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Single system design evaluation of a Mexican-American adolescent substance abuser

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Introduction

This is a single system case study evaluating treatment of a 16-year-old female Mexican-American adolescent whose primary therapeutic issue is alcohol/drug addiction. The client was seen by myself in family treatment, using the structural family therapy model.

Youth Services, Inc. is a youth and family counseling center, serving clients between the ages of 12 and 17. It is the only adolescent day treatment program in Santa Cruz County. Youth Services focuses on alcohol and drug treatment, and gang, crisis, suicide, and conflict issues. Youth Services also operates three schools. The client chosen for this project was selected from a group of approximately 15 youth in the day treatment program who attend the on-site school, and receive individual, family and group counseling.

The purpose of this project is to evaluate the effectiveness of family treatment with regard to self-esteem improvement and reduction or cessation of alcohol/drug use. Two instruments have been used: Index of Self-Esteem (ISE) and The Drug Severity Index (DSI), to determine extent of drug and alcohol use.

Usefulness Within Agency

The majority of clients in the Youth Services program have problems with drugs and alcohol. One of the agency's objectives is to address this problem through group, individual, and family therapy. A major assumption of this study is that there is a relationship between low self-esteem and drug and alcohol use. Participation in the Youth Services program is examined regarding effectiveness in increasing self-esteem, with the hope that clients could benefit from this information through the agency increasing emphasis on esteem-building activities.

Many social services provide counseling for clients who are likely to have self-esteem issues. Instruments such as the ISE are useful as part of diagnosis and as an aid to treatment planning for such clients. The ISE and DSI are useful tools for monitoring and evaluating effectiveness of therapy and clinical practice. This is particularly important at a time when there is increased demand for accountability and competition for reduced funding.

The Context of Services

Youth Services, Inc. is a private local youth and family counseling center, with offices in Santa Cruz and Watsonville. It is a component of Santa Cruz Community Counseling Center, with non-profit status. For 19 years, Youth Services has been Santa Cruz County's primary provider of services to youth and families in crisis, including runaway and homeless youth. Any youth between the ages of 12 and 17, and their family, who are residents of Santa Cruz County are eligible for counseling services. Youth Services counsels youth at risk for drug, alcohol, and gang involvement, and youth and families experiencing crisis, suicide, loss, and conflict.

Primary program goals are prevention of adolescent victimization, prostitution, substance abuse, suicide, and juvenile delinquency. In addition to counseling, Youth Services operates three secondary alternative schools under the jurisdiction of the County Office of Education for youth in recovery from drugs and alcohol. Youth go to school, attend daily group therapy, individual, and family counseling. A 24-hour crisis hotline provides bilingual emergency counseling, short-term crisis resolution counseling, emergency temporary shelter placement, family reunification services for runaway youth, and referral.

The delinquency prevention program includes petty theft groups and special projects offering positive alternative activities. Community outreach is offered in schools, through parent groups, trainings for law enforcement and community agencies, and homeless outreach.

Youth Services operates at two sites centrally located in Santa Cruz and Watsonville near areas frequented by homeless street teens, with easy access to transportation. This study targets the Watsonville location, where over 75% of the clients are Latino (Manov, 1992). Most families served at this site are second generation Latino immigrants, many of whom are monolingual Spanish speaking farm laborers. Adolescents coming into treatment at Youth Services are typically dealing with family conflict, gang affiliation, and drug abuse, including marijuana, alcohol, heroin, cocaine, and methamphetamines. Parents in the client families may also have gang affiliation and substance abuse issues of their own, and frequently they face unemployment, inadequate housing, health issues, and high teen birth rate. Intergenerational conflict results from differing levels of acculturation of adolescent and parents. Low levels of motivation and self esteem are likely consequences of these environmental factors. Existing family conflicts may escalate when parents find that their children are involved with gangs and drugs.

Youth Services' Watsonville site reflects community demographics in a culturally diverse staff which is largely Latino. Counseling staff consists of two community liaisons, two drug treatment counselors, a family counselor, a gang counselor, clinical interns, a teacher and teacher's aide, program manager, and part-time licensed clinical supervisor. Counselors have a caseload of approximately ten to fifteen clients. Clinical and office staff are supervised by the program manager, who also coordinates interaction with the Santa Cruz

site.

Youth Services' overall goal is to provide prevention and treatment services to teens who are challenged educationally, socio-economically, culturally, and by negative peer influences to allow youth to become healthy, productive members of society. More specifically, the following goals are in place:

1. To provide comprehensive services to runaway and homeless youth and youth and families in acute stress situations, utilizing family therapy as the primary intervention strategy.
2. To provide access to services for homeless youth in order to increase their safety, reduce delinquency, and assist in their successful emancipation, as well as foster development of significant life skills.
3. Provide opportunities for...youth to participate in peer counseling, community activities, and classroom presentations.
4. To foster visibility of the program throughout the community in order to enhance access to services.
5. To evaluate service outcomes by the following indicators and report results...
    A. To reduce the rate of recidivism and/or arrests...
    B. To improve school or vocational performance...
    C. To receive 75% positive evaluations regarding services received from clients 6 months after treatment (State of California Center for Substance Abuse Treatment Grant Proposal, 1995).

Annually, over 3600 youth are reached through the agency's county-wide services. Youth Services works collaboratively with such organizations as the County Probation Department, C.P.S., the County Office of Education, five law enforcement agencies, county and city governments.

Services are provided through funding from Santa Cruz County, and Watsonville, Santa Cruz, Scotts Valley, and Capitola city funding, Health and Human Services grant

money, state mental health monies, and the State Office of Criminal Justice Planning.

Target Client

The focus of this study was a 16-year-old English-speaking Mexican-American female, who will be referred to as M to protect her anonymity. M was born in Santa Cruz County. M does not know how many generations of her mother's family were born in the U.S.; it has been observed that her mother, who was born in Texas, seems well acculturated. M was unable to give much information about her father. She describes her biological father, who lives in California, as an alcoholic and regular drug user with a prison record. She sees him twice a year. She lives in Watsonville with her mother, recently separated from her second husband, and two brothers, ages 7 and 19. M apparently socialized frequently with a young aunt who drinks, "but not alcoholically," enabling her to go out with her mother's approval. She liked hiking and swimming. Her mother works as an intern in the Probation Department. Mother and daughter were frequent church-goers, attending mid-week study groups together. Mother was resistant to the family therapy component of treatment, attending once since M began treatment, despite weekly calls and a home visit designed to create more investment in family treatment.

