Published in final edited form as:

J Adolesc Health. 2007 July ; 41(1): 35–41.

Reactions to a Concept for Physician Intervention in Adolescent Alcohol Use

Richard A. Yoast, Ph.D.,

Department of Alcohol, Tobacco and Other Drug Abuse Prevention, American Medical Association, Chicago, IL.

Missy Fleming, Ph.D., and

Department of Medicine and Public Health, American Medical Association, Chicago, IL.

George I. Balch, Ph.D.

Balch Associates, Oak Park, IL.

Abstract

Purpose—This study was designed to understand adolescent and parental perceptions, receptivity, and reactions to the concept of screening and brief intervention that primary care physicians can use to reduce alcohol consumption by their non-alcohol dependent adolescent patients.

Methods—A total of 6 nation-wide computer-assisted telephone focus groups were conducted; 3 with low-to-moderate risk for alcohol problems adolescents aged 15–17 years and 3 with parents of such adolescents.

Findings—Parents and adolescents held similar views on the prevalence and harms of adolescent alcohol consumption, but different levels of concern about them. After initial surprise and needed dispelling of misconceptions, all groups expressed interest, support, and suggestions for the concept of a physician-initiated, office-based intervention to address younger adolescent alcohol use.

Conclusions—Because both adolescents and parents of adolescents expressed interest in this type of intervention, physicians should be aware of this receptivity and consider focus group findings in how to structure development of a potential counseling-based intervention. Prior education about the target and nature of the intervention is necessary, lest adolescents and parents assume – incorrectly -- that it is about doctors preaching to high risk adolescents to stop drinking.

Keywords

adolescents; adolescent alcohol use; younger adolescents; brief office interventions; parental attitudes; telephone focus groups

Introduction

The majority of health, family, and social problems related to alcohol occur in non-dependent persons who consume in excess of recommended and/or legal levels [1]. Adolescent alcohol use can have serious consequences, some of which contribute to the leading causes of injury and death including automobile crashes, suicide, and drowning, in addition to other health

Correspondence and requests for reprints: Richard A. Yoast, Ph. D., Department of Alcohol, Tobacco and Other Drug Abuse Prevention, American Medical Association, 515 North State Street, Chicago, IL 60610, Telephone: (312) 464-4202, Fax Number: (312) 464-4024

Publisher's Disclaimer: This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final citable form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

problems such as depression, cognitive impairment, unplanned pregnancy, and sexually transmitted infections [2]. The behavioral consequences of alcohol use in 2001 had a societal price tag estimated at \$61.9 billion for medical care, work loss, pain, and lost quality of life [3].

Much research indicates widespread alcohol use among adolescents and attendant negative consequences. According to the 2005 Youth Risk Behavior Survey findings, nationwide, 43.3% of students in grades 9 through 12 (50.% in 12th grade) had consumed at least one drink of alcohol and 25.5% of students engaged in heavy episodic (binge) drinking (5 or more drinks in a row) at least once in the preceding 30 days. These rates increased with age and were slightly higher among males than among females. This consumption resulted in a sizeable youth population engaging in potentially health-damaging alcohol-related behaviors: in the last 30 days, 28.5% had ridden one or more times in a vehicle driven by someone who had been drinking and 9.9% (19.2% of 12th grade males) had driven when they had been drinking, and 23.3% of currently sexually active students had drunk alcohol or used drugs before last sexual intercourse [4].

Opportunity for Physician Intervention

One potential point of contact for intervention in adolescent alcohol use is the physician's office. The National Health Interview Survey 2005 data notes that in the United States almost all (93.0%) of adolescents aged 12–17 years had a usual place of health care, with 77.7% of these young people identifying a doctor's office and 20.2% identifying a clinic as the place where they received health care services. Close to one-third (31.8%) of adolescents in this age group had seen a health care professional within the past 6 months and 39.2% had seen a health care professional in the past year [5]. Because 71.0% of adolescents in this age group report seeing a health care provider in the past year and 77.7% report receiving that care in a doctor's office, developing core elements for a screening and brief office intervention for physicians seems important to consider. Compared to other primary care clinicians, more pediatricians and family medicine physicians regularly screen and counsel their patients [6] but often not in enough depth [7]. However, even pediatricians only screen for individual and family alcohol problems in less than half the cases [8–9].

