

# The Adolescent Substance Use Risk Continuum: A Cultural, Strengths-Based Approach to Case Conceptualization

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Many theories are used to conceptualize adolescent substance use, yet none adequately assist mental health professionals in assessing adolescents' strengths and risk factors while incorporating cultural factors. The authors reviewed common adolescent substance abuse theories and their strengths and limitations, and offer a new model to conceptualize adolescent substance use: The Adolescent Substance Use Risk Continuum. We posit that this strengths-based continuum enables clinicians to decrease stigma and offer hope to adolescents and their caregivers, as it integrates relevant factors to strengthen families and minimize risk. This model is a tool for counselors to use as they conceptualize client cases, plan treatment and focus counseling interventions. A case study illustrates the model and future research is suggested.

**Keywords:** adolescents, substance use, case conceptualization, cultural factors, strengths-based

For decades, theorists have worked to understand adolescent behaviors and conceptualize adolescent substance use. These theories have provided a strong base to conceptualize adolescent substance use, yet none integrate important counseling-focused concepts such as strengths and cultural factors. The Adolescent Substance Use Risk Continuum (ASURC) expands upon previous theoretical models and is designed to enhance counselors' ability to conceptualize adolescent substance use from a strengths-based, stigma-reducing, and culturally sensitive perspective. The ASURC adds to counselors' abilities to conceptualize adolescent substance use and enhances their abilities to create comprehensive treatment plans and interventions.

## Theoretical Underpinnings

The theory of planned behavior (TPB; Ajzen, 1985), social learning theory (SLT; Akers, 1973), social control theory (SCT; Elliott, Huizinga, & Ageton, 1985), and social development theory (SDT; Hawkins & Weis, 1985) are four theories that have been applied to adolescent substance use. The TPB was developed to describe an individual's behavior in a general sense, while the other three theories were developed to explain *deviant* and *delinquent* behavior. Even though these four theories were developed in the 1970s and 1980s and were not developed specifically for adolescent substance use, researchers have applied these theories to predict substance use within this population (Corrigan, Loneck, Videka, & Brown, 2007; Malmberg et al., 2012; Schroeder & Ford, 2012).

The TPB was developed as an expansion of the theory of reasoned action, which describes behavior as contingent upon an individual's beliefs about a certain behavior and the perceived social pressure on the individual to perform that behavior (Ajzen, 1985). In addition to individual beliefs and perceived social pressure, the TPB adds an additional element to describe behavioral intention: self-efficacy. Self-efficacy refers to one's perception of control to complete certain behaviors (Ajzen, 1985). Petraitis, Flay, and Miller (1995) introduced two types of self-efficacy related to adolescent substance use: use self-efficacy and refusal self-efficacy. Use self-efficacy consists of adolescents' beliefs about their ability to obtain alcohol or other drugs, whereas refusal self-efficacy is indicative of adolescents' beliefs about their abilities to refuse social pressure to use substances (Petraitis et al., 1995).

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SLT was developed to explain so-called deviant behavior, and it is heavily influenced by behavioral theories, particularly operant conditioning and reinforcement. Therefore, behavior is learned when it is reinforced (Akers, 1973). The anticipation of either reinforcement or punishment can lead to behavioral increase or decrease, depending on who has the most influence on the adolescent, and who controls the reinforcement or punishment. Delinquent behavior can be influenced and maintained by a variety of sources, including parents, family, peers and school (Petraitis et al., 1995).

Similar to SLT, SCT emphasizes the importance of rewards and punishments in terms of deviant or delinquent behavior (Elliott et al., 1985). The result of either punishment or reinforcement is influenced mainly by an individual's socialization into what the authors described as *conventional society* (Elliott et al., 1985). Conventional society points to general societal norms, largely congruent with dominant cultural norms. Therefore, according to SCT, an adolescent with a strong attachment to conventional society would have stronger internal and external controls and would be less motivated to choose delinquent behaviors. Inversely, an adolescent with a weak attachment to conventional society would have weaker internal and external controls and be more likely to engage in deviant behaviors (Elliot et al., 1985).

Hawkins and Weis (1985) integrated SLT and SCT to develop the SDT. The SDT is a developmental model of delinquent behavior that focuses on how adolescents are socialized through family, peers and school. Delinquent behaviors develop when adolescents are not socialized into conventional society appropriately. Opportunities for involvement with conventional individuals are seen as necessary but not sufficient for an individual to develop positive social bonds (Hawkins & Weis, 1985). There are two mediating factors associated with this socialization process toward positive social bonds: skills possessed by an adolescent and reinforcement of the opportunities for involvement (Hawkins & Weis, 1985). Skills that enhance an adolescent's ability toward social bonds include adolescents' social skills, or skills needed to interact and form social bonds with others (Hawkins & Weis, 1985). Similar to SLT and SCT, the SDT stresses the need for reinforcement, where behavior must be reinforced to continue (Hawkins & Weis, 1985).