M attended one local primary school and one middle school, doing well until reaching high school. Her first alcohol use was at age 14, and she was expelled from high school for cutting classes, drunkenness, fighting, and possession of a knife. She was also picked up for running away. No abuse or neglect was reported. M has thought about suicide, which her mother has treated as a manipulation; her father has attempted suicide. She self-referred to Youth Services, wanting to "change schools," from an alternative school where she was

placed following expulsion. She had previous counseling, and had no health problems.

Family history regarding alcohol and drugs revealed her mother as a non-user, and her biological father as an alcoholic and drug abuser. M's step-father does not use alcohol or drugs. M had an uncle who died of a drug overdose four years ago. A rare show of emotion overcame her when she revealed his death. M's older brother is a recovering heavy marijuana user. M's first alcohol use occurred when she was 14, the same year school attendance problems emerged, and her use pattern was 12 to 13 beers on a weekend. She had one blackout. Marijuana use was initiated after about a month in the Youth Services program. She described using 2 to 3 "hits" once a week in mid-February, which escalated to 4 times a week by mid-March.

M is an attractive, well groomed young woman. She made friends with both sexes among her peers. It was necessary to counsel her on appropriate behaviors with the young men in the program, and she needs guidance regarding social boundary issues. The site teacher reported good work in the classroom, but a need to do better with homework. She was disruptive in class, with some acting out behaviors. Cooperation with the program was difficult to establish. Her difficulty with authority figures possibly reflects a reaction to her mother's extremely authoritarian manner. M has been impulsive and manipulative, trying to control her mother and the program staff. During the first month in the program, her oppositional behavior was so marked that an all-staff intervention became necessary in order to establish her commitment to the program.

M's primary DSM IV diagnosis on Axis 1 was 313.81, oppositional defiant disorder. The secondary diagnosis was 305.0, alcohol abuse. Diagnosis was deferred on Axis 2. Her

treatment goal was "to get clean." M's oppositional behavior included active refusal to comply with rules, being deliberately annoying, easily annoyed by others or being touchy, and anger and resentment. M's alcohol abuse was characterized by failure to fulfill school obligations, including absences and expulsion from her previous school, suspension from the Youth Services school, and continued substance abuse despite her mother's threats to throw her out.

Literature Review

The literature review focuses on Latino adolescent drug and alcohol use, minority identity in relation to self-esteem and drug dependence, dynamics in Hispanic families that have been identified as contributing factors to alcohol and drug use/abuse, and the efficacy of using structural family therapy in treating these issues within the Latino family system. Demographics provide an important contextual framework for understanding the environment which has influenced the client.

Demographics

The residents of Watsonville tend to be young, with approximately 32 percent of the population under age 18, and their median age is 29. The 1990 U.S. Census lists 1,781 persons between the ages of 16 and 19 in Watsonville, 685 of whom are not enrolled in school. It is a low to moderate income community. Of 9,625 households, 783 families lived below the poverty level based on 1989 income. The median income of Watsonville is 28% lower than the rest of the county (DeLay, 1994,p.5). The unemployment rate for May, 1995 was 20-28% (depending on the source), compared with a national unemployment rate of 5.7%. Hispanic households are disproportionately poor in the city, with 68% of Hispanic

households being low income (B.A.S.T.A.Report, undated). Racism exists. For example, in a recent school district zoning dispute, the protagonists were the affluent, white community on the northern border of the district versus a larger southern area which includes many poor families. The white community wanted district lines changed in order to exclude their ethnically diverse neighbors. Other tensions in the community revolve around socio-economic issues, reflected by numerous families living in overcrowded conditions. The impact of immigration and the number of undocumented Hispanics has contributed to difficulties in reaching and counting this population, and represents a significant challenge to service providers.

A report published in 1990 by the Office of Substance Abuse Prevention (OASP) stated, "although numerous surveys of the use of alcohol and other drugs among adolescents have been conducted in recent years, relatively little is known about the problem among ethnic and racial adolescent minorities" (OSAP Report, vii). Among reasons cited for the lack of information are the unclear definitions of the terms "Hispanic" or "Latino," (which are used interchangeably in this report, depending upon the source), and a tendency to combine Latinos with other people of color into a generic "minority" category. It has also been noted that even less is known about what types of prevention approaches will be effective. The scarcity of information has generally been confirmed throughout the process of this literature review.

Alcohol and Drugs

The effects of poverty, availability of alcohol and drugs, and family factors such as parental use, are cited as factors contributing to drug/alcohol usage among minority youth. A

report for Proyecto Unidad (Manov,1992) mentions language barriers, low educational attainment, acculturation stress or intercultural conflict, and criminal justice system involvement as well. Acculturation stress includes, "racism, devaluation of one's cultural heritage, limited English proficiency, unresolved feelings of loss among recent immigrants, concerns about immigration status and possible deportation, conflict between Mexican-American and white values, and lack of understanding of how the education, legal, and social systems work in the United States" (Manov, 1992). The same report refers to Latinos drinking at an earlier age, more frequently, and in larger quantities. According to the same report, Latino youth "appear to have higher rates of multiple substance use and begin such use earlier" (Manov, 1992). Mexican-Americans, who comprise 93.2% of the Latino population targeted in the Proyecto Unidad report have high rates of marijuana and inhalant use, while heroin use shows high rates in some studies.

Self-Esteem

Personal self-esteem refers to "how the individual feels about the self in a comprehensive manner" (Porter & Washington, 1993, p.139-140). Self-esteem also includes a group component, which refers to how the individual feels about ethnic or racial identity. Levels of acculturation/assimilation are identified contributors to ethnic self-esteem, along with "economic imperialism...reinforced by cultural imperialism, [which relegates] colonized groups...to low status...and a negative group image" (Porter & Washington, 1993, p.144). Incompatible host cultures lead to cultural marginality, psychological distress and poor self-esteem. On the other hand, self-esteem among Hispanics is strengthened by personal support networks. Individuals with "extended ethnic kin networks may experience more personal

self-esteem" (Porter & Washington, 1993, p.153). For the purpose of this paper, family support is viewed as a fundamental component of the personal support network, resulting in emphasis on family therapy as a key treatment modality.

