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Variables Associated with Therapy Attendance in Runaway Substance Abusing Youth: Preliminary Findings

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Abstract

Service providers and researchers note that youth with substance abuse problems are difficult to engage in treatment and, when engaged, often drop out early. Estimates of the alcohol and drug abuse rate of runaway youth range from 70% to 95%. This study evaluated predictors of therapy attendance in a sample of substance abusing youth recruited through two southwestern runaway shelters. Runaway youth and their families ($N = 36$) were engaged into a 15-session ecologically-based family therapy (EBFT) intervention. Fewer days between the pretreatment assessment and the first therapy session, as well as less perceived parental care, predicted more therapy sessions attended. No relationship was found between level of substance use and treatment attendance. The findings highlight the importance of engaging families in therapy soon after the youth's arrival to the shelter, as treatment motivation may decrease as the crisis lessens.

Treatment of adolescents with substance use problems is challenged by their lack of motivation to change, difficult engagement, and premature termination (Feigelman, 1987; Stark, 1992), perhaps particularly so in light of developmental factors (i.e., autonomy issues, identity formation) that may be associated with opposition to treatment. Motivation is generally acknowledged to be a significant issue in addressing addictive behaviors (Miller & Rollnick, 1991). And, as the Institute of Medicine (1990) has observed, "the nature and success of drug treatment is complicated by the typical reluctance of dependent and abusing individuals to seek treatment or stay in it" (p. 9). Among adult addicts, over 80% are estimated to be in the precontemplation or contemplation stage of readiness for change (Snow, Prochaska, & Rossi, 1992). Even when drug dependent individuals contact a treatment system, early dropout is a significant problem. Ellis, McCan, Price, and Sewell (1992) found that the modal number of treatment sessions in the state of New Mexico for the treatment of alcohol and drug problems was one.

The lack of motivation among adolescent substance abusers is well-documented. For example, in a study of treatment engagement, Szapocznik and his colleagues (1988) reported that 62% of youth between the ages of 12–21 were unwilling to come to treatment. Similarly, treatment completion rates for youths in therapeutic communities have ranged from 10% to 18%, with approximately one-third of the youths leaving treatment within the first month (Pompi, 1994). Reported peer group treatment dropout rates have been as high as 49% (Liddle & Dakof, 1995) and 56% (Joanning, Quinn, Thomas, & Mullen, 1992). Ogborne (1995) reported that 33% (194 cases) of those aged 12 to 25 who presented to eight outpatient programs for substance abuse treatment dropped out before their assessment was completed.

Several studies have examined the relationship between age and dropout rates directly. Some found evidence that along the age continuum of substance abusers, youth is linked to higher substance abuse dropout rates (Feigelman, 1987), suggesting that younger abusers may be more resistant to entering a program for drug abuse treatment than older abusers. Yet, McLellan, Woody, Luborsky, O'Brien, and Druley (1983) noted that individuals who seek help at earlier stages of drug dependence often experience more favorable outcomes, highlighting the importance of working with adolescents who are beginning their involvement with drugs, as they may potentially receive the greatest benefit from treatment.

No treatment evaluation studies of runaway youth and families were found. Runaway youth are noted to be especially difficult to engage and maintain in therapy (Morrissette, 1992; Slesnick, Meyers, Meade, & Segelken, 2000; Smart & Ogborne, 1994). This may partly be due to the level of chaos in the family environment associated with runaway behavior. The family environment of runaway youth has been characterized by poor parenting practices, violence, neglect, and sexual abuse (Crespi & Sabatelli, 1993). Family therapy involves not only difficult engagement of youth, but also of parents. Parents may refuse participation due to fear of being reported to the state for child abuse. Alternatively, they may fear that their own problems (e.g., substance use, parenting practices, marital relationship) may be an issue in the therapy.

Researchers have noted that when working with runaway youth, including the family is almost always advisable given their involvement in precipitating the runaway behavior (Rohr & James, 1994). Teare, Furst, Peterson, & Authier (1992) reported that in their sample of shelter runaways, youths' greatest needs included living arrangements, family relationships, and communication with parents. Also, those youth not reunified with their family had higher levels of hopelessness, suicide ideation, and reported more family problems than those reunified. During a crisis, these youths and families may be more amenable than usual to counseling, and the need for intervention is intense, with the timing (when they have sought help at a shelter) critical (Post & McCoard, 1994).

