Welcome to Athealth.com's Professional Interview Series! We are pleased to bring you an interview with Dr. Howard A. Liddle, who answers questions about the "state of the science" of adolescent substance abuse research and talks about the practical aspects of assessing and treating adolescent substance abuse. The interview includes a brief clinical vignette that underscores treatment and intervention strategies.

Athealth.com: Welcome Dr. Liddle. I would like to start by inviting you to talk about the most important recent developments in the area of adolescent substance abuse research and treatment.

Dr. Liddle: This is a very important question with historical and contemporary overtones; there are several key issues to consider here.

First and foremost, adolescent substance abuse has become a bona fide clinical specialty in its own right, with its own theory, basic and applied research, practice guidelines, and policy studies. Clinical work in the field is grounded in the knowledge of adolescent development. Today's "state of the art" treatments are not step-down adult treatments applied to teens. Rather, they are tailored to the particulars, complexities, and multiple systems that make up the teen's ecology. Additionally, there are many opportunities for research of all kinds through federal funding agencies, foundations, and state and local agencies. The existence of research centers is a testimony to the specialty's evolution. Professional and scientific organizations and many scientific publications focus on the problems, needs, and policies pertaining to adolescence. I believe we are witnessing the beginning of a renaissance period in the history of the adolescent treatment specialty.

Second, the multidisciplinary nature of the specialty should be considered a major development, as well as a rich asset. Today adolescent substance abuse is addressed by a number of people who play vital roles in the lives of adolescents: teachers, school counselors, juvenile justice representatives, primary care doctors, psychotherapists, social workers, parents, and family members. Different professional specialties have come together to make theory based, practice and research contributions to the specialty. In treatment, the new models advocate a broadly coordinated response to the needs of the patient. This response is based on a systemic and ecological conceptualization. And, the systems approach more accurately reflects the real life of the adolescent, since they're involved in multiple social ecologies--each of which makes a unique as well as a shared contribution to the developmental outcomes of each teen. In treatment, therapists have to engage the adolescent in a productive manner; that really means understanding the subtleties and complexities of the teen's world. A "distant" stance does not facilitate the change process. There has to be a level of involvement in the life of the adolescent that demonstrates respect, interest, and caring, certainly, but also knowledge about his or her world-the world that
teens live in today, not the world that teens inhabited years ago. Concurrent work with the parent is fundamental to success as well.

Third, there is an integrative spirit about combining these multiple perspectives. We now have a much broader range of understanding about adolescent substance abuse that encourages the inclusion of the unique perspectives of medicine, developmental and clinical psychology, addictions studies, social work, and other disciplines. Our job as researchers and professionals in practice is to capitalize on this synergy of information in our treatment approaches.

Additionally, we have at our disposal a wealth of information on the basic scientific aspects of drug abuse such as how these problems come about, the efficacy of treatments, and so forth. Today more than ever before treatments are predicated on accurate, scientifically based knowledge about how problems develop (for instance, what the key risk factors are for substance abuse in early adolescence) and credible evidence about the kinds of characteristics and malleable environmental circumstances, such as family life, that protect kids against drug problems. This probably accounts for the increase in effectiveness of some of today's treatments. They are based on scientifically established knowledge about kids and their circumstances, not myths or assumptions that may or may not be accurate.

This brings me to my final point. The diverse nature of the studies being done has resulted in an explosion of information in the field. Data is available on many fronts and the challenge is to organize and apply the knowledge in a way that has a direct bearing on outcomes.

This is where the Internet can be helpful, namely, in packaging and delivering the information. Clinical journals advance research, theory, and practice, but they don't always answer the questions that practitioners have on a daily basis. The goal of using these advances in knowledge to influence everyday clinical practice in the variety of clinical settings is a major theme in the field now. Some of the most important challenges are how to take research-based, effective therapies and adapt them for use in regular treatment settings.

At health.com: Do you see any positive trends in the area of treatment outcomes, prevention, and intervention, specifically in terms of evidence-based practice guidelines?