Empowering the adolescent client with regard to his/her overall sense of self in relation to family, culture, and the dominant society is a prevention technique which can assist the adolescent in attaining skills in problem solving, decision making, goal setting, self-discipline, self-acceptance, and self-trust (Galan, 1988). These are skills which can influence the development of positive self-concept or self-esteem, and which the process of structural family therapy can support as poorly functioning family relationships are realigned.

In the context of this paper, the hypothesis is that drug-dependent clients are expected to have low self-esteem, and that self-esteem is effected in part by the level of functioning of the family system. Results from a study by Michael Gossop have shown low self-esteem to be associated with drug dependence, and that therapy directed toward increasing self-esteem has been tried with delinquents "with some success" (Gossop, 1976, p.751). Likewise, Phil and Spiers reported a relationship between poor self-concept and drug use (Phil & Spiers, 1978). Vega et.al., in their study of risk factors for adolescent drug use, note Hispanics as "more vulnerable to depressive mood and low self-esteem" (Vega, et.al., 1993,p.189). Reardon & Tosi relate low self-esteem in inability to cope with external demands, recognizing it as a major problem in anti-social adolescents.

Treatment

The OASP Report points to the importance of culture and level of acculturation, along with natural support systems, such as extended family and friends, and religion, when

providing services for Latino clients. OSAP demonstration treatment projects for youth in Latino communities included the following anticipated program outcomes: "improving family and peer relationships; improving young people's social skills and their parents' parenting skills;..." increasing self-esteem, goals which support the hypothetical basis of this paper.

Latino family and cultural values are cited as unique supports for adolescents recovering from alcohol and drug abuse. "Close identification with family, community and ethnic group; personalization of interpersonal relationships; establishment of positive roles in the family and community; and Mexican Catholic ideology" (Manov, 1992) are cited as strengths which can be drawn on to support treatment. On the other hand, while natural support systems in the Latino community are acclaimed in literature regarding treatment, the following problems have been cited:

1) natural support systems are themselves in a state of crisis;

2) response is limited due to the nature of the need; for example responding to a crack-addicted adolescent severely tests the system;

3) the system may refuse to help;

4) the adolescent may not have a support system;

5) the topic of addiction may be too sensitive for the adolescent to seek help.

Treatment obstacles are posed by poverty, language, poor transportation, and lack of familiarity of services. Gang turf conflict is a very real obstacle for Watsonville adolescents when opposing gang members come for treatment in "enemy" territory where Youth Services is located. Fear of the system regarding deportation or exploitation, and shame, along with denial and/or enabling, associated with alcohol/drug use by a family member, may deter

clients from seeking or committing to treatment.

Stein and Davis (1982, p.245) note traditional psychotherapy has "rarely been considered effective" in treating delinquency. Multimodality treatment has been recommended for adolescent alcohol and drug abusers. Developmental process suggests "habilitation is a necessary component of treatment, rather than re-learning and rehabilitation" (Manov, 1992). Treatment team members become role models, help in solving everyday real life problems. Treatment may call for alternative schooling.

Family Treatment: Structural Family Therapy

Comparison of therapeutic techniques and goals among different theoretical approaches to family work led me to select structural family therapy as the treatment of choice for the client. Additionally, this model is used and taught at Youth Services. Psychodynamic work with Latino clients is not as appropriate due to its emphasis on individual intrapsychic change, as opposed to the restructuring of the family organization in short-term, cross-cultural therapy. Bowen's model is potentially culturally inappropriate for Latino clients due to its emphasis on individuation, which contrasts with cultural values of inter-dependence. The strategic use of paradoxical and double-bind techniques in Bowen's model also might be interpreted as disrespectful by Latino clients.

> Engaging and retaining the adolescent's family is a critical element of successful treatment outcome. In family-centered treatment modalities, the family is viewed as the main resource to the adolescent,...with positive outcomes shown [through] teaching parents to effectively engage in role setting, monitoring, problem solving, and discipline...Strategic Structural Family Therapy [has been identified as] a highly effective, short-term,

> problem-focused approach. Youth Services has been using Strategic Structural Family Therapy...with Latino...youth since 1990. Studies of client outcomes at six months after program departure show substantial improvements in [alcohol and drug] use... (Manov, 1992).

Failure of Latino adolescents to resolve conflicts between the value systems of their peers and parents has been cited as a factor contributing to acting out behavior, including substance abuse. Szapocznik's theory of "differential acculturation" hypothesizes that faster acculturation among immigrant children than among their parents leads to stress and "lesions" in family relationships, which contribute to such behaviors as drug abuse (Santisteban & Szapocznik, 1982). The resulting decline in family influence points to the need and value of family therapy, more so in a culture noted for strong family bonds. One study showed reduction of drug use was "related positively to the amount of family support available during the program..." (Austin & Gilbert, 1989, p.12). Several studies have shown family discord, lack of family intactness, and poor quality parent-child relationships as significant contributors to drug use (Austin & Gilbert, 1989, p.8), while lower substance use was reflected when adolescents experienced positive, trusting relationships with parents, and in families where adolescents were more dependent on parents than peers for guidance and emotional support. Drug abuse has been identified as a multigenerational problem in many Hispanic families and communities (Austin & Gilbert, 1989, p.3), with familial modeling establishing expectations regarding benefits and sanction of drug use. Structural family therapy is invaluable in addressing maladaptive family structures where drug-abusing adolescents occupy central, powerful roles against weak parental subsystems.