The current study examined predictors of therapy attendance among a sample of runaway adolescents and their parents. Given the relationship between substance use and treatment attendance, it was expected that more adolescent substance use would predict fewer treatment sessions attended by the youth and family. Also, more perceived parental care was expected to predict more treatment sessions attended. Youth's perception of parental care and concern likely reflects a willingness by both the youth and parent to work together on the problem situation. Finally, youth and families who engaged early in the crisis were expected to attend more sessions than those engaged later, as motivation to participate in therapy may lessen as the crisis dissipates. Identification of factors associated with therapy attendance is useful so that therapists who work with runaway youth and families may focus their attention on those areas shown to increase retention of this hard-to-retain population.

METHOD

Participants

Youth were recruited from two runaway shelters in a large southwestern city as part of two larger projects examining family therapy outcome with substance abusing runaway youth. Thirty-six adolescents, including 20 males and 16 females, participated. The reported ethnicities included Native American ($N = 6$), African-American ($N = 3$), Hispanic ($N = 12$), and Caucasian ($N = 15$). Family constitution included 16 single-parent and 19 two-parent. See Table 1 for additional demographic information. In order to be eligible for participation, youth were required to

1. meet DSM IV criteria for alcohol or other psychoactive substance use disorder,
2. live within a 60-mile radius of the research site,
3. have the legal option of returning to a home situation (including foster care or another family member),
4. have a primary caretaker who agreed to participate in family therapy.

Procedure

Shelter staff referred potentially eligible youth to the project research assistants who then approached and engaged youth in the project. Youth who met preliminary eligibility criteria were fully informed of the nature and conditions of the study and the elements of informed consent. Upon this review, youth signed the research consent form. The youth's primary caretaker was then contacted by phone and was also engaged in the project. Parental consent for the youth's research participation was obtained, and the form was mailed to the parents for signing.

In order to ensure formal eligibility, the interviewer administered the Computerized Diagnostic Interview Schedule for Children (DISC; Shaffer, 1992), sections on alcohol, marijuana, and other drugs. If youth did not meet criteria for a substance use disorder, they continued with treatment as usual through the shelter. Otherwise, youth continued with the assessment battery. They were told that the assessment would take up to 3 hours to complete and that they would receive \$25 at the end of their participation. Generally, youth completed their assessment within 3 days of their arrival at the shelter.

FAMILY THERAPY—Treatment was provided by four therapists trained in ecologically-based family therapy (EBFT). Therapists included one male and three females with varied educational backgrounds. Two therapists were master's level counselors, one was a licensed psychologist, and one was a licensed alcohol and drug abuse counselor. The intervention included 15 therapy sessions, to be completed within 3 months, but no longer than 6 months.

Ecologically based family therapy is a multisystemic treatment based on the recognition that substance use and other related problem behaviors derive commonly from many sources of influence and occur in the context of multiple systems. It is based largely on family systems (Haley, 1976; Minuchin, 1974) conceptualizations of behavior and behavior change. Ecologically based family therapy posits that behavior problems can be maintained by problematic transactions within any given system or between some combination of pertinent systems, including the intrapersonal system of the individual adolescent, the interpersonal systems of the family and peers, and the extrapersonal systems of the shelter, juvenile justice system, school, and community. Treatment is not limited to the family but is directed toward assessing these multiple influences and intervening so that change is supported throughout all the systems affecting the problem behavior. In sum, EBFT includes sessions or parts of sessions held conjointly with all family members living in the home, but also includes individual sessions with the youth targeted on decision-making, emotion-regulation, or other intrapersonal factors which may be influencing substance use and other problem behaviors.

Materials

The assessment included interviews and self-report questionnaires. Assistance in completing forms was provided to youth as needed. Only those assessment instruments utilized in the current study are described.

