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Treating Adolescents with Family-Based Mindfulness

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Overview

The financial, societal, and human cost of adolescent mental health problems, most noticeably substance use problems, dysfunctional and criminal behavior, and compounding coexisting disorders are considered to be enormous and typically extend into adulthood. According to Miller (2004), the total cost of adolescent behavior problems in the USA in 1998 amounted to $437 billion (see Table 1.1). Only adjusting for the inflationary time-value of the dollar, the 2014-cost would be $625 billion, or 2.6 times the projected total 2014 national expenditure on mental health and substance abuse (MHSA).

Besides, adolescent behavioral and mood disorders generally exist in the context of proximal family problems, including parental mental health issues, substance abuse, domestic violence, and child abuse. These complex constellations of problems are difficult to treat with effectiveness and durability, and the probability of relapse and maturation into adult disorders are significant. For all these reasons, it is ever more important to promote a treatment system that has been proved successful for use with this adolescent population.

Franklin D. Roosevelt has said in 1940: "We cannot always build a future for our youth, but we can build our youth for the future." Children and adolescent mental health is one of the responsibilities that we must hold dearly as treating professionals. While some has said before that "The deepest definition of youth is life as yet untouched by tragedy," this is unfortunately rarely the case anymore as the impact that embattled parents and societies pass onto their children robs them every day of this privilege. In recognizing the apparent lack of an effective treatment approach for adolescents with problem behaviors, Dr. Jack Apsche developed a new contextual therapy, which he termed Mode Deactivation Therapy (MDT). Built on a cognitive theory framework, a unique approach to create functional alternative beliefs (FABs) was infused with elements from Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (DBT), and mindfulness practice. More than

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FACTORS	IMPACTS	MANIFESTATIONS	Compounding Deprivations	OUTCOMES	Outcomes
				Emotional and behavioral problems in later life	Individual
				Dissociative and somatoform disorders	
				Chronic conduct and behavioral disorders	
		Conduct and behavioral disorders		Suicide, self -harm, Accident & Emergency admissions	
		Depression and anxiety		Drug and alcohol problems, homelessness, poor physical health	
		Self-harm and suicidality		Serious mental illness in adulthood	
		Substance misuse		Unwanted pregnancy	
		Eating disorders		Reckless and aggressive behavior	
		Family/foster breakdown		Pro-social isolation and unstable relationships	
		Social communications/ASD		Contact with criminal justice	
		Early psychosis		Trans-generational parenting problems, neglect, and abuse	
Neuro-development and biological	Emotional and mental disturbance	Problematic personality development		Failing education, long - term under -employment	
Early trauma, neglect, abuse, and deprivations	Delayed or damaged personality development	Learning difficulties		Crime, violence, and prison	
Social and family factors	Difficulties in learning, communication, relationships, and behavior	Hyperkinetic/ADHD		Inpatient, residential placement, insecure accommodation	Social
Pre-natal & infancy →	Childhood	→ Adolescence		→ Adulthood	

Table 1.1 A developmental view of psychopathology in youth

30 separate research studies to date proved the effectiveness of MDT with empirical evidence and demonstrated its superiority compared to other therapy approaches for an adolescent population with behavior and other coexisting problems. These include substance abuse, post-traumatic stress disorder (PTSD), anxiety, depression, aggression, and suicidality. Overall, more than 90 % of participants in the research studies reported a history of childhood physical and sexual abuse, neglect, and exposure to violence. These circumstances commonly lead to core beliefs created as a protective response mechanism. Although these may not be appropriate in other daily situations, thoughts and emotions are automatically activated, which results in dysfunctional behavior to which affected persons generally respond negatively. Hereby, the circle of negative beliefs and dysfunctional behavior is further reinforced and strengthened.

MDT studies have proven that the unique combination of mode deactivation techniques, validation, clarification, and redirection (VCR) of core beliefs, acceptance, and mindfulness is effective in almost eliminating dysfunctional behaviors during and after treatment. This is especially true in a family therapy context. The family's beliefs are explored individually and collectively, and by treating the family as a unit in the process; dissonance is decreased, which further reduces the stress on the adolescent. We believe that our research has demonstrated with empirical evidence that the family-based mode deactivation methodology is superior to other cognitive-behavioral derived contextual therapies for the treatment of adolescents with problem behaviors. Therefore, in the context of the high cost impact of adolescent behavior disorders on the economy and societies, it is important to promote the family-based mode deactivation methodology among practitioners, families, and others who could benefit from its application. After all, youth are the future of the world, which is so desperate in need of thrifty and healthy new hands.