Delgado emphasizes the influence of relational dynamics in providing culturally competent treatment for Hispanic clients, at the same time noting that negotiation between parent and child "is not encouraged and does not provide enough latitude for a compromise..." (Delgado, 1988, p.64-65). Delgado's discussion of Hispanic family dynamics stresses the effect of the clash between the majority society's emphasis on independence versus the Hispanic value of interdependence, suggesting that the irreconcilable conflict between the two values may directly contribute to alcohol and drug use. Frederickson, et.al. recognize family contracting as a component of family therapy that has been effective in reducing adolescent drug abuse.

Structural family therapy provides a system that is harmonious with the person in environment perspective of social work, and it is suitable in the context of cross-cultural treatment. Salvador Minuchin developed structural family therapy, which focuses on context, rather than individual problems. The major thesis of structural family therapy is that an individual's problems are best understood within the context of family patterns, and that changes in family organization are a necessary antecedent to relief of the individual's symptoms. The therapist takes a leadership role in changing the structure that surrounds and maintains the symptom. Emphasis on the influence of the family's hierarchal organization and interdependence are compatible with Hispanic family structure and values. Minuchin states, "The therapist's framework...approaches the individual in his social context.... Therapy based on this framework is directed toward changing the organization of the family" (Minuchin, 1974, p.2). Minuchin describes the "site of pathology...[as] extracerebral as well as intracerebral" (Minuchin, 1974, p.9), i.e. existing within the patient, in his social context,

or in the interaction between them. Thus, the client living within a family is part of a social system to which he must adapt. As the therapist joins with the family, and facilitates alternative transactions between members, the changed organization enables movement to take place. "Structural family therapy is a therapy of action. The tool of the therapy is to modify the present, not to explore and interpret the past" (Minuchin, 1974, p.14). As a "therapy of action," cross cultural application is viable. Minuchin states:

> Interviews with effectively functioning families from different cultures will illustrate the normal difficulties of family life, which transcend cultural differences....The Family is a social unit that faces a series of developmental tasks. These differ along the parameters of cultural differences, but they have universal roots (Minuchin, 1974, p.15-16).

Minuchin speaks of the conflicting demands modern civilization makes on man. Within the environment of modern civilization, family functions include protection and socialization in response to the culture. Industrial society has "intruded forcefully" on the family. Within this world of transition, "the family's major psychosocial task - to support its members - has become more important than ever" (Minuchin, 1974, p.47). Minuchin's theory is useful in cross-cultural practice in which family stressors are greatly magnified in families dealing with a foreign culture and values, along with assimilation differences within the family itself. When the client is a teenager dealing with normal adolescent developmental tasks in a family that is dealing with poverty, "individual/psychological, cultural and institutional" (Brown, 1992, p. 232) racism, and conflicting value systems, parental tasks such as nurturance, supportiveness and role-modeling are seriously challenged. Parents

dealing with these stresses may be coping with survival from their own gang-affiliation and alcohol and drug use, contributing to the intergenerational problem.

Delgado's discussion of the Hispanic adolescent "caught between two worlds" (Delgado, 1989, p.65), highlights the importance of a multigenerational perspective in treatment. Additionally, Austin and Gilbert's (1989) discussion of the effect of poor parent-child relationships on alcohol and drug use points to the value of family therapy model in adolescent alcohol and drug treatment.

Structural family therapy has been selected as the principal treatment mode at the Spanish Family Guidance Center in Miami, where their work with Cuban families of drug-abusing adolescents has shown process-oriented work to be successful in addressing both acculturation-related and family relationship issues.

> In all cultures, the family imprints its members with selfhood. Human experience of identity has two elements: a sense of belonging and a sense of being separate. The laboratory in which these ingredients are mixed and dispensed is the family, the matrix of identity (Minuchin, 1974, p.47).

Work with drug abusing adolescents and their families may be hindered by resistance to entering treatment, with many clients lost prior to the first session. Some research has shown only 11 percent of families completing treatment. Drug abusing adolescents tend to deny drug use as a problem while they use the drugs to help them cope with personal and family problems. Once in treatment, they attribute family-related problems as the primary reason for being in treatment. Two approaches based on structural family therapy have been developed for such cases: Strategic Structural Systems Engagement (SSSE) and One Person

Family Therapy (OPFT). SSSE views resistance to treatment as a symptom of the family's inability to adapt effectively, using structural family therapy techniques to overcome the resistance. OPFT is designed to accomplish the goals of family therapy while working with one family member. With just one person present, enactment analogue is used, in which interactions are reconstructed using the concept of complementarity to infer patterns. This is achieved in asking the client, preferably the drug using adolescent, to describe or act out interactions, or by role playing. In changing his/her own behaviors, the client becomes the vehicle for change, often producing a family crisis as a result. The crisis may then serve to bring the family into treatment.

Design of the Evaluation Study

The purpose of this project was to assess the results of family intervention. Counseling was directed at increasing the client's feelings of self worth within the family system, thus reducing her dependence on alcohol and drugs in order to try to make herself feel valued. Treatment was partially based on structural family therapy techniques. The client was in a multi-faceted program, and other simultaneous therapeutic interventions were involved. This study was based on the family therapy component. Elements of case management were integrated into treatment, including assessment and monitoring overall services received by the client within the agency. Other elements of the agency's overall program for day treatment clients are: on site school, individual and group counseling, and 12-step meetings.

Based on the assumption that individual symptoms are rooted in family patterns, achieving a goal of family restructuring should produce changes in the individual client's

pathology. Cognitive restructuring was borrowed from behavioral/cognitive theory, and styles and patterns of communication explored. Therapeutic goals were addressed using techniques such as joining, reframing, reinforcement of desired behaviors.

Index of Self-Esteem

The ISE is a 25 item scale which measures problems with self-esteem. It is designed to measure the subject's view of him/herself. The scale was tested for validity with several ethnic groups, making it appropriate for the largely Latino population of clients at Youth Services. The ISE norm recommends that it be used with subjects over the age of 12, again appropriate to the Youth Services population.

The ISE shows excellent internal consistency, with a mean alpha of .93. The ISE has a test-retest correlation of .92. A coefficient of reproducibility of .90 is required to qualify a Guttman scale. The ISE shows known-groups validity, i.e. validating clinical judgements differentiating between clients showing problems with self-esteem and those who did not. Good construct validity is shown as ISE results equate with measures of related issues such as depression and sense of self.