## Strengths and Limitations of Theoretical Underpinnings

The aforementioned models have made significant contributions to how counselors conceptualize adolescent substance use. Particularly, these models highlight the role social influences play in adolescent substance use and, accordingly, how social influences impact behavioral factors like reinforcement, punishment and reward (Akers, 1973; Elliot et al., 1985; Hawkins & Weis, 1985; Petraitis et al., 1995). Additionally, all models have been validated empirically to be predictive of adolescent substance use (Corrigan et al., 2007; Malmberg et al., 2012; Schroeder & Ford, 2012). Although these studies provide empirical support for predicting adolescent substance use and highlight social influences and behavioral factors, limitations exist, namely a lack of specificity related to social influences, the use of problematic language, and failure to incorporate cultural factors and contexts. Below, we detail the strengths and limitations of the aforementioned models to provide a rationale for a more encompassing, strengths-based approach to conceptualizing adolescent substance use.

### Social Influences

Research has shown that social factors, such as family and peer group, play a mediating role in adolescent substance use in both positive and negative ways (Piko & Kovács, 2010; Van Ryzin, Fosco, & Dishion, 2012). Also, research highlights how important social influences are on adolescents' substance use. The TPB suggests that substance use is dependent upon the adolescent's individual attitudes of substance use and perceived social pressure to use substances (Petraitis et al., 1995).

SLT and SCT emphasize how behavior, including substance use, is learned through reinforcement or punishment (Akers, 1973 Elliott et al., 1985). Someone in the adolescent's life has to reward or punish the adolescent's substance use for it to continue or cease.

Further, the SDT emphasizes the socialization process in regards to deviant behavior in adolescents. According to the SDT, socialization begins within the family unit, where a child has variable opportunities to develop social, cognitive and behavioral skills (Hawkins & Weis, 1985). As a child grows older, ostensibly these skills are reinforced positively within the school setting and peer group (Hawkins & Weis, 1985). However, if children are not socialized appropriately in the family system, children may not develop socially, cognitively and behaviorally as expected. In turn, they may turn to substance use to cope with stressful life events. Further, if adolescents were not socialized appropriately in early childhood, they may be at greater risk to become involved with adolescents who use substances.

While the four theories emphasize social influences as a factor in adolescent substance use, the TPB, SLT and SCT used the term *social influences* in a general sense only, and do not differentiate between the different types of social influences. There are a variety of social influences, including family, peers, school, sports teams, clubs and religious organizations, and each can have a varied impact on adolescents' substance use. For example, involvement in religious organizations can protect some adolescents from substance use (Steinman & Zimmerman, 2004), while engagement with sports teams may increase adolescent substance use for others (Farb & Matjasko, 2012). The SDT was the only model discussed that divides socialization into three units: family, peer and school; however, the SDT suggests that family, peer, and school units all go through the same development process, seemingly at the same rate. Presumably, an adolescent is given the same opportunity for involvement with all three units toward the goal of creating healthy social bonds, and these opportunities are influenced by an adolescent's current social skills and reinforcement from others (Hawkins & Weis, 1985). This adolescent substance use conceptualization can be problematic because it suggests the family, peer group and school all go through the same developmental process simultaneously and fails to recognize that different units can have different influences (some positive, some negative) on an adolescent, and these influences may develop asymmetrically. Further, the SDT proposes that a "social bond" (Hawkins & Weis, 1985, p. 80) to conventional society is a common goal and that adolescents have the social skills in place to create these bonds. Although it is hoped that adolescents will have strong social skills and that their support systems will endeavor to create healthy social bonds, this may not be the case for all adolescents. Further, some adolescents who have strong social skills may use them to procure substances and influence others to use.

### **Problematic Language**

The developers of SLT, SCT, and SDT used the terms *deviant behavior*, *delinquent behavior*, and *conventional society* to describe aspects contained in their theories. In juvenile justice literature, the terms *deviant* and *delinquent* point to adolescent behaviors considered to be age-inappropriate and destructive to self and family, as well as illegal (Pope, 1999). However, these terms are not used to simply describe behaviors as they were intended—they have become labels used to classify and marginalize adolescents who have made poor choices and acted in ways incongruent with conventional society (Constantine, 1999). Often, these terms are applied to adolescents who encompass non-dominant cultural identities (e.g., race, social class), which can serve to further oppress and marginalize adolescents who may experience societal and structural inequality. At the very least, these terms define adolescents by choices they have made and may lead to assumptions about who they are, adding additional stigma and shame to worthy individuals who can learn to make different choices, which is incongruent with a strengths-based perspective.