In this chapter, the need for an effective methodology to treat adolescents with complex behavioral and comorbid disorders effectively will be established. This problem continues to have a high impact on families, societies, and institutions, and an effective intervention is required to reduce the damaging effects. Many therapy approaches, most noticeably cognitive-behavior and derived therapies, have gained much attention and applications in the last decade or two. However, to a large extent empirical evidence of its success in dealing with challenging and difficult-to-treat adolescent populations and their distressed families remain lacking. Research has provided proof that the mode deactivation methodology is effective and superior and therefore there is a requirement to promote and establish the knowledge and practice as widely as possible. In this chapter, the apparent extent of the adolescent behavioral problems is quantified and a cost-benefit analysis offered for family-based MDT for which supporting performance evidence is provided in detail in Chap. 5 when the empirical research is covered. An introductory discussion reflects on the broad conceptualization of MDT while offering reasons why the approach seems to be effective and superior in the treatment of this adolescent population.

Adolescent Problem Behaviors by the Numbers

While the adolescent arrest rate appears to have steadily declined in the past decade or two (see Fig. 1.3), the same cannot be said about conduct and emotional problems, and suicidal behavior. Although more recent numbers are not readily available, Collishaw, Maughan, Goodman, and Pickles (2004) illustrated a definite increase in conduct problems among boys and girls in the 15 years leading up to the new millennium (Fig. 1.1). Thereafter, the trend seemed to have stabilized in the following 5 years.

Similarly, albeit at a slightly less expansive rate, emotional problems have also increased in the same period. Hagell (2009, 2012) has reported evidence that contributed these trends mostly to changes to family structure (e.g., more cohabitation, more single, and step-parent families), increasing maternal employment,

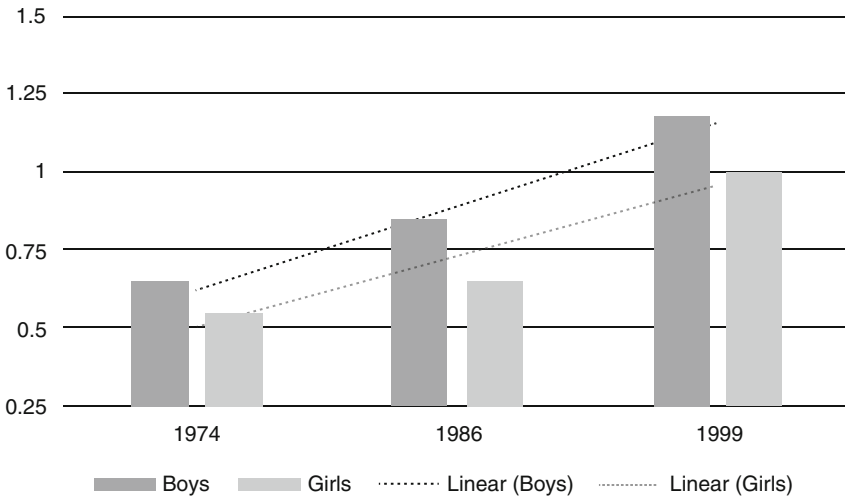

Fig. 1.1 Adolescent conduct problems by gender, 1974–1999

poorer family economic circumstances, increase in self-reported distress among parents, and decline in parental mental health. An awareness and understanding of these trends and factors are important in the analysis and reflection of interventions for adolescents that are holistic and sustainable (Fig. 1.2).

Although there is a tendency to exaggerate the problem of serious youth behavioral problems, especially pertaining to violent crimes and suicides, the occurrence remains unacceptably high. According to the Federal Bureau of Investigations (FBI), in 2012 almost 400 per 100,000 of the male adolescent population between ages 12 and 24 were arrested for violent crime index offenses, including murder, rape, robbery, and aggravated assault. The corresponding arrest rate for all offenses was 20 times higher. Homicide was the second largest cause of death for this population group.

According to statistics by the Center for Disease Control and Prevention (CDC), suicide was the third most common cause of death for US adolescents, resulting in about 4,600 deaths of youths between the ages 10 and 24 per year. However, those who have thought about, planned, or attempted suicide are much more, and even then, numbers are probably significantly underreported. A nationwide survey found that 16 % of all grade 9–12 students seriously considered suicide, 13 % reported creating a plan, and 8 % attempted suicide in the 12 months preceding the survey. According to 2014 CDC statistics, each year, 157,000 youths between ages 10 and 24 receive medical care for self-inflicted injuries in the USA. Furthermore, when looking at trends in Fig. 1.4, there seems to be a recent uptick in completed, attempted, and planned youth suicides.