The Guttman scaling technique uses five responses in progressive order from "rarely or none of the time" to "most or all of the time" in response to statements about feelings. Some items are positive statements, and others negative to partially control response biases. Scoring is accomplished by first reverse-scoring selected items, which are then totalled along with the remaining items. The final step is to subtract 25 from the total. The resulting score will fall between 0 and 100. The clinical cutting score is 30, therefore scores above 30 generally indicate a clinically significant problem, while those below 30 indicate the opposite.

Thus, high scores indicate a low sense of self-esteem.

Drug Severity Index

The Drug Severity Index (DSI), developed by Friedman and Glickman, provides a basic measurement of reduction or elimination of drug and alcohol use. It is in the form of a grid, showing frequency of use on one axis and type of drug on the other. Using the grid format, frequency of use is indicated on one axis, and type of drug on the other.

Numeric values are assigned to types of drug, and to frequency of use. Resulting risk level scores for the primary, secondary and tertiary drugs abused are multiplied by frequency of use, leaving a number which classifies the severity of use. Difference scores result from subtraction of first test score at beginning of treatment from those obtained at termination. Comparison of intermediate interval scores could be made as well, for example on a weekly basis.

Structural Family Therapy

The treatment modality in this study was structural family therapy. Interventions used in treatment consisted of:

1. Observation of family communication patterns. The therapist observed transactional patterns occurring among family members, keeping a subjective log of specific behaviors during each session. Study of the client's responses was operationally defined through the client's self-reporting, family feedback, appropriate verbalization during the session, and body language and affect, as observed by the therapist.

The therapist first joined with the client and family through showing empathy and encouraging verbalization and showing feelings. By following paths of family

communication, the therapist discovered which were open, closed or blocked, and began to recognize and help the family explore their dynamics. Explicit instructions during the session helped family members experience their own transactions, heightened their awareness. and helped them push through blocks and closures.

Using maintenance (Minuchin, 1974, p.125), a joining technique in structural family therapy whereby the therapist provides "planned support of the family structure," enabled the therapist to experience family dynamics. Active confirmation and support of family subsystems acted to confirm the client's strength and potential and/or strengthen her position in the family. Supporting one part of the subsystem, in this case M, this technique placed a restructuring demand on the other, i.e. her mother.

Tracking (Minuchin, 1974, p.127) occurred as the therapist accommodated to the family, followed the content of communications and behavior, and supported their participation. In this study, tracking included asking for clarification, repeating statements made during the session, and making approving remarks to show interest. As the therapist explained, modeled, and reframed communication patterns, and the family was helped in restructuring dysfunctional patterns, and individual members' symptoms were reduced.

Assisting the family in becoming aware of dysfunctional responses was operationally defined when the therapist pointed out maladaptive reactions and coping patterns as they emerged during the session, explained why they did not work, and invited members to explore alternative responses.

Review of family functioning and changes in communication skills between sessions was operationalized through family members' subjective self-reports on number of arguments

the previous week, and cooperative activities at home.

Self-esteem enhancement was operationalized as M was given recognition by the therapist and the mother for positive changes she made during the course of treatment, in reaching treatment goals, and helping her to identify and acknowledge positive contributions as they occurred during session. Strengthening M's boundaries, and decreasing the mother's rigidity, contributed to feelings of increased well-being for M. In session, M's individual autonomy was reinforced as the therapist and mother listened to and acknowledged her communications, and as mother and daughter were encouraged to talk to, and not about, each other. Imposing such rules in a session helped the family delineate boundaries, and helped the mother respect M's autonomy.

2. Evaluation of client cooperation with program. Client cooperation was operationalized through weekly monitoring of M's participation in components of the program, as well as quality of participation. The family therapist checked weekly with the classroom teacher regarding class participation, absences, tardies, and homework completion. Level of participation in group was determined through subjective observation of the primary therapists' reports to the family therapist. Participation in family therapy was operationalized by subjective observation on the part of the family therapist.

In the context of structural family therapy, support, education, and guidance are regarded as joining and restructuring functions. In the role of teacher, the therapist taught M how to function in the extrafamilial world. This included "the tricks of getting along in school" (Minuchin, 1974, p.157) and, in this case, suggestions regarding participation in family therapy.

The goal in monitoring M's cooperation with the program was to enable client and therapist to become aware of the client's level of functioning in relation to changes and improvements in family transactions in the coarse of therapy. It was hoped that cooperation with the program would improve as alcohol/drug use decline or stop, and self-esteem would be improved.

Desired Outcomes

Once treatment resistance was confronted, regular participation in family sessions should lead to meeting structural family therapy goals, such as restructured family organization and change in dysfunctional patterns, reduced client symptomology, and establishment of boundaries between family members. Improved communication between M and her mother were predicted as her mother learned to express a more nurturing attitude toward M, instead of maintaining her role as harsh disciplinarian. Feelings of empowerment within M, a developing sense of self and enhanced feeling of belongingness should result from shifts in family dynamics, and contribute to M's enhanced self-esteem. The opportunity to learn and practice new forms of behavior and interaction in family therapy should have a positive effect on M's interactions in other environments, including classroom, program activities, peer and other relationships. As M experienced resulting positive responses from others, her feelings of self-worth will be enhanced.

Lessened and/or abated continuing alcohol/drug use was a desired outcome. As family therapy addressed major stresses for the client, her need for coping should be lessened, and her use of drugs as a coping mechanism become less compelling. Even in her most oppositional moments, M maintained and verbalized her goal to stop using alcohol and

marijuana.

Cooperation with the program was a necessary requisite for this client and her mother in order to achieve desired goals. Both entered the program with resistance, and sabotaging behaviors, and the mother's modeling of such behavior made the client's commitment much more difficult to attain. Several styles of interventions were unsuccessfully used during M's two months in the program, including an intervention with all counseling staff members participating, individual counseling, and peer group intervention. A therapeutic break from the program resulted when the client was finally suspended for lack of cooperation. Cooperation with the program was operationalized by monitoring the appropriateness of M's behavior in the classroom and counseling, and in relationships with staff and peers, including male clients in particular.