*Conventional society* is a term used to describe societal norms, determined most often by dominant U.S. cultural groups (Duncan, 1999). Similar to the issues with the terms *deviant* and *delinquent*, the term *conventional society* may not account accurately for cultural nuances and differences that vary from dominant culture expectations, furthering societal and structural oppression, discrimination and inequality clients experience (Constantine, 1999). For example, according to SCT, weak attachment to conventional society contributes to weaker internal and external controls, and an adolescent can develop a weak attachment to conventional society when she experiences a strain between her aspirations and her perceptions of the opportunity to actualize such aspirations. Therefore, through an SCT lens, if this adolescent lives in a low-income neighborhood where crime and unemployment are prevalent, she may be perceived to have a weak attachment to conventional society (Petraitis et al., 1995), without taking into account that her environment is out of sync with conventional society and cultural norms as defined by the dominant culture.

### **Cultural Factors**

The final common limitation of the aforementioned models is the lack of inclusion of cultural influences on adolescents' substance use. As mentioned previously, these four models highlight the importance of social influences on adolescents' substance use yet do not specifically take cultural factors into consideration. The TPB discusses social influences in regard to an adolescent's beliefs and perceived social pressure (Ajzen, 1985); however, there is no mention that these beliefs might be influenced by cultural values and experiences. Similarly, SLT suggests that an adolescent's deviant behavior is influenced by positive or negative reinforcement received within the social context (Akers, 1973), yet fails to acknowledge that these positive or negative reinforcements are most likely influenced by cultural factors. The SDT outlines the socialization process through three different units (Hawkins & Weis, 1985), all of which exist within cultural contexts that influence adolescents' substance use, yet the authors do not cite this as a possibility. Similarly, SCT discusses social influences on a systemic level, focusing on adolescent academic and occupational goals (Elliott et al., 1985). Adolescents' cultural factors can influence their academic and occupational goals, as well as their perception of the likelihood of obtaining these goals. The theme among these four models is that they include factors influenced by culture without specifically mentioning or addressing culture or cultural variations.

We suggest a conceptual model for adolescent substance use that addresses specific social influences, uses inclusive and strengths-based language, and integrates cultural factors. We propose the ASURC as a model to meet this need. The ASURC asserts that while different social contexts are intertwined with one another, they all influence adolescent substance use in distinct ways. Further, the ASURC model uses strengths-based terms to reduce stigma and shame, and empowers clients and their caregivers to make person-affirmative choices. Finally, the ASURC integrates cultural components into all aspects of the model in order to provide appropriate context, acknowledging that adolescent substance use develops in a cultural context.

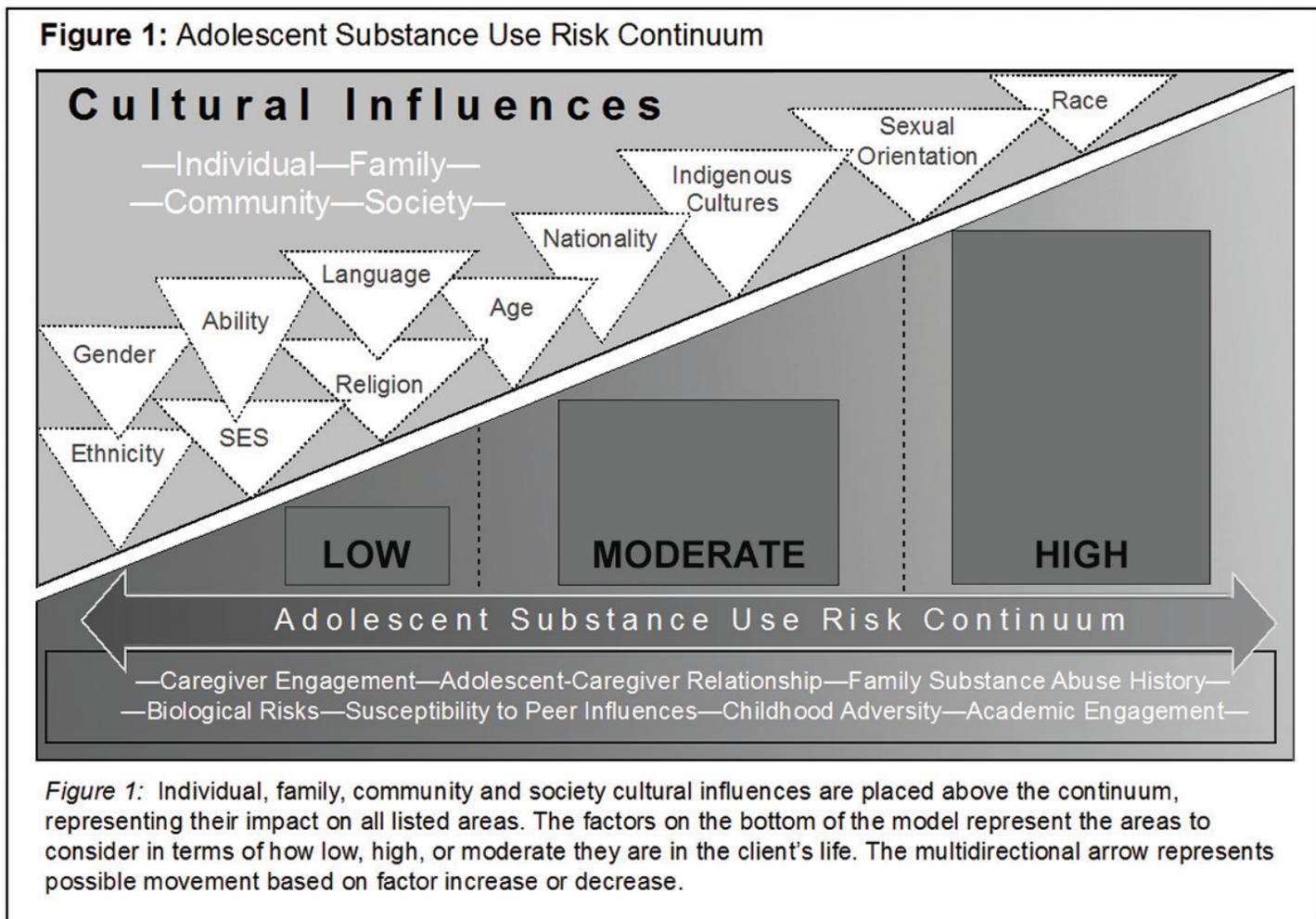
### **The Adolescent Substance Use Risk Continuum**