Risky sexual behavior is another area of concern among adolescents. In the last 20 years, both teen pregnancies and birth rates have been steadily decreasing

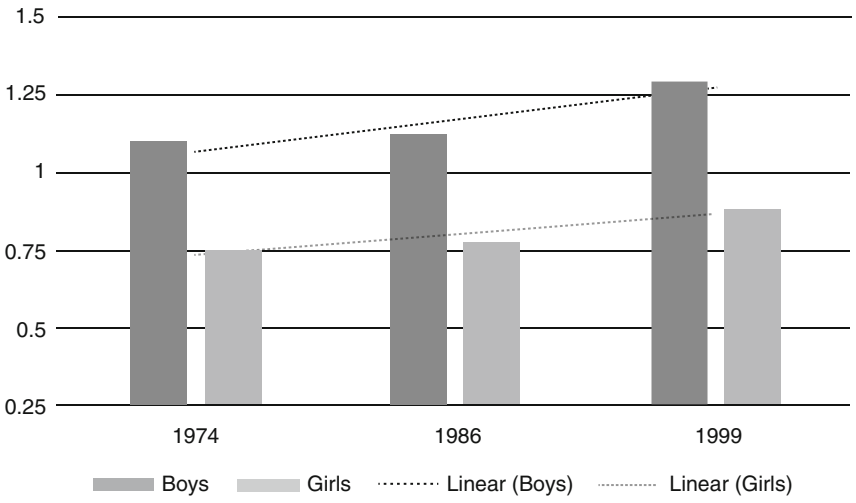

Fig. 1.2 Adolescent emotional problems by gender, 1974–1999

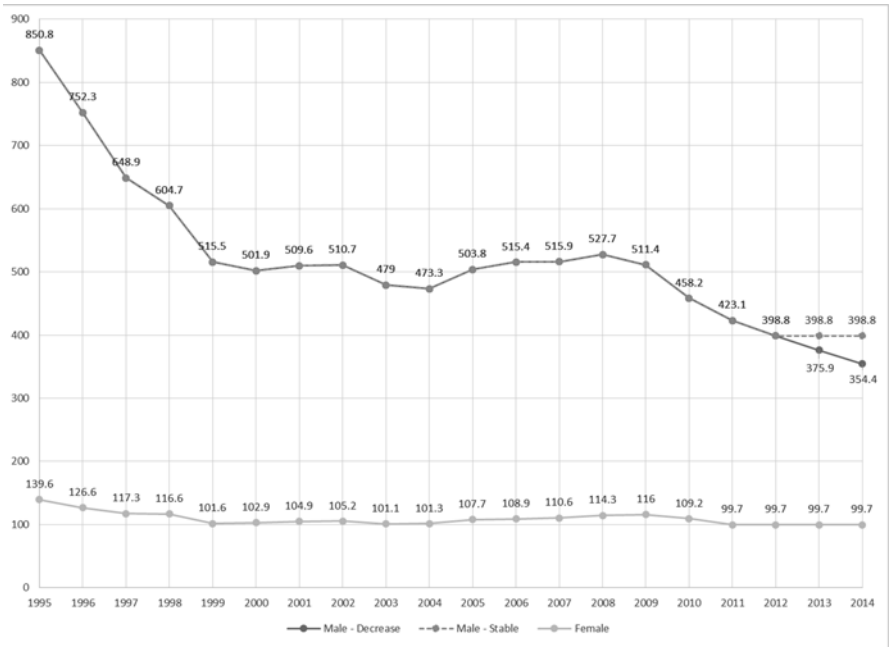

Fig. 1.3 U.S. Youth Violent Crime Statistics (1995–2014), males and females, ages 12–24 years. *Source*: Annual Arrest Rates Reported by the FBI Criminal Justice Information Services Division