Dr. Liddle: Evidence-based practice guidelines and treatment manuals are now available. The American Academy of Child and Adolescent Psychiatry has practice guidelines available for a variety of adolescent disorders, including ADHD, conduct disorder, and substance abuse. While these documents are not "how-to" treatment prescriptions, they are helpful because they sketch the psychological, behavioral, and environmental terrain of a clinical problem.

The execution of clinical interventions, as always, rests with the clinician; here we are dependent on her or his level of clinical competence.

The Center for Substance Abuse Treatment has revised TIPS volumes (Treatment Improvement Protocol Series) on "adolescent treatment" and "adolescent substance abuse assessment." Additionally, there is a forthcoming TIP from CSAT on family treatment of adolescent substance abuse.

On the "how-to" front, there is progress as well. In the Project MATCH tradition, CSAT is publishing several adolescent treatment manuals from brief interventions that were tested in the very
successful Cannabis Youth Treatment (CYT) Multi-site Study. The preliminary findings from this study are available online at Chestnut Health Systems.

Within the next couple of years, CSAT will also publish more adolescent substance abuse treatment manuals as part of their exemplary treatment model initiative. This new wave of treatment manuals will demonstrate that this specialty has come of age. These are well articulated, clinically feasible, and, in many cases, effective treatments that providers and systems of care (state mental health and substance abuse systems) need to know about.

The training that needs to occur in order to follow up on the advances brought by these manuals is another matter. Will the state systems support the kind of training that is needed to bring these effective treatments and interventions to counselors working hard in the clinical trenches? I sure hope so. If they can make that kind of commitment of resources and funds—well, that would be a breakthrough in the field itself.

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**Athealth.com: Could you elaborate on the outcome trends?**

**Dr. Liddle:** The outcome trends are significant:

- Large numbers of adolescents and their families can be engaged in these new "state of the science" therapies;
- Adolescents can change drug-taking habits as a result of these therapies;
- Adolescent involvement with legal and juvenile justice systems can be decreased dramatically;
- Pro-social aspects of the teen's life can be facilitated—parents and families can change, kids can stop affiliating with deviant peers, and adolescent school attendance and performance can increase significantly (See reviews by Weinberg, et al, 2000; Ozechowski & Liddle, 2000).

Family-based treatments are the most effective according to some reviews (Stanton & Shadish, 1997; Williams & Change, 2000). According to these experts, one of the "state of the science" family therapies is the treatment of choice for adolescent drug problems.

**Evidence Based Practice Guidelines**

As far as evidence-based practice guidelines are concerned, developments here are fairly recent and the by-product not only of increasing research and attention over the past decade, but also of the problems and complexities associated with treating adolescent substance abuse. Some examples of evidence-based practice guidelines are:

- Practice Parameters for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders
- Screening and Assessing Adolescents for Substance Use Disorders
- Treatment of Adolescents with Substance Use Disorders
**Athealth.com:** What are your thoughts about the pharmacological treatment of substance abuse in adolescents?

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**Dr. Liddle:** This is one of the most important areas and topics in our specialty but has received little research so far. Most researchers developing psychosocial interventions for drug using teens now accept that just as they must craft combination therapies in the behavioral realm, they need to devise combination therapies of behavioral and psychopharmacological interventions in the treatment of substance abuse as well.

In two of our current clinical trials, for instance, clinical teams of substance abuse counselors and psychologist supervisors work with contextually oriented child psychiatrists to determine appropriate, concurrent psychotropic medications for the kids in the treatment protocols. The child psychiatrist, of course, is fully in charge of the diagnosis and determination of the medication to be used, and she closely monitors medication compliance, reaction, and efficacy.

At the same time, the clinicians are in close contact with the child psychiatrist while they conduct the multiple systems oriented therapy-family work, school intervention, vocational planning, tutoring, other case management, and naturally, individual work with the adolescent.

These different interventions, including the use of medications for the teen or the parent, are coordinated. Interventions occur in the different realms simultaneously. The collaboration between the clinicians and the child psychiatrist is fruitful; it replicates in this clinical setting what happens in regular clinical practice. It also seems to address the practical, clinical needs of the case quite well. The medications for the teen typically target symptoms such as depression and anxiety, and they can facilitate the adolescent's or parent's participation in the individual, family, or group behaviorally-oriented treatments.