The aforementioned theoretical models contain strengths and limitations and influenced the development of the ASURC model. Prior models emphasized social influence on adolescent substance use, and we emphasize social influences in our model as well. However, we believe that different social systems will have different influences on each adolescent, and each social system develops at its own rate. Further, the included areas are not meant to be predictive of substance use, and can serve both as strengths and risk factors, depending on the individual's circumstances. The areas featured in our model include: parental and caregiver engagement, relationship between

parents and caregivers and adolescent, family history of substance use, biological factors, level of susceptibility to peer pressure, childhood adversity, and academic engagement. While we believe the areas in our model have distinct impacts on adolescents, all areas interact and influence one another, and all areas are influenced by singular and intersecting cultural identities.

The ASURC emphasizes the importance of cultural considerations when conceptualizing adolescent substance use. We used Hays’ (1996) “ADDRESSING” model as a foundation. The included cultural factors are by no means exhaustive; counselors are encouraged to expand this list to work with their clients appropriately. Cultural factors should be considered in terms of the individual, family, community and societal contexts when applied to the ASURC areas. Further, it is important to consider ways in which cultural identities can serve as protective or risk factors, depending on the individual’s dominant and non-dominant cultural identities, and the identities most salient to the client. Client cultural influences are subjective experiences, and counselors should take great care and time to determine their relevance for each client.

Further, the ASURC is a strengths-based approach to conceptualizing adolescent substance use. Previous theories contain the use of problematic language, such as *conventional society*, *deviant behavior*, and *delinquent behavior*, when describing adolescent substance use. We feel the use of this language can lead to stigma and instill a sense of shame for this population. Focusing on strengths while using the ASURC will aid clinicians in fostering a sense of hope while working with this population. Strengths are not a separate component of the model, but rather are incorporated in each aspect of the model.



As the name suggests, the ASURC (Adolescent Substance Use Risk Continuum) is a *continuum*, ranging from minimal risk to high risk. The continuum starts at minimal risk instead of no risk because substance use and addiction can occur in anyone. Further, a continuum suggests that an adolescent can move bi-directionally along the continuum depending on changes. This potential for movement can instill hope and serve to reduce shame associated with adolescent substance use. To use the ASURC model (see Figure 1), one starts at the bottom of the model and considers how the areas listed serve as adolescent protective or risk factors. When working through these areas, cultural identities are incorporated. These identities are represented above the entire model to indicate how they influence everything underneath them. Cultural factors should be considered from the perspective of the individual, family, community and society as a whole, because their influence could be different in each area. Finally, the counselor determines where the adolescent falls on the risk continuum. Because multiple aspects influence an individual's location on the continuum, it is important to note the protective and risk factors associated with each of the model's areas for any specific client. This assessment can assist counselors in developing holistic treatment plans that address not only adolescents' substance use, but also their strengths and areas that could be enhanced as they strive to eliminate substance use.

## Model Components

### Cultural Influences

There are many cultural factors to consider when conceptualizing adolescent substance use. The ASURC is based on Hays' (1996) ADDRESSING model. There are nine overlapping cultural influences included in the ADDRESSING model: age, disability status, religion, ethnicity, socioeconomic status, sexual orientation, indigenous heritage, national origin and gender (Hays, 1996). To these we added race and language. This list is not exhaustive but rather a starting point to consider how culture can be a protective or risk factor for adolescents.