Operational Definitions

Five goals were identified for this project:

1. Overcome treatment resistance. Long and short term goal. Attendance and observations of client's affect (oppositional, cooperative) were logged on a weekly basis by family therapist. Notation of weekly attendance regarding both the client and her mother was made. Ratings regarding client's affect were noted according to Likert scale of 0 - 5, through subjective observation. Treatment resistance was addressed through outreach to the mother through a home visit, all-staff and peer interventions, and frequent contact with M.
2. Increase self-esteem. Long term background goal. Operationalized by Index of Self-Esteem (ISE) by W.W. Hudson. Administered to M as a pretest prior to

beginning family therapy, midway through the study (approximately 3 to 4 weeks), and at the end (8 weeks).

This goal was to be met through structural family therapy sessions, although treatment took place in the context of a multi-faceted program. This case study proposed that structural family therapy's role in instituting transformation in family transaction patterns would lead to symptom relief in the client. As the family system experienced improved dynamics and communication, individual members would feel relief leading to increased feelings of well-being, including self-esteem.

3. Reduce alcohol/drug use. Short and long-term goal. Operationalized through use of the Drug Severity Index (DSI) developed by Friedman and Glickman. Administered to client simultaneously with the ISE to track incidence of use. As M experienced an improved relationship with her mother through structural family therapy, her need for alcohol and marijuana use as a means for escaping from family/personal problems should be reduced. Family therapy achievements would be supported by client's participation in other therapeutic activities in the program.

4. Communication with mother. Should be impacted by structural family therapy, as communication patterns reorganize to adapt to new relational formations. Changes in communication patterns were operationalized through subjective comments and observations during each weekly session; were logged by the therapist weekly in subjective treatment diary notes. Determining factors: extent of arguments previous week, to be determined by asking client; extent of eye contact during session, to be observed by therapist; extent of exchange of appropriate information/communication,

determined by subjective observation of therapist.

An unforeseen issue emerged during the difficult joining process with these clients. M's oppositional affect and behavior included hostile responses regarding scheduled family sessions, in which she announced that her mother would not be attending. In an effort to engage the mother, who would not respond to phone messages, a home visit was planned and carried out. The first and only family session occurred the following week. M was suspended from the program 3 weeks later for lack of cooperation in individual, group, family counseling and classroom, including a declining attitude toward the program and lack of commitment to her contract and goals.

Although structural family therapy is appropriate cross-culturally, engaging Latino clients into a majority culture system, such as counseling, directly conflicts with values of family pride, support, and privacy. During the lengthy and challenging process of trying to join with mother and daughter, scheduled sessions were sabotaged by both, perhaps reflecting a cultural anomaly. During the first family session acknowledgement of their efforts to be there, and of the cultural leap they were taking, was made in an effort to reinforce their participation. A Guttman scale of 0 to 5 was used to rate observations.

5. Cooperation with program. Improved cooperation with the program was operationalized through weekly records of absences, tardies, homework, and participation in class/group/family therapy. Improved social participation would be evidenced by talking and level of responding in class, group, and family therapy,

operationalized each week through subjective comments and observations from other staff regarding absences, tardiness, completion of homework, and class assignments. Logged weekly in treatment diary notes, scored with an impressionistic scale of 0 to 5.

6. Social participation in program. Operationalized through subjective comments and observations regarding extent to which client talked responded to others. Initiating communication, and showing through affect/behavior her willingness to take responsibility for her part in treatment were monitored to determine M's level of commitment to the program. Behavior changes included improved eye contact and body language messages. Logged weekly in treatment diary notes. A Guttman scale of 0 to 5 was used to rate observations.

Recording intervals: records of subjective observations were kept on a once a week basis, and noted following each session of family or individual therapy. Data was collected and recorded by family therapist; some records were obtained from other staff, such as school attendance/tardiness from the site teacher.

Time Frame and Monitoring Process

The time frame was a two month period, with once a week family meetings. The length of treatment was determined by M's lack of cooperation, which resulted in her suspension after 2 months in the program. Family therapy began January 31, 1996. An early pre-test was administered December 27, using the Index of Self Esteem and Drug Severity Index. These instruments were repeated at the end of the first and second months of treatment.

Research Design: Single Subject

The general type of research design utilized in this study was a single subject, AB design. This design was selected because it supported measurement devices chosen to assess critical components of the treatment plan, specifically, evaluation of the impact of family therapy on the client's alcohol and drug use, and self-esteem. The baseline, or A, represented the client's alcohol/drug use, and self-esteem rating prior to beginning treatment as indicated by the pretest. The B stage consisted of observations and self-report during the period of intervention. Comparison of the baseline, established by pretest, and post-test results illustrated changes in alcohol/drug use and self-esteem.

Strengths inherent in the single system design included flexibility in measuring and modifying interventions. The project was workable within time constraints, measures were age and ethnically appropriate to the client, and not time-consuming to administer. The weaknesses are that interactions with the subject, and therefore most observations, was based on approximately one hour a week of direct, structured contact. Throughout the week, the client interacted with many other staff members, and other modalities of treatment. Due to M being exposed to several components of treatment at the same time, it was difficult to determine which modality or combination of modalities led to changed scores or behaviors. Another weakness stems from the limited time frame of the study with resulting inability to do multiple baseline measures or more complex design which, in this case, could include all the modalities of treatment, and determination of the efficacy of each in the treatment program and overall results. Time constraints also affected the accuracy of results in that adolescents as a group, and as addicts, require more extensive treatment than this project

allowed. Subjective measurements constituted another weakness. Use of weekly log and diary were used to help alleviate or reduce the impact of this problem. Index of Self-Esteem scores would have been more useful if they were designed to include amount of use; assessment based on "once a week" use versus "12 to 15 beers once a week" is significantly different.

M was selected using criteria that indicated a reasonable prognosis for longevity in the program. Issues such as referral source and level of family involvement observed during intake were considered. The subject chosen was partially self-referred and partially influenced by her former teacher, who is presently site teacher at Youth Services, therefore came into the program willingly. Her mother works for the probation department, possibly indicating increased likelihood for cooperation and participation in family therapy due to her work with troubled adolescents.