Research has shown that compared to those who begin using alcohol at age 21 or older, those who begin drinking before age 14 or 15 are more likely to develop alcohol dependence within 10 years of drinking onset (and before age 25), and are more likely after drinking to experience unintentional injuries, motor vehicle crashes, physical fights and unplanned and unprotected sex [10–13].

Screening of adolescents can identify problems at early stages, support interventions before long-term abuse patterns and effects occur, and prevent further problems and progression to dependence. Thus, over the last twenty years medical researchers have developed a screening and brief intervention (SBI) strategy to reduce the avoidable problems resulting from non-dependent alcohol use [14]. SBI is a time-limited, short term, patient-centered, motivational counseling strategy that a) identifies use; b) explores if, how, and when drinking causes problems (e.g., in particular situations or ways); and c) develops patient behavior change strategies (i.e., with brief counseling and advice) to reduce consumption or to avoid it in particular situations or ways and to reduce harm from drinking. Follow-up meetings with patients can ascertain success or failure and may be used to develop further plans if needed.

Although not designed to treat alcoholism or specifically to achieve abstinence, SBI can be effective in greatly reducing alcohol consumption and risk behaviors. Extensive testing has shown SBI to be effective with many different populations in a wide range of primary care settings to promote significant, lasting reductions in drinking levels in at-risk drinkers who are

not alcohol dependent [15]. Research on the development and use of SBI with adolescents has shown reductions in use and in related negative consequences and problems, and increased engagement in treatment [16–21].

Despite this evidence for the effectiveness of SBI interventions, such interventions do not seem to be widely used to reduce adolescent alcohol-related risks. Physicians who offer alcohol assessment and interventions may expect or experience resistance from adolescents and their parents whose opinions about such services are not very well understood. National surveys found that adolescents aged 14–17 years would, in order of preference, consult non-adult friends or siblings, their mothers or fathers about a serious substance abuse problem [22]. Adolescents who used alcohol frequently were less likely to report having had a physical examination in the last year and were more likely to have foregone medical care when they needed it than adolescents who infrequently or did not use alcohol [23]. However, more than half of adolescents reported that they had discussed drugs and alcohol with a health care provider [24] and with one of their parents [25]. These findings are consistent with a national parent and youth survey in which parents thought that their children would talk to someone else about dealing with pressures to drink alcohol even though they thought their children wanted more information about this. Although ninety-five percent of parents indicated they had talked with their child about alcohol/drugs, only 20% indicated that they received “a lot” of information from doctors compared to getting information from other sources [26]. These findings suggest limited receptivity to a physician-directed, screening and brief office intervention to address younger adolescent alcohol use; however, specific reactions to this concept have not been explored either among parents or adolescents.

This study investigated adolescent and parental reactions and receptivity to the concept of a possible physician screening and brief intervention with younger adolescents who are just starting to drink alcohol. Developing an intervention of this type requires listening to the people for whom the intervention is designed in order to understand their needs, perceptions, and behavioral predispositions.

Methods

Focus groups are well suited to identify and describe in-depth issues that are not well known or understood by researchers [27]. In this study, all focus groups were conducted by computer-assisted telephone [28–29] that permitted parent and adolescent members from throughout the US to participate. All participants joined their assigned group on their personal telephones from their own home or work place and used only first names. Such anonymity has been demonstrated to disinhibit candor about sensitive topics [29].

Data Collection and Analysis

Six nation-wide computer-assisted telephone (CAT) focus group sessions were conducted over three weeks: three groups of low-to-moderate risk adolescents (one of each gender and one of both genders) and three mixed gender groups of parents of such adolescents. Each session lasted about 90 minutes; all sessions were audio-taped, observed by at least one of the authors or co-authors, and transcribed with participants’ permission. All groups were moderated by professional qualitative research consultants. The co-authors separately reviewed the transcripts and their notes for key themes across and between groups; agreement on key points was readily established.