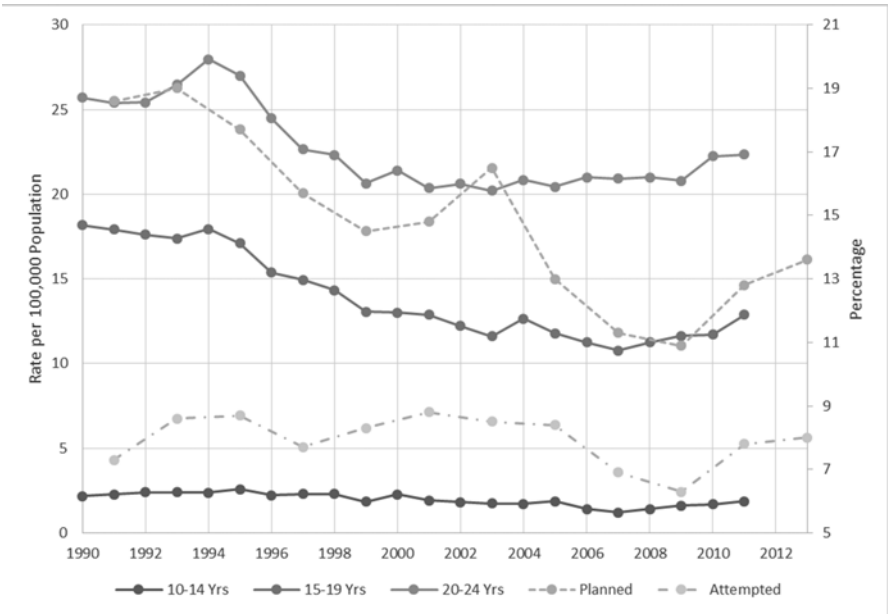

Fig. 1.4 U.S. National Suicide Statistics (1991–2011), males by age group. *Source*: Center for Disease Control and Prevention

(see Fig. 1.5), although increasing proportions of adolescents reported engaging in sexual activity. According to the CDC, in 2013, almost 50 % of high school students in the USA had sexual intercourse before. This ratio is significantly associated with academic performance, with as much as 69 % of students with D- and F-grades engaging in sexual activity, about one-half of them with four or more partners, and one-fourth of them has sexual intercourse for the first time before age 13.

The use of alcohol and drugs among high school students in the USA has been relatively stable in the past 10 years (see Fig. 1.6), but remains at problematic levels. About one in five students reported binge drinking at least once during the 30 days before a CDC national survey conducted in 2013, while at least one in four used drugs at the time. In addition, the prevalence of behaviors that commonly contribute to violence is also high. In 2013, 18 % of high school students carried a weapon, 7 % were threatened or injured with a weapon on school property, 25 % were involved in a physical fight, 3 % were injured in a physical fight, and 20 % reported being bullied on school property.

When viewed together, these statistics still represent an epidemic of compound behavioral problems that are linked to other factors of family and personal functioning. Deviant or dysfunctional behavior and school performance are often surface indicators of deeper issues such as emotional distress, adverse home environment, lack of self-regulation and social skills, and a history of child maltreatment. These problems all have a cognitive component in common that, when understood in the youth's context, can be managed, which is important as problem behaviors such as

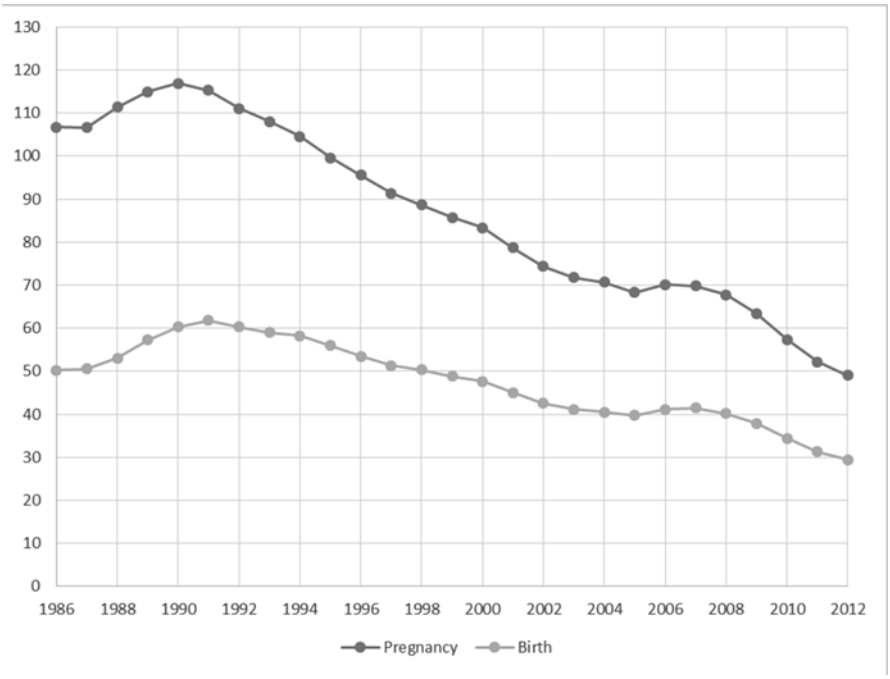

Fig. 1.5 US teenage pregnancy and birth rate per 1,000 girls aged 15–19. *Source*: Kost and Henshaw (2010)

