APPENDIX

PRE Y POST TEST

Module 1

We will be matching pre and post-tests to assess the integration of new knowledge, skills and attitudes with respect to working with adolescents who are at risk or actively using substances. As such, we will not ask for your name, but a unique identifier which will allow us to pair the pre with the post-test. Please fill in your unique identifier below - it should be your birthdate (Date_Month_Year), gender (M/F) and your first and last initial. For example, for a female named Jane Doe who was born on February 3, 1980, her unique identifier would be **03021980FJD**.

Unique Identifier_____

Please circle one of the following.

PRE-TEST **POST-TEST**

Answer the following true/false questions.

_____ 1. Adolescent substance abuse is uniquely a health problem.

_____ 2. The region in the world with highest prevalence of alcohol use/abuse is the Middle Eastern Region.

_____ 3. A combination of genetics and environmental factors can determine an adolescent's future use/abuse of substances.

_____ 4. Inhalants are often used more in female adolescents than in males.

_____ 5. All adolescents who have experienced poverty will be substance users

Fill in the blanks on the following questions.

6. _____ can be perceived to be more socially acceptable among young people due to cultural norms.

7. Provide three routes of drug administration.

_____ _____

_____

8. Name three protective factors related to adolescent substance use.

_____ _____

_____

9. Name three risk factors related to adolescent substance use.

_____ _____

_____

Check the box which most closely corresponds to your response.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Most young people will experiment with alcohol or other drug use.					
All substance use by adolescents should be considered misuse.					
Substance use is all or nothing - people cannot manage their substance use.					
Adolescents don't exhibit any of the physical problems associated with alcohol and other drug use.					

Module 2

We will be matching pre and post-tests to assess the integration of new knowledge, skills and attitudes with respect to working with adolescents who are at risk or actively using substances. As such, we will not ask for your name, but a unique identifier which will allow us to pair the pre with the post-test. Please fill in your unique identifier below - it should be your birthdate (Date_Month_Year), gender (M/F) and your first and last initial. For example, for a female named Jane Doe who was born on February 3, 1980, her unique identifier would be **03021980FJD.**

Unique Identifier: _____

Please circle one of the following.

PRE-TEST **POST-TEST**

Answer the following true/false questions.

1. ___ An adolescent in middle adolescence will have developed the capacity for abstract reasoning.
2. ___ The major task of adolescence is to determine one's identity.
3. ___ Controlling impulses is an easy task during adolescence.
4. ___ Puberty is the first stage of adolescence.
5. ___ Managing feelings is an important skill that young people can learn to lower the risk of alcohol and other drug use.

Fill in the blanks on the following questions:

6. The_____of the brain is responsible for decision-making.

7. Name three factors that reduce adolescent substance use.

_____ _____

_____

8. Name three core components of youth wellbeing.

_____ _____

_____

9. Name three developmental assets that young people need to succeed.

_____ _____

_____

Check the box which most closely corresponds to your response.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Most adolescents will experiment with alcohol or other drug use.					
All substance use by adolescents should be a major concern.					
Substance use is all or nothing.					
Environment is a major influence on adolescent choices.					

Module 3

We will be matching pre and post-tests to assess the integration of new knowledge, skills and attitudes with respect to working with adolescents who are at risk or actively using substances. As such, we will not ask for your name, but a unique identifier which will allow us to pair the pre with the post-test. Please fill in your unique identifier below - it should be your birthdate (Date_Month_Year), gender (M/F) and your first and last initial. For example, for a female named Jane Doe who was born on February 3, 1980, her unique identifier would be **03021980FJD.**

Unique Identifier: _____

Please circle one of the following.

PRE-TEST **POST-TEST**

Answer the following true/false questions.

1. Traumatic experiences impact individuals differently.
2. Most consumers of mental health services are trauma survivors.
3. Trauma survivors tend to have worse health outcomes than those who have not experienced trauma.
4. Trauma survivors never heal from trauma.
5. Trauma symptoms are adaptations to the stressful situation.

Fill in the blanks on the following questions:

6. _____is a symptom of trauma where a client is overly aware of experiences of danger.

7. Name the three trauma-related disorders, according to the DSM V.

_____ _____

_____

8. Name three drug-related health outcomes which are associated with adverse childhood experiences.

_____ _____

_____

9. Name the most common responses to trauma.

_____ _____

_____

10. What are three ways strategies for providing trauma-informed care?

_____ _____

_____

Check the box which most closely corresponds to your response.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Most trauma survivors re-experience their traumas.					
The majority of trauma survivors are female.					
Trauma and substance use are interrelated.					
Most of the health problems experiences by trauma survivors are somatic.					
About half of the persons in substance use treatment are trauma survivors					

Module 5

We will be matching pre and post-tests to assess the integration of new knowledge, skills and attitudes with respect to working with adolescents who are at risk or actively using substances. As such, we will not ask for your name, but a unique identifier which will allow us to pair the pre with the post-test. Please fill in your unique identifier below - it should be your birthdate (Date_Month_Year), gender (M/F) and your first and last initial. For example, for a female named Jane Doe who was born on February 3, 1980, her unique identifier would be **03021980FJD.**

Unique Identifier: _____

Please circle one of the following.