Recruiting Participants

A marketing research firm experienced with this kind of research involving youths, risky behavior, confidentiality, and parent/guardian consent used its nation-wide databases to screen

and schedule participants by telephone. Based on researchers' and project advisory board members' recommendations, adolescents were screened to be: 15–17 years old because they were presumed old enough to have experienced considerable exposure to adolescent drinking and young enough to remember it and be in touch with their earlier and current views. Adolescents had to receive parental permission to speak with recruiters prior to their telephone screening. Adolescent participants and their parents both signed consent forms. All focus group participants were paid an honorarium of \$75 that could be kept or donated to a charity of their choice. These procedures were approved by the Western Institutional Review Board.

All prospective adolescent participants were screened to:

- ☐ Have done at least one of the following:
 - Had 5+ drinks of alcohol on one occasion (but not regularly)
 - In the past month had gotten drunk or very high
 - In the past month had been with friends when the friends have gotten very drunk or very high
 - More than once had driven after drinking or driven or ridden with someone else who had done so
 - Decreased their use of alcohol
- ☐ Have done NONE of the following:
 - Had 5 or more drinks on 5 or more occasions in the past month
 - Live, or lived in a home with someone who abused alcohol or was currently an alcoholic
 - Regularly consume alcohol (weekly or more often)
- ☐ Be current high school students or recent graduates
- ☐ Have consumed alcohol in the past 30 days
- ☐ Be able to communicate orally in English (the language of the focus groups)

Parent participants in the focus groups were screened in a two-stage process to be parents of such adolescents, but not parents of the adolescent sample. After filling the adolescent focus groups, recruiters used the same screener to identify additional adolescents at low-to-moderate risk for alcohol problems then, without revealing their responses to parents, invited their parents to participate in focus groups. A total of 44 participants in all groups (21 adolescents and 23 parents) came from 35 cities in 18 states across the continental U.S.

Discussion Topics

Following a discussion guide, the moderator asked adolescents about alcohol use and attitudes based on their personal observations; participants were discouraged from discussing their own alcohol use. Topics included peer attitudes about drinking, pressures to drink, parental awareness of drinking, circumstances under which adolescents are most likely to drink alcohol, observed consequences of drinking alcohol, behaviors that had specific consequences, where and how adolescents got help with alcohol-related difficulties, and their unprompted suggestions about how their doctor might help -- followed up with aided reactions to aspects of a brief screening and office counseling intervention of 2–4 discussion sessions. Topics discussed in the parent groups included perceptions of adolescent alcohol use, their own attitudes about adolescent drinking, definitions of what constitutes a drink, consequences of adolescent-age drinking, sources of preventive help, and their unprompted suggestions about

how a child's doctor might help, followed by reactions to the idea of a brief screening and counseling intervention (2–4 discussion sessions) available to adolescents ages 13 to 15 years who had started to experiment with alcohol and were self-described moderate drinkers. The intervention was proposed as part of a model that targets younger adolescents because the age of initiation is decreasing, younger drinkers are less likely to be habituated and may be more receptive to intervention, and physicians are trusted as knowledgeable about the medical consequences of drinking alcohol.

Findings

Perceptions of Adolescent Usage and Consequences

Adolescent focus group participants noted that peer alcohol use ranges from weekly intoxication to occasional beer drinking while watching television and that alcohol, particularly beer, is especially accessible. With reference to drinking, one adolescent said that *"it's accepted as part of adolescent life."* Alcohol consumption is so prevalent that some young people may feel indirectly pressured to drink just to participate in activities. As one put it, *"Everyone else is having fun and getting crazy and you're like sitting there. So, like, you do it."*

These adolescents were quite aware of problems which can arise from adolescent alcohol use. As one participant put it, *"Alcohol use or abuse can be a chain reaction. It affects everything you do and the people you know."* Participants felt that their parents were aware of adolescent drinking patterns but considered them common among children other than their own.