When clinicians consider adolescents' cultural identities, it is important to do so within individual, family, community and societal contexts. To consider only one context diminishes the multiplicity of adolescents' experiences, and it can negate the impact these contexts have on them. For example, it is common for societal context to be overlooked in favor of individual experiences due to the importance placed on individualism by the dominant culture (Johnson, 2006). When societal context is neglected, structural inequality may be ignored. Structural inequality denotes the oppression or restrictions non-dominant groups experience when they attempt to access resources, including mental health treatment, which are available without hindrance to dominant culture groups. Structural inequality can impact adolescents' beliefs about their ability to choose not to use substances and their ability to achieve success and access resources, and can reduce hope about their life circumstances (Hancock, Waites, & Kledaras, 2012).

**Religion and spirituality.** Religion and spirituality can be a protective factor for adolescents. Higher levels of religious involvement tend to correlate with lower levels of substance use (Mason, Schmidt, & Mennis, 2012). Mason et al. (2012) identified two specific aspects of religiosity associated with lower levels of alcohol and drug use: social religiosity and perceived religious support. Social religiosity refers to public displays of religious behavior, such as church attendance and participation in religious activities; perceived religious support encompasses emotional support one receives from a religious institution as well as tangible support like materials or money donated by a religious organization (Mason et al., 2012). Private religiosity, such as personal importance of religion and individual prayer, was not found to be a protective factor (Mason et al., 2012), suggesting the more social aspects of religion are more beneficial for preventing adolescent substance use. Similarly,

religion may be a risk factor when adolescents, such as lesbian, gay, or bisexual (LGB) youth, feel judged, shamed, or shunned by their religious community, which may increase the likelihood of substance use (Barnes & Meyer, 2012).

**Ethnicity.** Ethnicity is significant because reported substance abuse and dependence rates are higher for people of color than for White people in the population (Substance Abuse and Mental Health Services Administration, 2012). Of the total population of people of color, who represent only 38.5% of the U.S. population, 9,319,277 people reported substance abuse and dependence. This number is particularly staggering when compared to White people, who represent 61.5% of the population, 15,713,373 of whom reported substance abuse and dependence (Substance Abuse and Mental Health Services Administration, 2012). These statistics demonstrate that adolescents of color are more likely to develop substance abuse issues than their White counterparts. However, these statistics do not incorporate issues related to structural inequality, nor do they speak to restricted treatment access or racial groups' protective factors that could be bolstered. For example, Native Americans, who have the highest statistical rate of substance use, also emphasize spirituality and the importance of the extended family (Sue & Sue, 2013). These factors can serve as protective factors for Native American adolescents. Similarly, researchers have found religious engagement among African American adolescents to be a protective factor (Steinman & Zimmerman, 2004). African American adolescents who attended religious services regularly had lower substance use rates than their peers who did not.

**Socioeconomic status.** Socioeconomic status (SES), particularly education level, influences substance use in adolescents, and subsequently intersects with race and ethnicity. Adolescents who drop out of high school are more likely to engage in substance use, and lower levels of education are associated with higher prevalence of substance-related diagnoses (Henry, Knight, & Thornberry, 2012). American Indian, Latino, and African American adolescents' math and reading proficiency rates are less than half of White adolescents, most likely due to structural inequality in low-income schools. Students in these groups are less likely to graduate from high school than their White peers (Henry et al., 2012). Furthermore, living in poverty or low SES are associated with higher risks of substance use, and adolescents from racial minority groups are at a higher risk for living in poverty and low-SES families (Van Wormer & Davis, 2013).

**Sexual orientation.** Sexual orientation is another cultural factor to consider. The LGB community is at greater risk for substance use compared to heterosexual individuals (Brooks & McHenry, 2009). One explanation for the increased risk in the LGB community may be due to homophobia and heterosexual superiority and internalized homophobia, which can lead individuals in the LGB community to turn to substances as a way to cope (Brooks & McHenry, 2009). Further, gay bars are a mainstay of the LGB community, and even though adolescents may not be allowed to drink legally, bar environments may be integral during adolescents' *coming out* process (Brooks & McHenry, 2009). Socialization in a bar environment can lead to adolescent substance use as a way to fit in and cope.

### Caregiver Engagement and Adolescent–Caregiver Relationship

Family environment can serve as a protective or risk factor for adolescent substance use. A key factor associated with family environment is parental or caregiver supervision. Strong caregiver supervision has been shown to minimize an adolescent's risk-taking behavior, such as substance use (Van Ryzin et al., 2012). While caregiver supervision is an important protective factor for adolescents, it also is important for adolescents to be able to experience a sense of autonomy within their family of origin. Allen, Chango, Szwedlo, Schad, & Marston (2012) defined autonomy within the family of origin as adolescents' ability to have opinions and beliefs that differ from their caregiver(s) and can

be fostered through a supportive adolescent–caregiver relationship. Positive relationships between caregivers and adolescents can increase self-esteem and healthy coping skills, leading to a decrease in risk-taking behaviors (Piko & Kovács, 2010). According to Piko and Kovács (2010), high levels of both satisfaction and caregiver support perceived by the adolescent define this positive relationship. Further, positive relations within the family can lead to higher levels of family obligation perceived by the adolescent. Family obligation is the perceived importance of spending time together, family unity and family social support; higher levels have been found to deter adolescents from unhealthy risk taking, including the use of alcohol and drugs (Telzer, Fuligni, Lieberman, & Galván, 2013).