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**Athealth.com:** What are your thoughts on inpatient treatment?

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**Dr. Liddle:** When we consider any treatment plan or intervention it is important to bear in mind that there is, or at least there should be, a spectrum of care available (both in terms of intensity and level of restrictiveness). Residential treatment falls on the end of the spectrum. It is an intensive intervention and represents a restrictive kind of care. A stay at a residential care facility can interrupt the cycle of drug taking and the deepening of a drug using lifestyle.

Residential treatment needs to be understood as part of a continuum of services that teens and families require. Studies indicate that the quality of the post-treatment environment—particularly relationships with family and non-drug using friends and involvement in school and pro-social activities—are critical predictors of recovery. In other words, without a change in the teen's post-residential care environment, residential treatment alone is unlikely to be effective.

This is where aftercare or outpatient services enter the picture. And again, the nature and quality of these services is critically important. These services can now be based on available scientific evidence—evidence on which a transportable and clinically practical treatment model can be based.

Folks looking for residential or outpatient services need to inquire about the scientific evidence that
has influenced that particular program. If the program providers are skittish about discussing this with a parent, teen, or other referral source, there may be cause for concern. Today, given the stage of development of this specialty and the spirit of accountability in all care systems, every treatment program should be based on the available clinical research evidence about how kids recover from drug problems.

Athealth.com: **What do you consider the "most dangerous" drug(s) available to adolescents today?**

**Dr. Liddle:** This is a tricky question since the response has to correspond to how we understand adolescent drug use today. That is, if we understand adolescent drug use contextually and multidimensionally, then the answer must not only be in terms of this or that particular drug but also include the significant psychosocial and current environmental factors that contribute to the teen’s drug use or abuse.

At a basic level, the classic answer is that either heroin or cocaine is a "more dangerous" drug than alcohol or marijuana. However, if the teen is binging heavily on alcohol (going to parties, driving while intoxicated, engaging in high risk sexual behavior or alcohol-related violent acts) he or she is engaging in day to day behavior that is extremely dangerous and surely life threatening.

Additionally, as our knowledge about drugs increases, the answer to this question might change. Consider the case of marijuana, the most frequently used illegal drug in the United States. The drug’s active ingredient, THC, affects nerve cells in the part of the brain where memories are formed. We have good evidence that short-term memory is severely affected by marijuana and that smoking marijuana causes some changes in the brain that are similar to those caused by cocaine, heroin, and alcohol.

Many researchers believe that these changes place a person at greater risk of becoming addicted to other drugs such as heroin or cocaine. On the basis of this new scientific information, we ought to be much more worried about drugs such as marijuana—a drug that many parents of today’s teens tried or used. Consequently, these adults may make sharp distinctions between the danger of drugs such as alcohol and marijuana versus that of cocaine or heroin. These distinctions may not hold up so well when we take a contextual approach—an approach that asks about the level and nature of the multiple impairments that accompany a teen’s substance use or abuse.

Drug abuse derails the developmental trajectory of a teen. Longitudinal studies about the consequences of drug abuse paint a very unsettling picture:

- Serious mental health and relationship instability
- Marital and job dissatisfaction and failure
- Criminal justice involvement and legal problems
- Alcohol and drug addiction

These are some of the negative, long-term outcomes for kids who begin using early, progress to drug abuse in the teen years, get involved in the juvenile justice system, perform poorly in school,
get thrown out of school and their home, and affiliate with drug using peers.

It is a process that further solidifies a drug using lifestyle that treatment must replace.

At health.com: Are there simple assessment tools for substance abuse you would recommend for use by therapists who are not chemical dependency specialists?

Dr. Liddle: Yes, there are many assessment and screening instruments: The Problem Oriented Screening Instrument for Teens, the GAIN, the Personal Experience Inventory, and the Teen Services Review.

At health.com: Establishing a therapeutic alliance with an adolescent sounds fairly intimidating to most professionals. Do you have any special tips to offer?

Dr. Liddle: I like the fact that you chose the word intimidating. There really is a lot of truth to that for therapists. Let's talk about your vignette first, and then I will say a few words about intimidation and therapists.

At health.com: Let's discuss our clinical vignette.