As predicted by the adolescents, parents in their own focus groups considered drinking a common problematic adolescent behavior, but not typically for their own children. Some parents said their children had never had a drink; others said their children may have tried alcohol. A few knew their child had been drunk; and a few described their children as "social drinkers". Although they all shared concerns about hard core drinking, one subset mentioned their children's difficulties finding like-minded friends who didn't drink alcohol.

Much discussion in all of the adolescent and parent focus groups centered on the physical, psychological, social, and financial risks related to drinking alcohol – especially drinking and driving. (Indeed, one parent described alcohol use among adolescents as *"just the beginning of a spiral" of problems – much like the previously cited adolescent's "chain reaction."*) However, adolescents minimized the risks while parents described their tremendous anxiety about those risks. Many parents considered any adolescent drinking risky. Most parents considered unsupervised parties unacceptable and no parent supported the concept of letting children drink at home because it is safer than drinking elsewhere. Some parents even rejected the concept of harm reduction strategies, proposed during the adolescent groups, because they believed that these condoned drinking and were ineffective. Table 1 illustrates the differences between adolescent and parent views toward the consequences of adolescent-age drinking as well as some of the shared or similar concerns.

Participant Reactions to a Screening and Brief intervention Concept

When asked about whose help might prevent or reduce alcohol-related problems for adolescents, none of the adolescent focus group participants mentioned physicians. When asked the same question, only two parents from two separate focus groups mentioned physicians. All groups were asked what role, if any, they saw for physicians in helping adolescents avoid the harms associated with adolescent alcohol consumption. For both adolescents and parents, the idea was new. They shared common initial images of alcohol interventions: lectures and demonstrations by school or legal authorities intended to stop high-risk adolescents drinking.

Strong initial skepticism among adolescents came from fear that personal information will not be kept confidential from parents; that return visits would raise suspicions among parents; and they did not believe they would receive any information they hadn't already received from other sources. Much depended on their relationship with their doctor, which varied among from a "good," trusting one to a non-existent relationship (*"We don't connect"*) or one in which they viewed the doctor as the parents' potential spy. At the same time, many of these adolescents recognized potential benefits of such a program: the authoritative medical knowledge of physicians, their personal knowledge of the adolescent's health, and perhaps their knowledge of the family health situation.

Another barrier to these adolescents' acceptance of a physician intervention was their assumption that the purpose is to stop them from drinking. Further explanation and discussion of the intervention's purpose as harm reduction opened more of them up to the intervention concept.

After initial surprise and skepticism, adolescents became somewhat intrigued by the discussion of the intervention and offered several suggestions to ensure receptivity to and success for screening and brief intervention: that physicians had to serve as equal partners with their patients (*"Respect me and talk to me as an equal -- no holier than thou approach"*) being "straight up" about the subject matter (*"Tell it like it really is"*), and rely on real-life examples. Group or individual interventions were acceptable. Some preferred group settings because they seemed safer. However, they felt that participants should be strangers to each other and that while adults (including parents) could be present – they should not be the adolescents' own parents.

Like the adolescent participants, parents initially tended to think of this intervention as one for high risk alcohol-related behavior, requiring referral to social services or the police or "some correctional place" -- despite the moderator's introduction and reminders that it was for low- or moderate-risk drinking behaviors. They, like the adolescents, considered trust a critical component of an adolescent patient-physician relationship; it ranged among them from *"My children are sort of like in awe of their doctors ..."* to *"...[M]y kids aren't too thrilled about their family doctor – there's no closeness there."* Some parents reacted to the idea with surprise and incredulity. They had not thought of the doctor in such a role and had difficulty imagining what it might entail or how a doctor might undertake it. Many were sure that the doctor would not have the time required for a conversation with their child about alcohol-related dangers. (*"I hate to say it, but most doctors don't take the time or don't have the time. They're overworked and rushed."*)

Yet, given either the experience or acceptance of the possibility of physician help, parents liked the idea. After all, as one put it, *"Almost all kids need to go in for physicals... That is the perfect opportunity for the doctors to bring that [drinking] up."*

