches are outlined below.

Multidimensional Family Therapy (MDFT):
This is an outpatient family-based drug abuse treatment for teenagers. MDFT views adolescent drug use in terms of a network of influences (made up of individual, family, peer, and community) and utilizes this network to reduce unwanted behavior and increase desirable behavior in different settings. Treatment includes individual and family sessions held in the clinic; in the home; or with family members at family court, school, or other community locations.

Multidimensional Family Therapy for Adolescent Cannabis Users:
This manual-based treatment integrates family therapy and substance-abuse treatment and has been proven effective with a cannabis-using adolescent population. The treatment focuses on the adolescent and the parents, as well as on patterns of family interaction, both within the family and with other systems such as schools, courts, and other support networks. The manual is available at: http://www.chestnut.org/LI/cyt/products/.
Brief Strategic Family Therapy (BSFT):

This intervention is used to treat adolescent drug use that occurs with other problem behaviors such as conduct problems, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, impaired family functioning, and risky sexual behavior. BSFT is a family systems approach based on the premise that the drug-using adolescent is displaying problem behaviors that are indicative of what is going on within the family system. BSFT holds the principle that patterns of interaction in the family influence the behavior of the adolescent. The role of the BFST counselor is to plan interventions that carefully target and provide practical ways to change the patterns of interaction (e.g., failing to establish rules and consequences) that are directly linked to the adolescent’s drug use.

Brief Strategic Family Therapy for Adolescent Drug Abuse:

The National Institute of Drug Abuse has made an online version of the BSFT manual available at the following internet address: http://www.nida.nih.gov/TXManuals/bsft/BSFT2.html.

Multisystemic Therapy (MST):

This treatment approach targets multiple systems that contribute to the development of delinquent behavior in adolescents including family, peers, school, and the neighborhood. MST is tailored to each individual’s needs and may include individual, family or marital therapy; peer group counseling; and case management. Services are provided within the adolescent’s natural environment, such as the home or school, which facilitates both the application to and the maintenance of treatment gains in the “real world.” MST also helps adolescents and their families develop social support networks through such means as making connections with extended family or religious communities. MST has been shown to significantly reduce adolescent drug use during treatment and for at least 6 months after treatment.

Community-Based Interventions

Community-based interventions provide mental health services within the normal environment of an individual or population. Service sites may include the home, school, or other neighborhood settings, which increases access to care for underserved populations, particularly for individuals who do not have the resources to travel to specialty clinics. Because teenagers are influenced by many aspects of their environment (such as family, peers, teachers, cultural norms), community interventions often take place across a number of settings to maximize the social ecological validity of the intervention and to support practice of skills learned in treatment. Community interventions may target specific individuals who have already begun to display high-risk behaviors—such as drug and alcohol abuse, delinquent behavior, and unsafe sexual behaviors—or they may target select groups who may be at greater risk for engaging in these behaviors—such as athletes who are at greater risk for steroid use and teenagers who live in a community with a lot of gang violence. In many community interventions, a social support component for adolescents and their parents is important and may decrease the likelihood of relapse. Three interventions for adolescents displaying high-risk behaviors, which include a community-based component, are described below:

**Adolescent Community Reinforcement Approach (ACRA):**

This treatment approach recognizes the powerful role the environment plays in encouraging or discouraging drug use. It attempts to rearrange environmental contingencies to make substance use a less rewarding behavior. ACRA blends an operant model with a social systems approach to teach teens new ways of handling life’s problems without drugs or alcohol. It focuses on the interpersonal interaction between individuals and those in their communities. ACRA teaches adolescents when and where to implement the techniques learned in treatment as well as how to build on positive reinforcements and use existing community resources that will support positive change. ACRA also guides adolescents in developing a positive support system.

**The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users:**

This 14-session treatment model consists of 10 individual sessions with the youth, 2 sessions with one or two caregivers, and 2 sessions with both the youth and caregiver(s). This treatment uses functional analyses to identify triggers for drug use as well as other prosocial activities that compete with drug use, skills training in a variety of areas including relapse prevention, and the “Happiness” scale to monitor progress. The manual is available online at:

Student Assistance Program (SAP):

This substance abuse intervention is a school-based program for identifying, assessing, and treating students with alcohol and/or substance abuse problems. There are more than 1,500 student assistance programs in the country; however, these programs vary widely. For example, some SAPs refer all identified alcohol and drug users to clinics for treatment, while other programs bring trained clinicians to the school to provide intervention on-site. The most effective school-based substance abuse interventions are empirically guided and manualized, and focus on providing psychoeducation and skills training to adolescents. In addition, effective programs enforce school-wide policies regarding alcohol and drug use. Preliminary analyses of certain programs suggest that adolescents who participate in SAPs can show reduced substance use.