PRE-TEST **POST-TEST**

Answer the following true/false questions.

1. __ Adolescent substance use must be identified and addressed as soon as possible

2. __ Staying in treatment for an adequate period of time and continuity of care afterward are not important.

3. __ Role of the family is pivotal

4. __ Treatment must be general

5. __ Family members can play an important role in treatment engagement and in treatment outcomes. Research has shown that family interventions can bring about

Fill in the blanks on the following questions:

6. Effective _____ for adolescents requires some form of behavioral therapy.

7. Name three different types of treatment.

_____ _____

_____

8. Name three areas of training needs to develop treatment professionals.

_____ _____

_____

9. Name three different types of family treatment

_____ _____

_____

Check the box which most closely corresponds to your response.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Effectively treating AOD use in adolescents requires also identifying and treating other mental health conditions they might have.					
The largest proportion of adolescents who receive treatment are referred from juvenile justice system.					
The effects on families may continue for generations.					
The therapist has to be willing to challenge their habitual ways of engaging family members into the process of treatment.					

Module 6

We will be matching pre and post-tests to assess the integration of new knowledge, skills and attitudes with respect to working with adolescents who are at risk or actively using substances. As such, we will not ask for your name, but a unique identifier which will allow us to pair the pre with the post-test. Please fill in your unique identifier below - it should be your birthdate (Date_Month_Year), gender (M/F) and your first and last initial. For example, for a female named Jane Doe who was born on February 3, 1980, her unique identifier would be **03021980FJD.**

Unique Identifier: _____

Please circle one of the following.

PRE-TEST **POST-TEST**

Answer the following true/false questions.

1. The presence of risk factors in multiple domains increases the likelihood of gang involvement.

2. Making money is the key reason that juveniles join gangs

3. Females represent approximately 10% of gang members

4. Juveniles who feel little commitment to their schools are at increased risk for gang involvement.

5. The presence of risk factors in multiple domains increases the likelihood of gang involvement.

Fill in the blanks on the following questions.

6. _____ is the key reason juveniles join gangs.

7. Name three components of what constitutes a gang.

_____ _____

_____

8. Name three intervention levels to address gang issues.

_____ _____

_____

9. Name three components of a comprehensive gang strategy.

_____ _____

_____

10. Name three risk factor domains associated with gang membership and behavior.

_____ _____

_____

Check the box which most closely corresponds to your response.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Most crime is committed by relatively few gang members.					
The role of females in gangs is increasing.					
Young men are the majority of the victims of violence.					
Incarceration is the most effective solution to the gang problem.					
The police have primary responsibility for responding to gangs.					

APPENDIX

SAMPLE CONSENT FORM

Consent for the Release of Confidential Information

I, _____, authorize _____Clinic to receive
(name of client or participant) from/disclose to
_____
(name of person and organization) for the purpose of
_____
(need for disclosure)

the following information_____
(nature of the disclosure)

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically on _____ unless otherwise specified below.

(date, condition, or event)

Other expiration specifications:

_____

Date executed_____

Signature of client_____

Signature of parent or guardian, where required _____

INTERVENTIONS APPENDIX

ADOLESCENT COMMUNITY REINFORCEMENT APPROACH (A-CRA)

ACRA Goals

The goals of the individual ACRA sessions with adolescents are to:

• **Promote abstinence from marijuana, other drugs, and alcohol.** ACRA helps promote abstinence by working with adolescents to modify the conditions that promote substance use. To reach this goal, therapists use a procedure called the functional analysis of substance use that helps an adolescent identify (1) the antecedents to marijuana, other drug, and alcohol use, (2) the actual marijuana- or other drug-using behavior, and (3) the positive and negative consequences of their use.

• **Promote positive social activity.** ACRA assumes that adolescents can be more successful at terminating substance use behavior if they learn how to increase their involvement in positive, reinforcing behaviors. A procedure called the functional analysis of prosocial behavior helps adolescents identify prosocial activities they enjoy or would enjoy and helps them see the benefits of being involved in these activities. Therapists then gradually encourage adolescents to spend more time in these activities.