A 15-year-old girl is brought in for her first visit by her mother. The mother reports that the client has been using alcohol since age 11, marijuana since age 14, and the mother suspects that the daughter is also using ecstasy with her 23-year-old boyfriend. The mother is hysterical and is threatening to kick her daughter out of the home. The client has had several issues with school (one suspension, missing school, etc.) and has recently been arrested for possession.

Dr. Liddle: Clinically, there are numerous questions to be explored. A major challenge is to come up with a case conceptualization that leads to comprehensive, well-coordinated therapeutic action. A treatment program using today's best therapies addresses multiple aspects of a teenager's life simultaneously.

Let's take a look at the risk factors that are presented:

- Here is a young girl who is already advancing along the continuum of drug abuse by engaging in increasingly dangerous drug abuse. Early use (age 11 clearly qualifies as early initiation) is a strong predictor of the development of an abuse diagnosis as well as a host of other poor developmental outcomes. Alcohol experimentation and use at age 11 would make a therapist think that there must be alcohol available in the girl's house and that the
parent or guardian is drinking and/or laissez faire about the girl's risky behavior.

- She is at risk for being put out of her home.
- The relationship with her mother is quite strained. Parent-teen relationship factors are among the strongest predictors of use and, on the other side of the coin, they are among the strongest protective, or risk buffering factors, against drug use and deviance in general. Even after problem behaviors, including drug use, have begun, parenting skills and the family environment matter. In the context of certain forms of treatment, family relationships can be a very strong antidote to deviance and the slide toward serious problems.
- She is involved in a suspect and advanced relationship with an adult. This circumstance, in combination with her drug use, is very deleterious. The girl's development is both immature and accelerated. Circumstances such as these accelerate or catapult development into areas that the teen may be emotionally, psychologically, and developmentally unprepared to meet, especially in terms of appreciating the risks and consequences of behavior.
- Her school problems show a lack of connection and represent missed opportunities for her to develop needed competencies. Lack of education opens the door to an escalation of life problems. Expulsion from regular school, the slide toward alternative schools, and then no school at all-these are dangerous and also predictive of a tough road ahead.
- Legal problems requiring a response from the juvenile justice system can represent the straw that breaks the camel's back. Juvenile justice systems (drug court models, collaboration with juvenile court judges) are not necessarily sympathetic to therapeutic jurisprudence philosophy (preferring to build more prisons to warehouse younger and younger offenders). Depending on the jurisdiction, the level of coordination between juvenile court, the treatment provider, and the skill that the treatment provider possesses in coordinating a treatment program that fits, hand in glove, with the sanctions that are imposed by the juvenile court, this girl's involvement in the juvenile justice system could be like that of so many other kids: filled with punishment and devoid of any opportunity to participate in scientifically proven treatments.

A clinician here would be worried not only about this list of clear and present dangers, but also about the interaction, current trajectory, and pace of acceleration of this girl's problems. Teen problems, drugs, behavior problems, risky sexual practices, and driving while intoxicated—these all correlate with becoming disconnected from social institutions that are important to development (i.e. schools, religious or faith based institutions, pro-social peers groups, and families).

In a situation of this sort, double, triple, or quadruple trouble can occur. When so much risk is present, the odds turn more and more against you, and something is bound to give. One problem leads to and compounds the next: school expulsion creates tension at home; legal and juvenile justice problems create less opportunity for attention to the underlying causes of problem behaviors, and so forth.

As a teen is dislocated from developmentally important, indeed vital, social institutions, he/she is further disconnected from mainstream life. In these situations the teen has fewer opportunities to develop needed competencies and more opportunities for affiliation with deviant peers. An insidious pessimism can overtake teens as well as parents. Failure in a treatment program (and the treatment program’s failure to help them), failure in school, and failure in and by families creates a powerful spiral of pain, pessimism, and doom.

It is this progression that we seek to decelerate and eventually reroute. To that end, therapists are taught not only about the risk and protective factors (how to block or facilitate them) but also what
we could call the "physics" of a situation—the relationship between cascading problems and terrible life outcomes. This "interaction effect," the negative synergy that can exist between problem areas, can saturate the lives of those who enter treatment.