Conversely, low caregiver involvement can be a risk factor for adolescent substance use. Adolescents who have low caregiver supervision are more likely to engage with peers who use substances and, subsequently, use substances as a way to find social support (Van Ryzin et al., 2012). Additionally, adolescents who do not have positive relationships with their caregivers have a more difficult time self-regulating their behaviors and increased risk for using substances as a way to cope with stress (Hummel, Shelton, Heron, Moore, & van den Bree, 2013).

### **Family Substance Abuse History and Biological Risks**

Family history of substance use is an additional risk factor for adolescents. Children of parents and caregivers who abuse alcohol are four times more likely to develop an addiction (Van Wormer & Davis, 2013). This risk may be partly due to biological predisposition, and part may be environmental. Scientists have begun to better understand how genes affect substance use disorder development and posit that 40–60% of alcohol use disorders can be explained by genes (Van Wormer & Davis, 2013). It can be difficult to determine whether an individual’s addiction is inherited through genetic composition or is learned via the family environment, or a combination of both. Genetics can include predisposition to impulsivity, and some scientists believe individuals at risk for substance use disorders may be biologically predisposed to overreact to stressful situations and life events. Individuals predisposed genetically to engage in sensation-seeking and impulsive behaviors are more likely to experiment with alcohol and other substances (Van Wormer & Davis, 2013). While biological risk can increase adolescents’ predisposition to develop addiction, *it does not necessarily lead to addiction* (Van Wormer & Davis, 2013). This message can instill hope and infuse self-efficacy in families who may have a history of substance abuse.

Adolescence is marked by an increase in risk-taking behaviors, which may be associated with developmental biology (Telzer et al., 2013). Adolescents show a heightened response in the ventral striatal, which is part of the brain’s reward system. This heightened response in the ventral striatal can cause adolescents to engage in more reward-seeking behaviors compared to children and adults. Further, adolescents show less activation in pre-frontal regions of the brain, the part of the brain in charge of executive functioning, which can lead to increased risk-taking behaviors (Telzer et al., 2013). Research has shown that an increase in family obligation can lead to decreased sensitivity in the ventral striatal and increased activity in the pre-frontal region of the brain (Telzer et al., 2013). These findings suggest that improved quality in the adolescent–caregiver relationship can jettison substance abuse. Specifically, increased family obligation can help buffer some adolescent biological risks for substance use.

### **Susceptibility to Peer Influences**

Peer relationships can play a role in the development of adolescent substance use. During adolescence, individuals start to spend more time with peer groups than with their families (Piko & Kovács, 2010). Additionally, adolescence is marked by a heightened sense of reward. This focus on reward can lead to an increased desire for adolescents to please their peers, making it more difficult

for them to resist peer pressure (Van Ryzin et al., 2012). If adolescents associate with peers who use alcohol and drugs, they are more likely to begin using substances as a way to be accepted by their peer group (Van Ryzin et al., 2012).

Inversely, if adolescents are associated with peers who are not involved in substance use, they are less likely to use substances (Van Ryzin et al., 2012). Moreover, there is a negative correlation between adolescents who are involved in supervised extracurricular activities and substance use (Farb & Matjasko, 2012). Specifically, involvement in school-based activities such as performing arts, leadership groups and clubs is associated with lower rates of substance use (Darling, Caldwell, & Smith, 2005). However, there is a positive correlation between athletics and substance abuse, meaning adolescents involved in athletics are more likely to engage in substance use (Farb & Matjasko, 2012). Researchers believe this positive correlation is due to the subculture of high school athletics that promotes alcohol and drug use (Denault, Poulin, & Pedersen, 2009).

### **Childhood Adversity**

Adolescents who experienced childhood adversity are at greater risk for developing substance use disorders (Benjet, Borges, Medina-Mora, & Méndez, 2013). Childhood adversity refers to family instability such as parental and caregiver mental illness, substance use, and criminal behavior, witnessing domestic violence, and experiencing abuse, neglect, interpersonal loss, and socioeconomic disadvantage. Researchers have suggested that this relationship is due to the self-medication hypothesis, in that adolescents who experience childhood adversity may turn to alcohol and drugs in order to alleviate the pain they encounter as a result of such experiences (Benjet et al., 2013).