Confidentiality from parents vs. involving them posed an intense dilemma for parents. They believed that the child is more likely to be open with the physician if the child believes that the information will not be revealed to the parents. However, they wanted to know if their child is involved in any risk-related behavior. At the very least they would appreciate knowing that it is not a serious physical problem or they would "go crazy" imagining worst-case scenarios. However, if the only way to get the child to be honest with the doctor is to promise and deliver confidentiality from the parent, many parents would accept that. As one said, *"I think that it's important for us to realize that as much as we want to know and not have our feelings hurt, the goal is the health of a child. On that basis, if a physician that we trust tells us that he wants to see the child for whatever reason, it has to be okay because the child's health comes first."*

Parents expect and hope that the doctor would encourage children to get their parent involved. Some suggested that the doctor might even serve as an intermediary for the involvement.

No parent rejected the idea of follow-ups and several saw particular advantages, such as building a caring, trusting, accountable relationship between the adolescent and the doctor and raising the perceived importance of risks related to adolescent alcohol consumption. Some enthusiastically welcomed the idea of the doctor inviting the adolescent back to talk for two or three more sessions.

Overall, parents thought that the intervention might have some valuable, but limited effect. It would not replace the need for involved parenting, active school programming, or adolescent peer reinforcement. The intervention would require careful marketing, but would never replace the role of parents. Table 2 describes focus group members' negative and positive responses to the proposed intervention.

Conclusions

Qualitative research of this sort provides rich data that are most useful in exploring and understanding what and how people think, feel, and behave. It employs a uniquely intensive purposive sampling technique, not a probabilistic one. Where findings are similar across groups, as they often are in this study, confidence in the findings is enhanced.

One issue is the target population to include in testing. For instance, adolescent males have higher rates and heavier use of alcohol than adolescent females and are less likely to use ambulatory care [30,31]; consequently, they could be included in development of concepts for an intervention. Another crucial issue is the guarantee of confidentiality [32]. Findings from other research studies are fully consistent with this [31,33].

Both parents and adolescents expressed sufficient interest and ideas to justify developing further the concept of a brief intervention by physicians for adolescents who have just started to use alcohol. They saw the adolescent environment as replete with risks associated with drinking alcohol. Initially many found the intervention concept – both the idea of a brief physician intervention and the idea of harm reduction -- unfamiliar, surprising, and even counter-intuitive; however, after discussing the idea for a while, most parents and many adolescent focus group participants saw opportunities and benefits in the concept of a brief physician office visit intervention. They also had some concerns and suggestions about how the concerns might be met. Parents' concern for their children's safety tended to over-ride concerns about the intervention.

Parental and adolescent preconceptions about SBI included: that any alcohol intervention is "correction" or "police work" for adolescent risky drinking; that doctors have no time for discussion or follow-ups; that all doctors can do is "lecture" or "preach" to adolescents; and that doctors might interfere with or try to supplant other legitimate influencers, such as parents and schools. Consequently, the intervention concept will require detailed development and should be clearly communicated to targeted physicians, adolescents, and parents. This communication should leave little room for parents' and adolescents' imagination and misguided preconceptions.

Acknowledgements

This research was conducted in part through a grant (1 RO 3 AA121186) from the National Institute of Alcohol Abuse and Alcoholism to the American Medical Association. Everyone who has contributed significantly to this work is listed.