Much of the initial work involves addressing the teen's or family's emotional reactions to the circumstances. Our treatments are very practical and focus on family management strategies including monitoring and building skills for developing new kinds of family relationships. The initial work often involves a frank appraisal and airing of the despondency, pain, frustration, anger, embarrassment, and despair that is present.

Parallel Dynamics

Of the many parallel dynamics that a therapist is trying to manage, I would like to stress three that I feel are deserving of primary attention. These are important because therapists who are unaccustomed to working with adolescents may not be sure where to start and may experience the turmoil associated with adolescent life and development as a therapeutic obstacle rather than as a therapeutic window of opportunity.

1. The Quality of the Therapeutic Alliance

In establishing a therapeutic alliance, it is critical to find a stance that is neither too authoritarian (like a police officer or probation officer), nor too "pal-sy" (as in, "treat me like your friend", or, "I belong to your world").

Instead, the therapist must negotiate a middle ground that will allow for appropriate advocacy. It is important to be a visible and practical advocate in the teen's life; by that I mean:

1. Working with juvenile justice, going to court with the adolescent, standing in front of the judge and talking about how the treatment is progressing;
2. Working directly with the school district to find the most appropriate setting;
3. Sitting down with the parent(s) and the adolescent to begin to engender therapeutic dialogue;
4. Visiting the teen in his/her environment. Understanding something about where this young person hangs out, where he/she lives, and the people with whom he/she associates. Or, helping the teen comply with his/her urinalysis regimen.

The trust and reliability that is established through this type of advocacy—this type of "being there" for and with the adolescent--is one that will not prove to be as transient or capricious as that of the "friend" or as problematic and contentious as that of the "probation officer."

Establishing the therapeutic alliance sets the stage to engage the adolescent in a way that will be more conducive to exploring change and changing.

2. Windows on the Life of the Adolescent

A key to effective therapy is to know which windows are open. In the above case study there are many open windows, or active issues that need attention. Some of these windows open to the outside world of the adolescent (i.e., her academic problems, her
legal involvement, and her peer group).

Other windows open into the inside world of the adolescent. For example, one might consider her relationship with her mother or boyfriend. However, the core issue here is her self-identity—who she is, what she wants, who she wants to be. Obviously, the existential distinction between inside and outside is blurred. Nevertheless, it is important that the therapist see the windows already open as well as those the teen opens as she moves through therapeutic change and not force windows open at inopportune moments because it is a therapist's prerogative or agenda.

3. **Engage the Adolescent**

Find creative ways to meaningfully engage the adolescent. This means going where they go and understanding what makes sense to them.

Another way of looking at this is the advent of play therapy for younger children. Play therapy was developed in an effort to engage children meaningfully in therapy. By the same token—and because we know that working with adolescents is not the same as working with adults—we must find ways to engage the adolescent in the therapeutic process. This is critical because of the adolescent's extrusion from supportive relationships and environments and entry into precarious relationships and dangerous settings.

Although this can be a challenge for therapists, it remains a critical ingredient to the therapeutic alliance.

So, in our case above: What are her interests? Where does she hang out? What healthy activities does she enjoy? At the same time, use the windows that are available to allow the therapeutic alliance to take on depth and breadth in concert with the complexity of the adolescent's life.

Now, this brings us back to the issue of the therapist who feels "intimidated" by the prospect of treating adolescent substance abuse. Even in the case noted above, knowing where to start can be intimidating.

Looking at a straight line, I can determine where it begins and ends. However, if I am looking at a circle, it is difficult to say for certain where it begins and where it ends. In the latter case, the therapist must look for, and start with, the windows that present themselves as opportunities to engage the adolescent in a meaningful way.

Another issue to consider is the countertransference that therapists encounter when working with adolescents. The volatility of adolescent development complicated by substance abuse, social extrusion, disenfranchisement, and other problems can be quite challenging for any therapist. These issues can challenge the therapist's sense of competence. In order to manage this dynamic, therapists are called to a higher level of self-awareness and self-monitoring.