SAMPLE CHARACTERIZATION—The examiner administered a demographic questionnaire to characterize the sample. These demographic items included age, gender, homeless experiences, self-identified ethnicity, and parent and sibling information.

FAMILY MEASURE—The Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979) consists of 25 items, and is a measure of two dimensions of parent-child relationship—perceived parental care versus rejection, and control versus autonomy. It has good reliability in both clinical and nonclinical samples and has demonstrated construct and predictive validity (Klimidis, Minas, & Ata, 1992). Researchers have documented the suitability of using the PBI with homeless adolescents (Dadds, Braddock, Cuers, Elliott, & Kelly, 1993).

MEASURE OF SUBSTANCE USE—The primary measure of quantity-frequency of adolescent substance use was the Form 90-I developed for NIAAA funded Project MATCH (Miller & DelBoca, 1994). The Form 90-I combines the timeline follow-back method and grid averaging and has shown excellent test-retest reliability for indices of drug use in major categories (Tonigan, Miller, & Brown, 1997) with kappa's for different drug classes ranging from .74 to 1.0. This structured interview yields a daily reconstruction of all drug classes, and provides a percentage for days of all drug use (in the prior 90 days), the primary dependent measure.

RESULTS

To examine the relationship between demographic variables and treatment attendance, three one-way analyses of variance (ANOVAs) were completed with the number of therapy sessions attended as the dependent variable and ethnicity (Hispanic versus Caucasian), family constitution (single versus two parent), and gender (male versus female) as the separate independent variables. Number of treatment sessions completed did not differ between Hispanics ($M = 9.6$, $SD = 6.1$) or Caucasians ($M = 12.5$, $SD = 5.1$; $F(1,26) = 1.76$, $p > .05$), males ($M = 9.7$, $SD = 6.0$) or females ($M = 11.8$, $SD = 5.5$; $F(1,26) = 1.17$, $p > .05$) or between single ($M = 12.8$, $SD = 5.2$) and two-parent families ($M = 9.2$, $SD = 5.7$; $F(1,26) = 3.63$, $p > .05$). Treatment completion rates by therapists were also examined to rule out differential client dropout by therapists. Number of completed treatment sessions were similar among all therapists ($F(3,35) = 0.9$, $p > .05$).

In addition, a bivariate correlational analysis was conducted to examine the relationship between other variables potentially associated with treatment attendance. However, no relationship was found between treatment attendance and age ($r = -.05$, $p > .05$), total number of nonsubstance related diagnoses ($r = -0.25$, $p > .05$), physical/sexual abuse ($r = 0.06$, $p > .05$), and number of lifetime runaway episodes ($r = 0.09$, $p > .05$).

A multiple regression analysis (MRA) was conducted to assess the joint relationship between three predictor variables and the number of completed family therapy sessions. The three predictor variables were:

1. percent days of alcohol and drug use,
2. PBI care score, and
3. number of days between the pretreatment assessment completion and first therapy session.

The predictor variables were entered into the full model, and a backwards elimination technique was used to derive the most parsimonious model. The three predictors accounted for 26% of the variance in number of completed therapy sessions, $F(3,35) = 3.66$, $p < .02$. Elimination of nonsignificant predictor variables led to a two predictor solution wherein an increased number

of completed sessions was found with fewer days to the first therapy session ($p < .02$) and less perceived parental care ($p < .05$). These two predictors accounted for 20% of the variance in the number of completed therapy sessions indicating that alcohol and drug use was largely unrelated to the number of completed therapy sessions.

DISCUSSION

No known study has examined variables associated with treatment attendance of runaway youth and families. Identification of factors associated with treatment drop out is essential for therapists who work with runaway youth and their families. Therapists may address those factors in the therapy context with the goal to increase treatment attendance. The current study addressed this gap in the literature through examining the preliminary findings from a treatment study with shelter-bound runaway youth and their families.