References

1. Saitz R. Unhealthy alcohol use. *N Eng J Med* 2005;352(56):596–607.
2. National Research Council and Institute of Medicine. Reducing Underage Drinking: A Collective Responsibility. Committee on Developing a Strategy to Reduce and Prevent Underage Drinking. In: Bonnie, Richard J.; Ellen, O'Connell Mary, editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press; 2004. p. 13-20.
3. PIRE (Pacific Institute for Research and Evaluation). Underage Drinking Costs. At <http://www.udetc.org/UnderageDrinkingCosts.asp>. This is an update of Levy DT, Miller TR, Cox KC. Pacific Institute for Research and Evaluation. Costs of Underage Drinking. Updated Edition. Calverton, Md: USDOJ, OJP, Office of Juvenile Justice and Delinquency Prevention; Enforcing the Underage Drinking Laws Program, 1999.
4. Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance – United States, 2005. Surveillance Summaries, June 9, 2006. *MMWR* 2006;55No. SS–5
5. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Health Statistics. Vital and Health Statistics. Summary Health Statistics For U.S. Children: National Health Interview Survey. 2005 [Accessed: 10/14/06]. Available at: http://www.cdc.gov/nchs/data.series/sr_10/sr10_231.pdf
6. Halpern-Felsher BL, Ozer EM, Millstein SG, Wibblesman CJ, Fuster DC, Elster AB, Irwin CE. Preventive services in a health maintenance organization. How well do pediatricians screen and educate adolescent patients? *Arch Pediatr Med* 200;154:173–179.
7. Millstein SG, Marcell AV. Screening and counseling for adolescent alcohol use among primary care physicians in the United States. *Pediatrics* 2003;111(1):114–122. [PubMed: 12509563]
8. Greer SW, Bauchner H, Zuckerman B. Pediatrician's knowledge and practices regarding parental use of alcohol. *Arch Pediatr Adolesc Med* 1990;144(11)
9. Marcell AV, Klein JD, Fischer I, Allan MJ, Kokotailo PK. Male adolescent use of health care services: where are the boys? *J Adolesc Health* 2002;30:35–43. [PubMed: 11755799]
10. DeWitt DJ, Adlfa EM, Offord DR, Ogborne AC. Age at first alcohol use: risk factor for the development of alcohol disorders. *Am J Psychiatry* 2000;157:745–750. [PubMed: 10784467]
11. Ellickson PL, Tuckers JS, Klein JD. Ten-year prospective study of public health problems associated with early drinking. *Pediatrics* 2003;111:949–955. [PubMed: 12728070]
12. Hingson RW, Heeren T, Jamanka A, Howland J. Age of drinking onset and unintentional injury involvement after drinking. *JAMA* 2000;284:1527–1533. [PubMed: 11000646]
13. Hingson RW, Heeren T, Winter MR. Age at drinking onset and alcohol dependence. Age at onset, duration and severity. *Arch Pediatr Adolesc Med* 160:739–746. [PubMed: 16818840]
14. Fleming, MF. Screening, assessment, and intervention for substance use disorders in general health care settings. Providence, RI: Association for Medical Education and Research in Substance Abuse; 2002. Project Mainstream: Strategic Plan for Interdisciplinary Faculty Development: Arming the Nation's Health Professional Workforce for a New Approach to Substance Use Disorders; Part I. Evidence Supporting the Strategic Plan.
15. Poikolainen K. Effectiveness of brief interventions to reduce alcohol intake in primary health care populations: a meta-analysis. *Prev Med* 1999;28(5):503–9. [PubMed: 10329341]
16. Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. *Alcohol Clin Exp Res* 2002;26(1):36–43. [PubMed: 11821652]
17. Knight JR, Sherritt L, Van Hook S, Gates EC, Levy S, Chang G. Motivational interviewing for adolescent substance use: a pilot study. *J Adolesc Health* 2005;37:167–9. [PubMed: 16026730]
18. Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. A new brief screen for adolescent substance abuse. *Arch Pediatr Adolesc Med* 1999;153(6):591–6. [PubMed: 10357299]
19. Suzuki K, Takeda A, Murakami S, Yuzuriha T, Hiezima M, Yoshimori C, Fuzibayashi T. Brief intervention for smoking, problem drinking and drug abuse by high school students. *Nihon Arukoru Yakubutsu Igakkai Zasshi* 2003;38(6):475–82. [PubMed: 14750357]Japanese