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**Athealth.com**: *How do you encourage therapists to work with parents, families, and/or guardians?*

**Dr. Liddle**: There is no inoculation against adolescent drug use, but we now know a great deal
about what puts a teenager at risk for developing drug problems and what kinds of things that can protect a teen from antisocial activities such as alcohol and drug use.

Relationships are critical in combating teenage drug use. The slogan of one of the more effective, science-based campaigns is Parents - The Anti-Drug. It captures an important message—the power of parents to influence the development of their kids throughout the teenage years. Drug use is not thought of as a moral failing but as a health, lifestyle, or mental health issue. Parents need to adopt a developmental perspective when trying to make sense of their teen’s drug use.

Adolescence itself brings a new and dramatic stage of family life. Parents and teens are required to make changes in own lives and their relationships with each other. It is best if parents are proactive about the developmental challenges of this stage—particularly those that pertain to the possible use of alcohol and drugs. Parents should not be afraid to talk directly to their kids about drug use, even if the parents have had problems with drugs or alcohol themselves. The following are strategies that help parents prevent or address teen drug use:

- Families matter. Realize that the parent-adolescent relationship is a critical ingredient in preventing and addressing teen drug use (even after drug use has begun).
- Adopt a developmental perspective about drug use. Think about why kids do what they do. Teens say they use drugs for different reasons: relieve boredom, feel good, forget troubles, relax, take risks, ease pain, feel grown-up, demonstrate independence, belong to a particular group, look hip, etc.
- Give clear no-use messages about smoking, drugs, and alcohol. Communicate your family values about this in direct and indirect ways.
- Express love and concern as the basis of your expectations about no-use.
- Help your teen address and deal with peer influence and pressure to use substances.
- Get involved—become familiar with your teen's friends and their parents.
- Talk to other parents, particularly parents of the teen's friends.
- Supervise teen activities.
- Encourage healthy activities. Help teens find alternatives to just hanging out. After school activities and sports protect against drug experimentation.
- Increase awareness of and monitor the teen's whereabouts.
- Take every opportunity to build relationships with the teen. Small talk isn't really small; it can sustain critical connections with a teenager.
- Spend time with the teen. Family activities and dinners together are important.
- Set a good example. Be honest about your own experiences with drugs and alcohol, but be firm in your insistence that no drug or alcohol use is allowed.
- Notice the way you talk to your teen. Make your comments appropriate to the teenager's age. Resist the urge to threaten or badger. Above all, elicit and listen to what the teen has to say throughout the day and whenever you are in contact.
• Seek resources and information from friends, school, church, social groups, or professionals.

• Remember that even after drug use has begun, parents and families can still affect their teen's behavior and persuade them to stop using drugs.

• Also remember that there are new treatments for adolescent drug problems that have been shown to be effective.

Athealth.com: Do you frequently encounter adolescents with co-occurring disorders? If so, what are the primary disorders that you see in conjunction with adolescent substance abuse?

Dr. Liddle: In fact, we do. Some studies demonstrate that up to 80% of adolescent substance abusers present with conduct disorders; over 30% present with anxiety disorders and ADHD; over 30% present with depression; and again, over 30% present with PTSD.

The main message for clinicians is that treatment of adolescent substance abuse disorders is complex. These rates of co-morbidity require that a therapist be knowledgeable about many things - drugs, depression, anxiety, trauma, family conflict, learning problems, developmental delays, and dysfunction of all sorts.

It also illustrates how difficult it is to disentangle and make sense of the clinical presentation of most teen substance abusers.

The third implication is in the area of clinical training. Many of us in the field are deeply concerned that clinicians are not being properly trained to treat adolescent substance abuse.

Athealth.com: Tell us a little about your work at the University of Miami Center for Treatment Research on Adolescent Drug Abuse (CTRADA).

Dr. Liddle: We develop and test therapies for adolescent substance abuse. Our research has determined that a comprehensive, theory-based, family-oriented treatment can be devised, manualized, and taught to clinicians.

In this sense, therapists can be equipped with progressive treatment alternatives that demonstrate efficacy in treating serious adolescent drug abuse and mental health problems. Our studies show that the effects of this treatment, called multidimensional family therapy, are durable. We have followed kids and their families for one year after treatment ends, and results show that positive changes, including decreased drug use, an increase in school grades and involvement, and changes in the family's functioning, persist a year after treatment. Obviously, longer-term follow-ups are needed. Other kinds of services may be needed to maintain these changes, but we are very encouraged by the longitudinal results of these studies.

