TRANSFORMING TEEN THERAPY

Presented by David Flack, MA, LMHC, SUDP

CASE STUDY: ANDREW

Andrew never knew his father. Then, at age four he witnessed the death of his mother from an overdose. They were living in a car at the time. With no family members willing to take him in, Andrew entered foster care. Between the ages of four and fifteen, he had nearly a dozen placements. With each move, his behavior became more problematic – including oppositional behavior, angry outbursts, lying, hoarding food, and stealing.

At nine, Andrew started drinking alcohol. By eleven, he was using alcohol and marijuana regularly. At fourteen, he discovered meth and went to inpatient. He ran after three days, later reporting, "Inpatient was stupid. I had to go to my room at like 9:00pm and couldn't have any books or music, at least not anything I wanted. Just stupid crap like rainforest sounds. So, I'd just lay there, not sleeping because nobody goes to sleep that early, and think about stuff. If I didn't leave, I would've gone nuts."

Following inpatient, Andrew's substance use and behavioral issues continued to increase. By sixteen, he was on probation and had moved into a transitional living program after several months on the streets. He reported his drug of choice was meth and he used "something" every day. "Meth if I can get it, but other things, too… Ritalin, coke, crack. Or just drinking or smoking weed. I'm not picky."

At intake, Andrew met the DSM-5 criteria for alcohol use disorder-severe, amphetamine use disorder-severe, cannabis use disorder-severe, and cocaine use disorder-moderate. He also had a long list of pre-existing mental health diagnoses that included PTSD, ADHD, conduct disorder, and major depressive disorder-severe.

Andrew reported a desire to stop using amphetamines, cocaine, and alcohol. "Those things are messing up my life!" However, despite possible legal consequences and the threat of losing his housing, he reported no desire to stop using marijuana. "It's my life. People should just leave me alone. Besides, weed is pretty much the only thing I've got… My friends have ditched me. My family wants nothing to do with me. Why would I stop?"

Although Andrew repeatedly stated he didn't think treatment of any kind was necessary, he agreed to enter services. "I gotta do it or I'm going to juvie and I don't want that. Besides living on the street isn't really that great, I guess."

Based on the information provided, how would you describe Andrew's attachment style?

In what ways does Andrew's behavioral concerns (substance use, probation problems, running, etc.) illustrate his attachment style?

Based on his attachment style, what challenges would you anticipate in working with Andrew?

ANDREW'S BACKPACK

In what ways might the [bleep] in Andrew's backpack contribute to his stuckness?

In what ways might Andrew's substance use be functional? How about other behaviors?

In your opinion, why has past treatment been ineffective?

What would you do differently?

TRUST MARBLES

Brené Brown (2010) stated, "Trust is built one marble at a time." In clinical settings, these marbles can be labeled *authenticity*, *consistency*, *non-judgment*, *usefulness*, and *transparency*. Which of these marbles are commonly present in your interactions with participants? How?

For you, what are potential obstacles to using these trust marbles?

What are some ways you could be more intentional in using the trust marbles?

STAGE-SPECIFIC INTERVENTIONS

Developed by Prochaska, Norcross, and DiClemente, the Stages of Change is an evidence-based transtheoretical model that identifies five steps in the process of change. Below are brief descriptions of the stages and a few stage-specific interventions for each:

- ***Pre-contemplation.*** The person doesn't believe they have any problems related to the target behavior, so sees no reason to make changes. To help clients in this stage, focus on therapeutic alliance, validate the client's lack of desire to change, and provide non-biased, objective information.

- ***Contemplation.*** The person is considering the possibility a problem exists, but hasn't decided if change is necessary. To help clients in this stage, explore the pros and cons of continuing the target behavior, explore contradictions, and provide opportunities to imagine or experience alternatives.

- ***Preparation.*** The person has identified a problem related to the target behavior and is deciding what to do next. To help clients in this stage, encourage small initial steps or experiments, continue to explore and solidify motivation for change, and help eliminate obstacles to change.

- ***Action.*** The person has decided to change the target behavior, has developed a plan, and is now putting that plan into action. To help clients in this stage, explore ways to implement change, provide support, foster self-efficacy, and remain solution focused.

- ***Maintenance.*** When the new behavior has become habit, the person has entered this stage. I propose that six months of changed behavior is a good milestone for this. To help clients in this stage, we can provide ongoing support, continue exploring real or perceived obstacles, and build resiliency.

Where in the Stages of Change would you place Andrew? Why?

What interventions do you think would be effective with Andrew? Why?

What obstacles would exist for you in meeting Andrew where he's at?

EPILOGUE: ANDREW TODAY

Andrew remained in services with me for about three years. By that time, he'd stop use of all substances, improved his ability to manage difficult feelings, engaged in trauma-specific therapy, and successfully completed all probation requirements. He had also moved into a transitional living program for young adults who had aged out of foster care.

In his final treatment journal entry, Andrew wrote, "I've been in treatment a lot. That's my fault, I guess, but before now nobody ever said it was up to me or asked me what I wanted. Not this time. You asked me what I thought. At first, I said there was no reason to do anything different, because I didn't have a problem. Eventually, though, I decided I don't need to be a lonely, angry kid anymore. So, thanks for that, and thanks for ruining drugs for me."

Now in his mid-twenties, Andrew recently completed his associate degree in human services and looks forward to attending a four-year college sometime soon, where he plans to study art and psychology. Andrew gave permission to use his story for training purposes. His name and some identifying details have been changed to protect his confidentiality.

FURTHER RESOURCES

Books

- **Attachment in Psychotherapy**, by D. Wallin
- **Beautiful Boy**, by D. Sheff
- **Becoming Attached**, by R. Karen
- **Changing for Good**, by J. Prochaska, J. Norcross and C. DiClemente
- **The Deepest Well**, by N. Burke Harris
- **Elusive Alliance**, by D. Castro-Blanco and M. Karver
- **Existential Psychotherapy**, by I. Yalom
- **Motivational Interviewing**, by W. Miller and S. Rollnick
- **Motivational Interviewing with Adolescents and Young Adults**, by S. Naar-King and M. Suarez
- **The Orchid and the Dandelion**, by W. T. Boyce
- **Trauma and the Avoidant Client**, by R. Miller
- **Treating Addiction**, by W. Miller, A. Forcehimes and A. Zweben
- **Treating Attachment Disorders**, by K. Brisch
- **Treating Trauma in Adolescents,** by M. Straus
- **Tweak**, by N. Sheff

Other Media

- **How Childhood Trauma Affects Health Across a Lifetime**, TedTalk by N. Harris (available at www. tedmed.com/talks/show?id=293066)
- **Never Give Up: A Complex Trauma Film by Youth for Youth**, produced by the National Child Traumatic Stress Network (available at www.nctsn.org/resources/never-give-complex-trauma-film-youth-youth)

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