As expected, fewer days between the youth's pretreatment assessment and the first family session predicted more completed therapy sessions. Once the pretreatment assessment is completed, the data highlight the importance of scheduling the first therapy session quickly. Unlike street youth, runaway youth who access the shelter system are asking for help, and are open to assistance during the period of crisis when the youth is in the shelter. When the family is in a state of disequilibrium with the youth out of the home, parent and child motivation may be high to receive intervention and address family interactional patterns. It is possible that if the first session occurs after the crisis has lessened or when the youth has returned home, motivation to remain in therapy lessens. That is, therapists working with runaway youth have noted that these youth and parents experience a "honeymoon" phase when the youth first returns home. It is during this period when family members report few problems and are pleased to be reunited. Family members may believe that they are less in need of therapy, which leads to earlier treatment drop out.

The youth's perception of parental care predicted therapy attendance, but not in the expected direction. The youth's perception of *less* parental care and nurturance predicted *more* therapy sessions attended. The youth's report of less parental nurturance and care may not reflect "reality," and parents may have very different perceptions of their own level of care. However, the perception of less parental care may reflect the youth's ease at expressing anger and acknowledging negative feelings. Expressiveness and dissatisfaction may be conducive to the therapy process as one goal of therapy is to discuss areas of disappointment, anger, and frustration with the goal to mend relational connections. Families of youth who report greater parental care may prematurely terminate therapy as they consider there to be fewer family-related issues to resolve. Alternatively, the report of greater parental care by youth may reflect defensiveness to addressing family issues. However, future research will need to further explore this finding.

Contrary to prediction, substance use did not predict the number of completed family therapy sessions. Thus, in this study, heavier and lighter users completed a similar number of treatment sessions, which may be the result of the engagement process. Although all youth in the current project met DSM criteria for a psychoactive substance use diagnosis, many project youth stated that they did not have a drug problem and were resistant to substance abuse therapy. Hence, in the engagement process, therapists avoided the discussion of the therapy as drug and alcohol treatment and, instead, appealed to the youth's perceived needs and motivators. The therapist was described to the youth as an ally who may be useful when dealing with family members, probation officers, court appearances, and the school system (Slesnick et al., 2000). As family variables are identified by youth as being of most concern when they are removed from the home (Teare et al., 1992), and the failure to have a supportive family may be the single largest factor associated with adolescent homelessness (Rotheram-Borus, 1991). It follows that family

variables, rather than drug use variables, would be most predictive of family therapy attendance.

Several limitations of the current study should be considered when interpreting the findings. First, the sample size was small. Replication of the current findings using a larger sample is needed. Second, no information was gathered from parents to predict treatment attendance. It is likely that parent variables, including substance use and mental health issues, also influence treatment attendance. As mentioned, the youth's reports of parental care, a predictor used in the current study, may not correspond to an independent rater's observations of parental care or with parent reports. Finally, this sample of youth was recruited from runaway shelters. Findings may not generalize to family therapy with street youth who refuse to stay in local shelters.

More research that evaluates variables associated with treatment retention in runaway youth is needed. These youth have been identified as "hard to work with" (Kufeldt & Nimmo, 1987) and few researchers have attempted to conduct mental health research with this population. Research and treatment with this population is complicated by logistical difficulties in locating youth who may "be on the run" for missed therapy sessions or for follow-up assessments. Engagement of youth and their primary caretakers into treatment and research programs is also difficult given many youth's and parent's previous negative experiences with other social service agencies, low level of trust, and high level of family disorganization and chaos. However, the current study indicates that runaway youth and their families are not resistant to intervention, and are more likely to continue in therapy when the youth and family are engaged early in the crisis.

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TABLE 1

Characteristics of the runaway youth sample (N = 36)

	Mean	SD	Comments
Age	15.2	1.4	Range 12–17
Annual family income	\$25,551.00	\$36,970.00	Range 0–\$190,000
Percent days alcohol/drug use	47.9%	31.3%	Range 6–100%
Number of runaway episodes	2.8	2.4	Range 1–11
PBI care score	19.3	7.3	Range 5–30
Number of completed sessions	10.6	5.8	Range 1–15
Days to first session	18.9	25.8	Range 1–111
Total number of diagnoses	2.2	1.7	Range 1–6
Current GPA	2.4	0.8	29 youth in school
Percent ever sexually abused	25.0%	44.0%	9 youth
Percent ever physically abused	38.9%	49.0%	14 youth