As these treatments have become refined and their scientific basis has increased, we have moved toward testing and transporting these therapies into non-research, clinical settings. Here, we
address how to apply research-based treatments in regular clinical settings—as well as how to deal with the system and provider level challenges that arise in the adoption of manualized, evidence-based therapies.

One of our more exciting ventures is my work with the states of Connecticut and Vermont to bring family-based treatment into their substance abuse delivery systems. These locales are very committed to importing evidence-based treatment that will transform the practice delivery system.

Ahealth.com: From your perspective as an expert in the field of adolescent substance abuse, what are the most important recommendations you would convey to a clinician who encounters an adolescent with substance abuse issues in their practice?

Dr. Liddle: First, there is the question of whether the therapist has been prepared to work with cases of this kind. Has the therapist been trained in adolescent development and dysfunction specifics? Has the therapist been trained in family therapy? Does the therapist know how to work with multiple systems of influence, such as schools and juvenile justice systems? And fundamentally, has the therapist been trained in adolescent drug abuse treatment?

Knowing about a teen’s mental health problems or knowing how to do family therapy does not say anything about a therapist's capacity to treat adolescent drug problems.

Knowing how to take a comprehensive drug history, understanding how to do integrative therapy that addresses mental health and drug abuse, learning how to work with multiple systems and forces that need to be addressed and directly targeted in the treatment of adolescent drug use—this is a tall order for most therapists. Not insurmountable, but surely a tall order.

This is where training comes in. The field has to pay more attention to, and provide practitioners with, more opportunities for ongoing, in-depth training in these research-proven therapies. In addition, there are many good clinical articles and treatment manuals for working with teens with drug and behavior problems. There are also practice guidelines, Internet sites, and, of course, research studies that tell practitioners which therapies have the best evidence of efficacy.

Second, we need to acknowledge that the foundation of treatment is the therapeutic alliance with the teen and the parent. Our studies show that a therapist can do things to facilitate or make worse a working alliance with the teen or parent. It is important that the therapist know how to convince teens and parents of the basic proposition that there can be something in the therapy for the teen, individually, and for the parent as well.

Third, a multisystemic assessment is fundamental to drug abuse treatment with adolescents. Key questions include:

- What is happening in the family?
- Is the parent using drugs?
- What is the family environment on a daily basis?
- What is the emotional temperature in the house on a day-to-day basis?
• Is the teen in school and how is she or he doing there?
• Does the parent have any contact with the school?
• Are there learning or behavior problems at school?
• What developmental competencies does the teen have and which ones are absent?
• What about his or her peer relationships?
• How connected is he or she to a deviant peer culture or to antisocial ideals?

Athealth.com: What do you most enjoy about your work with teens?

Dr. Liddle: I enjoy the challenge of conducting progressive, meaningful research and advancing the clinical work being done to improve outcomes for adolescents through our clinical ideas, our treatment manuals, and our data.

It really is a challenge. The stakes are high for these kids. They generally have had problems for some time, and when we pick them up, they have moved pretty far along the trajectory of life problems. Their families are fed up, the social institutions have excluded or want to punish them, and only the deviant peer underworld wants them.

Our work, strange as it may sound, has an existential level. There are "meaning of life" dimensions to our therapy—we are engaging the kid and his or her family in a quest to determine what kind of life they want, what kind of future they want to have. Will his or her future be one that is filled with heartache brought on by addiction, job failure, relationship and psychological distress or one with a job that pays a decent wage, a family life that is supportive and nurturing, and personal relationships that can be fulfilling without drug use?

That's the real fun—when it all comes together. We formulate these theories, package them in interventions, and test them using good scientific methods. Then, we take great joy in watching some of the kids and their families not only change their drug use and abuse but also their lives at the most basic levels. I feel so fortunate to be able to do this kind of work.

Athealth.com: Thank you on behalf of our community of mental health practitioners. It has been a pleasure to speak with you today.