There did not appear to be risks for the subject in the design of this project. Confidentiality and anonymity were protected, by changing names and other information that could identify the client.

Stages of Intervention

Prior to beginning family counseling sessions, the client was given the pretest. This meeting provided the opportunity for a preliminary joining and assessment of the client's affect, level of function, appropriateness, amenability to working with this therapist, and attitude toward family counseling. Her oppositional attitude was clearly demonstrated in affect and responses to the therapists' attempts at joining. These included a negative reaction to family counseling, indicated by her refusal to make eye contact, threats to leave the

program if she had to do family counseling, and monosyllabic answers to questions regarding family dynamics, which were limited to "fine." Additionally, she was assessed for suicidal ideations, which appeared directed at punishing her mother due to M's anger at her mother's rigidly controlling attitude.

Each session included a check-in regarding specific areas of client participation, specifically communication and cooperation with the program. This information, along with treatment diary notes, was logged weekly by the family therapist on simple charts designed for that purpose.

Approximately one month later, the ISE and DSI scales were administered a second time to determine midpoint scores. Following the last session, the ISE and DSI measures were administered one more time. There was a sense of urgency to complete M's testing due to her lack of commitment and questionable longevity in the program. Youth are at high risk for relapse or minimal commitment to sobriety, dropping out of program for lack of commitment, violating probation or, in the case of M., suspension from the program.

Results

Drug Severity Index (DSI) scores were obtained by multiplying assigned numeric values of drug use with frequency of use values. The scores were then added together to obtain an overall DSI score. M's pretest indicated alcohol use only, with a numeric value of 1. M reported frequency of use as 2-3 times per month, resulting in a score of 4, and a DSI baseline score of 1 x 4 = 4. One month later, M. reported alcohol use once a month. The value of alcohol, 1, multiplied by the value of frequency, 2, resulted in a score of 2 for alcohol. Additionally, she used marijuana, with a value of 1, multiplied by the frequency

value of 4, resulting in a score of 4 for marijuana. Adding the two scores together results in a DSI total for her second test of 6. M's DSI post-test score was 10, reflecting a reported drop to one time a month for alcohol use, and an increase of marijuana use to a reported 2 - 3 times per week.

The Index of Self-Esteem (ISE) was administered simultaneously with the DSI. The first step in scoring is to reverse score each of the positively worded items, then total the score for the scale. The clinical cutting score of 30 discloses a clinically significant problem for those scoring above 30, providing a standard for evaluating treatment, and assessing whether the therapeutic goal of resolving the client's problem with self-esteem has been met. M's pretest ISE score after reversing the positively worded items was 33, which results in an actual score of 8, according to the scale's scoring formula: S = sum of Y - 25. This simple scoring formula then produces a range of scores between 0 and 100. M received a score of 37 midway through her attendance in the program. Her post-test ISE score was 28, lower than the previous one, perhaps indicating a higher level of comfort on returning to her previous school, and being with old friends, following suspension.

Treatment diaries or logs did not show patterns of improvement, and treatment resistance preempted the positive outcome results predicted as a consequence of family therapy. Notable differences were observed twice during M's treatment episode, both resulting from staff interventions questioning M's commitment to the program. The second intervention resulted in her suspension from the program, based on peer and staff recommendations, and M's worsening oppositional attitude, which was sabotaging her treatment and jeopardizing her peers' success.

Discussion

The original goal of improved self-esteem and reduced alcohol/drug use resulting from structural family therapy was not realized. Instead, a new symptom surfaced, that of treatment resistance as described in Strategic Structural Systems Engagement theory. Although M was present for all but one scheduled family session, her high level of oppositional behavior as shown by body language, lack of response, and defiant attitude preempted reaching therapeutic goals during these meetings. She would have missed most if not all sessions had she not been reminded as she was walking out the door that she had an appointment. Meanwhile, self-reports indicated continued alcohol use at the same level of 12-15 beers on weekends, and marijuana use beginning half-way through the two month treatment period. An exceptionally low ISE pretest score may have been due to denial, grandiosity, or lying. Her mid-point score was 7 points above the cutoff point, possibly indicating more honest answers.

M's mother was seen three times, and only once for family therapy. The first meeting occurred spontaneously during M's first week in the program, when she was assessed for suicidal ideation. Three weeks of calls to the mother scheduling and reminding her about sessions resulted in unanswered phone messages, and no-shows for appointments. An unannounced home visit, with followup letter reminding her that family therapy was a required component of the program, resulted in her one-time attendance.

Communication log results showed high scores (4 and 5) following each of the two staff interventions for: eye contact, exchange of appropriate information, attitude, extent of talking and responding. All other weeks showed scores of 0 or 1. Variables indicating lack

of cooperation with the program included gradually deteriorating classroom behavior in all areas except attendance. These included classroom participation, tardies, and homework completion. Family therapy scores were low due to M's marginal participation (0,1,0,0,5,0,0,0,4). Group therapy, observed twice a week by the family therapist, showed inconsistent scores during the first weeks (5,2,2,1,3), followed by three weeks of zero scores, and a final score of 3 after the last staff intervention.

M's mode score for overcoming treatment resistance was 1, due to the fact that she showed up, albeit unwillingly. She scored 5 and 4 for the sessions following the two staff interventions. Her mother's scores related to treatment resistance were zeros, with the exception of the unscheduled home visit, and the one family session she attended.

Log notes mainly reflected variations on the theme of M's oppositional, defiant attitude. Sessions following the two staff interventions were characterized by excessive crying, with a minimum of other communication. At those times, she did let her defenses down, appearing to listen and take in information.

Although treatment goals and goals for this project were not met, M's attitude and behavior in the two sessions following staff intervention appear to be hopeful signs, in that M was able to let her defenses down for even a brief time. The staff anticipates the therapeutic suspension from the program will eventually result in M's return, along with a more malleable attitude. M has been seen at her new school site since suspension from the program, and will continue to be tracked until or unless her status changes.

The potential of treatment resistance was not factored in the initial planning and design for this project, which is an oversight in light of the makeup of the target population.