school truancy, using alcohol and drugs, bullying, fighting, shoplifting, stealing, and other risky behaviors have potentially serious consequences for adolescents, their family, friends, school, and community (Bartlett, Holditch-Davis, & Belvea, 2007). With few exceptions, adolescent problems have their roots in their family's behaviors and interrelational connections. Therefore, where possible, adolescent problems should be addressed in the family context, with parent(s)/caregiver(s) participating in the therapeutic process. Thereby, a much more holistic course is taken that has proven to be more effective and sustainable. A family's beliefs and behaviors form a complex and dynamic network, which is highly reinforcing. Family-based adolescent interventions are relatively modern and yet to be convincingly established, especially in terms of consistency, statistically significant effect sizes, and treatment retention (see Chap. 14: MDT in the Wider Social Context, for a comparison of different methods and conditions). Although promising treatment are starting to emerge—including Brief Strategic Family Therapy (BSFT), Family Behavior Therapy, Functional Family Therapy, Multidimensional Family Therapy (MDFT), and Multisystemic Treatment—they are still deemed "probably efficacious" and "promising" (Austin, Macgowan, & Wagner, 2005). Also, internalized disorders such as Obsessive-Compulsive Disorder (OCD), social anxiety, and other nonaggressive dysfunctional behaviors (e.g., eating disorders, substance abuse) appear to be more successfully treated with other existing family-based approaches,

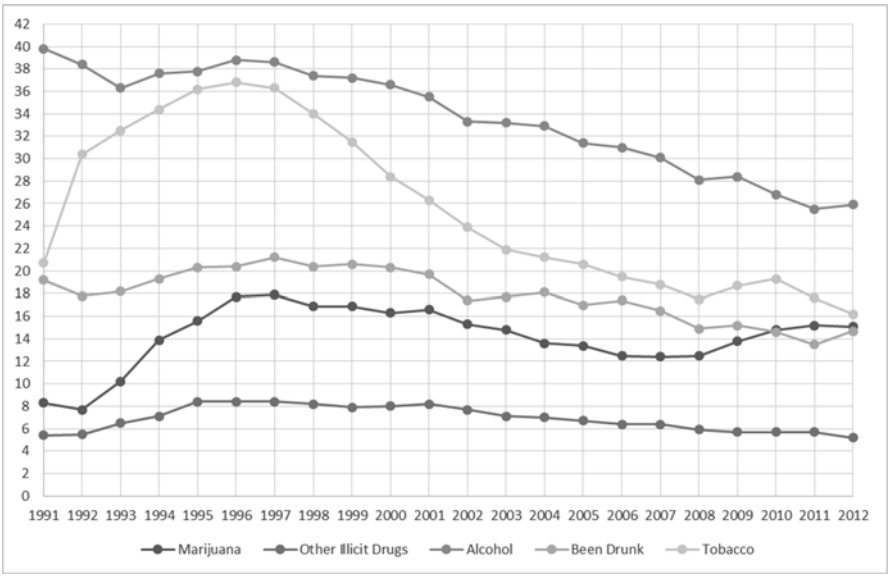

Fig. 1.6 30-day prevalence of use of various drugs for grades 8, 10, and 12 combined. *Source*: Johnston, O'Malley, Bachman, and Schulenberg (2014)

but not adolescent conduct disorders, personality disorders, aggressive behaviors, or a hybrid of these with comorbid conditions (Miklowitz, 2012; Segool & Carlson, 2008; Watson & Rees, 2008). It is our assertion that MDT is different.

Family-Based Mindfulness Therapy for Adolescents

As mentioned before, family-based interventions for adolescent problems are relatively new and unproven, but received growing attention in the past 10 years. The integration of the concepts and techniques of mindfulness in family approaches remains very novel and largely untested. A Pubmed search for the key phrase "adolescent psychotherapy" revealed a rapid increase in publications over the past 15 years (Fig. 1.7). The majority of these are not in a family context, but the trend does give an indication of the acknowledgement and growing importance of finding effective interventions for adolescent behavioral and mental health problems.

The next Pubmed search contained the key phrase "family therapy" and revealed a similar trend, although the rapid increase in activity started slightly earlier, nearly 20 years ago, and did not attract as much attention. Nevertheless, the fast growth is indicative of the understanding that the family unit as a system is vital in the onset, development, and maintenance of intra- and interpersonal distress. Although the efforts emphasizes family relationships as an important factor in psychological health, broad approaches and techniques are utilized that do not necessarily focus on adolescent issues (Fig. 1.8).