Not only are adverse childhood experiences a risk factor for developing substance use disorders, but also for substance use opportunities (Benjet et al., 2013). One possible explanation for such opportunities is the presence of substances in the family environment. For adolescents who experienced child abuse or neglect or who witnessed domestic violence, there is an increased chance that substances were present in their household, making it easier for them to gain access to substances (Benjet et al., 2013).

The absence of childhood adversity can be a protective factor against adolescent substance use (Benjet et al., 2013). Another protective factor in terms of childhood adversity is early intervention (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). Early intervention can help children develop healthy coping skills to manage stress. Healthy coping strategies can be implemented to replace more negative coping strategies like substance use (Durlak et al., 2011).

### **Academic Engagement**

Academic engagement can have positive and negative effects on adolescents' potential substance use. Adolescents who drop out of high school are more likely than their counterparts to engage in substance use (Henry, Knight, & Thornberry, 2012). Further, early school disengagement can be a warning sign to predict high school dropout (Henry et al., 2012). For some adolescents, school engagement can be a protective factor. Particularly, adolescents who experience a positive school climate and have strong school engagement are less likely to use substances (Piko & Kovács, 2010). A positive relationship between adolescents and their teachers can be another protective factor. Previous studies have shown that adolescents who have a positive relationship with their teachers and have a high level of perceived support from teachers are less likely to engage in substance use (Demagnet & Van Houtte, 2012).

The case study below provides an example of how clinicians can use the ASURC to conceptualize and plan interventions when working with this population.

## Case Study

John is a 14-year-old, biracial male and high school freshman. He lives with his mother and grandmother, both of whom are African American, and they reside in a low socioeconomic neighborhood. Both John's mother and grandmother work full-time, and his mother works a second job, leaving John unsupervised after school and on the weekends. John's father, a 38-year-old Puerto Rican male, left the home when John was 4 years old. Prior to his father's departure, John witnessed domestic violence between his parents. During a fight, John intervened on his mother's behalf and his father hit him. After this event, John's mother forbade her husband from living in their home and sought counseling services for her son. After his father left, John had only sporadic visits with him, mainly due to his father's alcohol use. In addition to John's father's alcohol use, there is family history of substance use on his mother's side. His maternal great-aunts use alcohol, and his maternal uncle uses marijuana daily.

This year, John made the varsity football team and has been spending time with the senior football players after practice during the week and on weekends. In addition to being involved with the football team, John is involved with his church community. At school, John is an average student, earning mostly Bs and Cs, and he reports that he enjoys learning.

John started drinking and smoking cigarettes shortly after joining the football team in order to impress the junior and senior football players. Initially, John was hesitant to drink or smoke; however, after using more frequently, he started to enjoy it and reported feeling more relaxed. Currently, John drinks with his friends on the football team two to three times a week and smokes with them daily. John drinks only when he is with this group of peers, yet he has started to smoke when he is alone.

Over the past two months, John's grandmother has caught him sneaking back into the house at night smelling like alcohol and cigarettes. The first two times this occurred, John's grandmother decided not to tell his mother because she believed John when he said it would not happen again. When John's grandmother caught him a third time, she told his mother. John's mother was surprised when she heard this news because she believed she and John had a close and honest relationship. Distraught, John's mother brought him to counseling.

## Case Analysis Using the ASURC Model

Conceptualizing this case using the ASURC model reveals that John has both protective and risk factors related to his substance use. In terms of his family environment, John's mother reports that she and John have a close and honest relationship. This close relationship serves as a protective factor for John because a positive relationship between adolescents and their parents is associated with a decreased risk of adolescent substance use (Piko & Kovács, 2010). Yet, John has minimal supervision at night and on the weekends due to his mother and grandmother's work schedules. Low caregiver supervision is a risk factor for John because research shows that it is associated with an increased risk of adolescent substance use (Van Ryzin et al., 2012). The family's low SES impacts John's low caregiver supervision, and low SES can be associated with a higher risk of substance use (Von Wormer & Davis, 2013).

This year, John joined the football team, and previous research has shown that involvement in athletics in high school can be a risk factor for substance use (Farb & Matjasko, 2012), and adolescents who become associated with peers who use are at an increased likelihood to use (Van Ryzin et al., 2012). Furthermore, adolescence is a period characterized by a heightened sense of reward (Van Ryzin et al., 2012), suggesting that John may have an increased desire to please his peers and difficulty resisting peer pressure. At this point in time, John is drinking only when he is with his friends on the football team, suggesting this peer group is influencing John, yet he has begun smoking alone. Additionally, John is involved in his church community, which serves as a protective factor because being involved in a faith community lowers the risk for substance use in adolescents (Mason et al., 2012). Religious engagement, particularly among African American adolescents, can be a protective factor (Steinman & Zimmerman, 2004), which may be true for John if he identifies with this part of his racial identity as a biracial youth.