The Residential Student Assistance Program (RASP)

(RASP) is a residential substance abuse prevention program for high-risk adolescents, modeled after the Westchester Student Assistance Model. More information is available at: http://www.sascorp.org/residesap.htm or http://www.sascorp.org.
Integrated Treatment Approaches for Adolescents

Although there is strong evidence to support the need for integrated treatment models, there are few existing treatments that address both trauma and substance abuse problems among adolescents. Some of these models are highlighted below:

**Seeking Safety (SS)**

SS (Najavits, 2000) is a manualized treatment for co-occurring SUD and PTSD in adults developed by Lisa Najavits, PhD (Najavits, 2002). The focus of SS is to eliminate or reduce risky or dangerous behaviors, situations, or symptoms including substance abuse, dangerous relationships, severe psychological symptoms, and self-harm behaviors. The treatment model posits a meaningful connection between past trauma and current self-abusing behaviors, and it utilizes 25 topics or modules divided among cognitive, behavioral, and interpersonal themes that can be selected based on the individual’s need (Najavits, 2002).

Applying SS to an adolescent population involves minor modifications of the original manual to suit the developmental level of adolescents. Modifications include offering the information verbally if an adolescent refuses to read the handouts, using hypothetical third-person examples to discuss situations, limited parental involvement with the adolescent’s permission, and discussing details of the trauma if the adolescent chooses to do so (Najavits, Gallop, & Weiss, 2006).

In randomized, clinical trials, SS has shown significant improvements over treatment as usual in both incarcerated (Zlotnick, Najavits, Rohsenow, & Johnson, 2003) and community (Hien, Cohen, Miele, Litt, & Capstick, 2004) adult female samples. When implemented with adolescent girls, SS showed greater improvements than did treatment as usual in substance abuse domains, PTSD cognitions, levels of deviant behavior, as well as anorexia and somatization ratings (Najavits, et al., 2006).
**Risk Reduction Through Family Therapy (RRFT)**

RRFT (Danielson, 2006) is an intervention developed to reduce the risk of substance abuse and other high-risk behaviors, revictimization, and trauma-related psychopathology in adolescents who have been sexually assaulted. RRFT integrates several existing empirically supported treatments, such as Trauma Focused-Cognitive Behavioral Therapy, Multisystemic Therapy, and other risk reduction programs for revictimization and risky sexual behaviors. Adolescents participating in this treatment can be heterogeneous with regard to symptom expression, thus a clinical pathways approach is taken in the RRFT manual. The manual consists of 6 primary components: Psychoeducation, Coping, Substance Abuse, PTSD, Sexual Education and Decision Making, and Sexual Revictimization and Risk Reduction. A pilot trial of RRFT is currently under way.

**Trauma Systems Therapy for Substance Abuse in Adolescence**

TST-SA (Suárez, Saxe, Ehrenreich, & Barlow, 2006) is an adaptation of Trauma Systems Therapy (TST) (Saxe, Ellis, & Kaplow, 2006) to the problem of adolescent traumatic stress and substance abuse, utilizing existing promising practices for treating adolescent substance abuse, traumatic stress, and emotional regulation problems. The application of TST to adolescent substance abuse includes several modifications to the existing intervention. Motivational interviewing strategies are included to engage youth in treatment and to establish a commitment to change. Additionally, parents and teens are provided with psychoeducation about substance abuse and its interaction with symptoms of traumatic stress. This approach incorporates a strong emphasis on behavior management strategies for parents to increase monitoring and appropriate limit setting, particularly around drug use and high-risk behaviors. In addition, the model incorporates substance abuse treatment strategies such as parent-teen communication skills, recognizing and planning for substance abuse cues or trigger situations, cognitive and interpersonal problem-solving techniques, and other relapse-prevention techniques. Careful attention is given to the connection between substance abuse and negative emotions associated with the experience of trauma. In addition, youth learn skills to manage emotion, behavior, and substance abuse cravings. An open trial of TST-SA is currently under way.
Psychiatric Care and Psychotropic Medication

The commonalities between posttraumatic stress disorder and substance use disorders suggest that pharmacotherapies targeting a specific neurotransmitter or neuroendocrine system might be particularly beneficial (Brady, Back, & Coffey, 2004). An important goal of pharmacotherapies for this population is to decrease PTSD symptoms so that the adolescent does not utilize substances of abuse in order to distance himself/herself from the traumatic event. Some antidepressants have been shown to improve intrusive and depressive symptoms of PTSD. Furthermore, standard pharmacotherapeutic treatments for SUDs may be useful for individuals with co-occurring PTSD. Integration of pharmacotherapy and psychotherapy may be beneficial in order to maximize treatment outcomes in this population.

For More Information

Substance Abuse and Mental Health Services Administration (SAMHSA) Model Programs
http://modelprograms.samhsa.gov/

Society for Adolescent Substance Abuse Treatment Effectiveness (SASATE)

The National Institute of Drug Abuse (NIDA)
http://www.nida.nih.gov

The National Institute on Alcohol Abuse and Alcoholism (NIAAA)
http://www.niaaa.nih.gov