Treatment resistance is expected, with "more than 40 sources" (McCown & Johnson, 1993, p.3) identified. The same authors noted no more than 25 percent compliance rates and keeping of initial appointments. Literature on treatment resistance suggests interventions should be geared toward quick completion, i.e. within 1 to 3 sessions, creating a paradox in working with adolescents, who require longer term treatment. Rapid intervention is desirable in terms of working against excessive homeostatic process, i.e. enhancing family functioning before the family returns to previous dysfunctional patterns. At Youth Services, long-term treatment is expected, including on-site schooling along with therapeutic interventions. The treatment format at Youth Services may need to be reevaluated in terms of working with treatment resistant clients, to forestall losing clients such as M.

McCown and Johnson suggest lack of compliance with treatment might be averted or lessened by spending less time initially on the diagnostic phase. M's resistance when given the pre-test for this paper was obvious, resurfacing each time she was presented with forms to fill out. Since M responded to every aspect of the program with an oppositional attitude, spending less time on diagnostic paperwork may not have significantly affected her suspension, but should be considered with future clients, hopefully precluding treatment resistance and loss of clients.

Frequent contact is recommended as a means of keeping treatment resistant families involved. Youth Services is at an advantage in this respect in having a day treatment program which includes a regular school schedule. Frequent contact with parents can be problematic, as with M's mother, in that there is little leverage for engaging resistant parents, even in the case of mandated clients.

Youth Services is an outstanding agency in the area of staff supportiveness, a great advantage in working with a difficult population. The risk of therapist burn-out was not addressed in the literature reviewed for this project, yet should be considered in this highly challenging work.

The innovative, multi-faceted program at Youth Services is at the cutting edge of treatment for adolescent drug/alcohol treatment and gang involvement, and is in a constant state of flux, learning, and growth. The learning component works both ways, as indeed it should, in staff learning from clients and vice-versa. Perhaps the most detrimental circumstance that could occur would be stagnating into a rigid format, jeopardizing the unique circumstances each adolescent brings into treatment with him/her. The same would be true for members of the treatment team. Although at times painful and challenging to the therapist personally, rewards are painstakingly reaped at personal and professional levels, fostering dedication to carry this work on. Social work practice with this population requires cultural sensitivity, resilience, a healthy support system personally and within the agency setting, creativity, vision, and hope. McCown and Johnson succinctly conclude: "Finally, remember that life goes on, largely out of control of even the most skilled and gifted therapist." (p.304)

APPENDIX

Index of Self-Esteem

The ISE is a 25 item scale which measures problems with self-esteem. It is designed to measure the subject's view of him/herself. The scale is based on tests which included several ethnic groups, making it appropriate for the largely Latino population of clients at Youth Services. The ISE norm recommends use for subjects over the age of 12, again appropriate to the Youth Services population.

Scoring

The ISE shows excellent internal consistency, with a mean alpha of .93. The ISE has a test-retest correlation of .92. A coefficient of reproducibility of .90 is required to qualify a Guttman scale. The ISE shows known-groups validity, i.e. validating clinical judgements differentiating between clients showing problems with self-esteem and those who did not. Good construct validity is shown as ISE results equate with measures of related issues such as depression and sense of self.

The Guttman scaling technique uses five responses in progressive order from "rarely or none of the time" to "most or all of the time" in response to statements about feelings. Some items are positive statements, and others negative to partially control response biases. Scoring is accomplished by first reverse-scoring selected items, which are then totalled along with the remaining items. The final step is to subtract 25 from the total. The resulting score will fall between 0 and 100. The clinical cutting score is 30, therefore scores above 30 generally indicate a clinically significant problem, while those below 30 indicate the opposite.

Thus, high scores indicate a low sense of self-esteem.

Drug Severity Index

The Drug Severity Index (DSI), developed by Friedman and Glickman, provides a basic measurement of reduction or elimination of drug and alcohol use. It is in the form of a grid, showing frequency of use on one axis and type of drug on the other. Using a grid format, frequency of use is indicated on one axis, and type of drug on the other.

Scoring

Numeric values are assigned to types of drug, and to frequency of use. Resulting risk level scores for the primary, secondary and tertiary drugs abused are multiplied by frequency of use, leaving a number which classifies the severity of use. Difference scores result from subtraction of first test score at beginning of treatment from those obtained at termination. Comparison of intermediate interval scores could be made as well, for example on a weekly basis.

Please check the box regarding your drug use during the last month

	1 x month	2-3 x month	1 x week	2-3 x week	4-6 x week
Alcohol					
Marijuana					
Speed, CR					
Paint/Glue					
Cocaine					
Heroin					
LSD/PCP					

AVAILABILITY: The Dorsey Press, 224 South Michigan Avenue, Suite 440, Chicago, IL 60604.

ISE

This questionnaire is designed to measure how you see yourself. It is n a test, so there are no right or wrong ansers. Please answer each item carefully and accurately as you can by placing a number by each one as follows:

1 = Rarely or none of the time
2 = A little of the time
3 = Some of the time
4 = A good part of the time
5 = Most or all of the time

___ 1. I feel that people would not like me if they really knew me well
___ 2. I feel that others get along much better than I do.
___ 3. I feel that I am a beautiful person.
___ 4. When I am with other people I feel they are glad I am with them.
___ 5. I feel that people really like to talk with me.
___ 6. I feel that I am a very competent person.
___ 7. I think I make a good impression on others.
___ 8. I feel that I need more self-confidence.
___ 9. When I am with strangers I am very nervous.
___ 10. I think that I am a dull person.
___ 11. I feel ugly.
___ 12. I feel that others have more fun than I do.
___ 13. I feel that I bore people.
___ 14. I think my friends find me interesting.
___ 15. I think I have a good sense of humor.
___ 16. I feel very self-conscious when I am with strangers.
___ 17. I feel that if I could be more like other people I would have it made.
___ 18. I feel that people have a good time when they are with me.
___ 19. I feel like a wall flower when I go out.
___ 20. I feel I get pushed around more than others.
___ 21. I think I am a rather nice person.
___ 22. I feel that people really like me very much.
___ 23. I feel that I am a likeable person.
___ 24. I am afraid I will appear foolish to others.
___ 25. My friends think very highly of me.

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