The next area of risk and protective factors in the ASURC model is childhood adversity. John witnessed domestic violence between his parents when he was younger, and as a result of attempting to intervene on behalf of his mother, John was hit by his father, a risk factor for adolescent substance use (Benjet et al., 2013). Fortunately, John's mother sought counseling services for her son after the incident occurred. Early intervention can help offset the negative effects of these experiences (Durlak et al., 2011), and it is possible counseling provided John with healthy coping strategies.

According to the ASURC model, biological factors can impact adolescent substance use. John has a family history of substance use on both his maternal and paternal sides, and genes can play a role in the development of substance use disorders (Van Wormer & Davis, 2013). Further, adolescents experience an increase in risk-taking behaviors due to biological changes associated with adolescence (Telzer et al., 2013), and these changes may cause John to engage in increased risk-taking and pleasure-seeking behaviors.

Higher levels of academic engagement correlate with lower levels of substance use (Henry et al., 2012). John reported that he enjoys learning, suggesting he could have a high level of academic engagement. Nonetheless, John is currently earning Bs and Cs at school, pointing to a disconnection between his motivation to learn and his current grades. This disconnect could be due to associated cultural factors. John is biracial and living in a low socioeconomic neighborhood, and adolescents who live in such neighborhoods and are racial minorities can be at a disadvantage due to structural inequality (Henry et al., 2012).

### **Case Discussion**

When taking all of the risk and protective factors into account, we placed John on the low end of moderate risk using the ASURC model. While John does have various risk factors contributing to his substance use, he also has protective factors that can help to buffer these factors. Further, John's cultural identities impact him in various areas of the model. In particular, John's biracial identity and living in a low socioeconomic neighborhood could be risk factors for substance use, while being involved in his church community is a protective factor. It would be important to explore with John how he views his race, SES, and religion, and if he sees them as protective or not. Further, it would be helpful to understand how John views his gender and sexual orientation, and how these identities affect his worldview.

Using the ASURC model to conceptualize John's case can assist counselors with their interventions with John and his family. While using the model, a counselor is able to assist John and his family to identify current strengths such as positive family relationships, involvement in his church

community, and potential for high academic engagement. Identifying these strengths allows John and his caregivers to concretize what is helpful in their situation and allows the counselor to encourage more of these behaviors as tools to strengthen weaker areas. For example, because there are strong family relationships, John's mother and grandmother can increase their engagement with John when they are away from home via texts or phone calls. Increasing parental engagement will be beneficial for the family, particularly John's mother and grandmother knowing who John is spending time with because his substance use is heavily influenced by his friendships on the football team. Similarly, because John likes to learn yet is not achieving high grades in school, tutoring programs can be sought to bolster his academic performance and solidify his academic engagement, as well as fill his time with positive activities that may decrease his desire to use. Additionally, it may be helpful to educate John and his caregivers about biological predispositions and risk factors in adolescence. This information can empower John to make positive choices when he understands both that he is not *destined* to develop an addiction and that he is experiencing normal physical changes. Additionally, it could prove helpful to talk with John and his family about how they might be experiencing structural inequality due to their race and SES. Engaging them in this conversation can normalize their experiences and serve to determine points where advocacy with and on behalf of the family may alleviate some of the strain they experience. Finally, because John's risk level is on the low end of moderate, structured substance abuse treatment may not be warranted at this time. Interventions could include assessing John's readiness to stop using and working through a change commitment while strengthening John's protective factors in an effort to decrease his risk factors.

## Future Research

Currently, the ASURC is a conceptual framework yet to be evaluated for efficacy with adolescent populations. Empirical research is needed to determine the model's viability, validity and efficacy. Further, qualitative research would inform clinicians about the ways in which adolescents and their families felt stronger and more empowered by engaging in counseling practices that use this model's approach.

Further research can be conducted to evaluate the degree of influence different components of the model have on adolescents with substance use concerns. Also, future research could investigate the relationship the model components have with one another, particularly the interplay of different cultural identities. Research is warranted to determine additional ways in which cultural factors can be used to strengthen clients and their families to mitigate deficit-based research and the pervasive negative cultural messages about non-dominant cultural groups and their struggles with substance use.

## Conclusion

The ASURC is a strengths-based approach focused on identifying protective and risk factors as counselors conceptualize adolescent substance use. While previous theories conceptualized adolescent substance use using strengths, they had limitations, including only discussing social influences in a general sense, use of problematic language, and lack of cultural influences. The ASURC builds upon the strengths of previous models while addressing their limitations. The ASURC model emphasizes the need for a strengths-based approach while working with adolescent populations and focuses on the importance of the consideration of cultural influences during the conceptualization process.

Finally, this model serves as a tool to help guide interventions that best serve adolescents and their families. Using the ASURC model for case conceptualization can help counselors determine the most salient factors of the model to the particular case, which will in turn assist in the treatment planning process. Future research is warranted to determine the viability of the ASURC model as an evidence-based practice.

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