20. Tait RJ, Hulse GK. A systematic review of the effectiveness of brief interventions with substance using adolescents by type of drug. *Drug Alcohol Rev* 2003;22(3):337–46. [PubMed: 15385228]
21. Tevyaw TO, Monti PM. Motivational enhancement and other brief interventions for adolescent substance abuse: foundations, applications and evaluations. *Addiction* 2004;99 (Suppl 2):63–75. [PubMed: 15488106]
22. Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA) and RTI (Research Triangle Park, NC). National Household Survey on Drug Abuse: NHSDA Report; Youths' Choice of Consultant for Serious Problems Related to Substance Use. Rockville, MD: 2003. <http://www.samhsa.gov/2k3/YouthConsult/YouthConsult.htm>
23. Ford CA, Bearman PS, Moody J. Foregone health care among adolescents. *JAMA* 1999;282:2227–2234. [PubMed: 10605974]
24. Kaiser Family Foundation, Seven adolescent magazine. Sexsmarts: A series of national surveys of adolescents about sex: Sexual health care and counsel. 2001. Viewed at: <http://www.kff.org/docs/sections/repro/sexsmarts.html> on 07/11/02
25. (SAMHSA) Substance Abuse and Mental Health Services Administration. Results from the 2005 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD.: 2006.
26. Kaiser Family Foundation. Nickelodeon/Talking with Kids about Tough Issues: A National Survey of Parents and Kids. 1999 [Accessed: 10/16/06]. Available at: <http://www.kff.org/youthhivstds/1460-kids.cfm>
27. Krueger, RA.; Casey, MA. Focus Groups: A Practical Guide for Applied Research. 3. Thousand Oaks: SAGE Publication; 2000.
28. Balch GI. C.A.T. (Computer-Assisted Telephone) focus groups: better, faster, cheaper focus groups for the “hard-to-reach”. *Soc Market Q* 2001;7:38–40.
29. Silverman, G. Introduction to Telephone Focus Groups. 1994 [Last accessed October, 2006]. [Http://www.mnav.com/phonefoc.htm](http://www.mnav.com/phonefoc.htm)
30. Marcell AV, Klein JD, Fischer I, Allan MJ, Kokotailo PK. Male adolescent use of health care services: where are the boys? *J Adolesc Health* 2002;30:35–43. [PubMed: 11755799]
31. Substance Abuse and Mental Health Services Administration. Results from the 2005 National Survey on Drug Use and Health: National Findings. Rockville, MD: 2006. (Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194)
32. Ford CA, Millstein SG, Halpern-Felsher BL, Irwin CE. Influence of physician confidentiality assurances on adolescents' willingness to disclose information and seek future health care. A randomized controlled trial. *JAMA* 1997;278:1029–1034. [PubMed: 9307357]
33. Balch G. Exploring perceptions of smoking cessation among high school smokers: a focus group study. *Preventive Medicine* 1998;27:A55–A63. [PubMed: 9808818]

Table 1
Focus Group Contrasting and Similar Concerns about Adolescent Drinking

Adolescent Concerns	Parental Concerns	Shared/Similar Concerns
Property damage	Alcoholism	Drinking and driving, particularly riding with a drunk driver
Injury or death	Loss of reputation, especially for girls, that affect future	Unwanted/unplanned sexual advances
School suspension or expulsion	Involvement in criminal behavior	Fights, violence as perpetrator or victim
Biomedical damage to organs and body systems	Uninhibited speech that damages relationships	Illegal drug use and other illegal behavior
Loss of self esteem, humiliation		Legal problems, arrests

Table 2
Focus Group Members Reactions to the Proposed Intervention

Adolescent Positives	Adolescent Negatives	Parental Positives	Parental Negatives
Physicians are authoritative	May have to breach confidentiality	Could use current physician visits	Physicians do not go far enough asking questions about alcohol use
Physicians know about families and alcoholism	Hard to find time for the appointments	Reach out to parents if there is a problem	Their child rarely sees his/her physician and thus would not immediately trust him/her
Physicians know about medical aspects of drinking	Physicians are parental spies	Parents wanted to know (at some point) about their child's problem and be involved in helping	Are unaware of brief or other interventions for alcohol problems short of alcoholism
	Only alcoholics need this type of intervention	Understand the value of alcoholism treatment	Have conflicting views about the acceptability of not being immediately involved in their child's getting help