• **Promote positive peer relationships.** This goal parallels the goal on positive social activity. Substance-abusing adolescents often center activities with friends on substance use. With this goal, ACRA therapists help adolescents identify attributes of "healthy" friendships and help them learn how to find and make new friends, how to deal with negativity, and how to ask for support.

• **Promote improved relationships with family.** Adolescence is a stressful time in the relationship between caregivers and the adolescent children in their care. This situation is probably even more stressful in families in which the adolescent is a substance abuser. Any distrust that caregivers have for the adolescent is reinforced by the adolescents' involvement in substance use. ACRA seeks to improve communication among family members as a way to enhance relationships.

The goals of the ACRA sessions with the caregivers are to:

• **Motivate their participation in the ACRA process**. It is possible that some caregivers may be reluctant to participate in an adolescent's treatment process. They may feel that the adolescent has "messed up" and the role of the treatment process is to "fix" him or her. The ACRA therapist's role is to help caregivers understand that they have an important role in helping their adolescent overcome a problem and to motivate the caregivers to participate in the therapy process.

• **Promote the adolescent's abstinence from marijuana, other drugs, and alcohol.** ACRA procedures teach family members behavioral skills aimed at discouraging an adolescent's drug use. The goal is to help caregivers understand how their behavior impacts the adolescent's substance use so that the caregivers will be motivated to change their own behavior to promote the adolescent's abstinence.

• **Provide information to the caregivers about effective parenting practices.** The information is based on the research of Catalano 9 10 (1998), Hops (1998), and Bry (1998) and includes measures to keep the adolescent from relapsing. These important parenting practices are:

- Be a role model by refraining from using drugs or alcohol in front of the adolescents in their care. This is the single most important parenting practice for caregivers.
- Increase positive communication with the adolescents in their care.
- Monitor adolescents' activities, including knowing where they are and whom they are with.
- Become involved in adolescents' life outside the home by encouraging and promoting prosocial activities.
- Teach and practice positive communication and problem solving skills in the family. Improving communication and problem-solving skills within the family promotes a more positive relationship between adolescents and caregivers and helps create a familial environment that is more conducive to recovery.

The ACRA goals of working with the community are to:

• **Improve an adolescent's environment.** An adolescent may be interacting with several different systems, such as schools and the probation department. The therapist's role is to serve as the adolescent's advocate in these settings. There may be times when the therapist directly interacts with school personnel or helps teach the caregivers skills so that they can advocate at school for the adolescent in their care. If the adolescent is on probation, the therapist can work with him or her and the probation officer to encourage fulfillment of the probation requirements.

• Teach the adolescent problem-solving skills and appropriate interactions through the use of roleplaying.

The essential components of the ***Adolescent Community Reinforcement Approach (ACRA)*** include:

- A toolbox of different procedures that clinicians are trained to use as appropriate with a participant
- Flexibility by the clinician to decide when and if to use procedures
- The procedures are:

- Overview of ***A-CRA***: Used during the initial session to describe the basic objective of the intervention and duration; includes an outline of procedures, sets positive expectations, and begins to identify the adolescent's reinforcers
- Functional Analysis of Substance Use: Based on a description of a common episode/behavior, internal and external triggers are outlined, using/non-using behaviors are clarified, positive and negative consequences of the behavior are clarified, and examples of how the information would be used are discussed
- Functional Analysis of Pro-Social Behavior: Based on a description of a common episode/behavior, internal and external triggers are outlined, the pro-social behavior is

clarified, positive and negative consequences of the behavior are outlined, and examples of how the information would be used are discussed

- Happiness Scale: The adolescent rates various areas of their life on a scale from 1 to 10 and the ratings are reviewed in order to help learn about the adolescent, learn what is going well in their life, and identify areas that might be appropriate for goal setting to improve their life
- Treatment Plans/Goals of Counseling: The Happiness Scale is used to select a goal category and set a goal using guidelines (must be brief, positive, specific, and within the adolescent's control), and progress of goals set is reviewed in subsequent sessions
- Increasing Pro-Social Recreation: The importance of a satisfying social life is discussed and new activities to sample are identified through use of problem-solving skills or a functional analysis of pro-social behavior
- Systematic Encouragement: After an activity is identified (e.g., adolescent wants to become a member of the YMCA), appropriate questions are identified (e.g., cost, times facility is open), role-plays (e.g., phone call to the YMCA) are done, and an initial contact is made during the session, the experience is reviewed during the next session
- Drink/Drug Refusal Skills: Includes enlisting social support, reviewing high-risk situations, presenting/reviewing options for assertive refusal, and role-playing refusal skills
- Relapse Prevention: Includes administering the functional analysis for relapse, discussing the behavioral chain of events, and describing and setting up an early warning system
- Sobriety Sampling: Includes negotiating a reasonable period of sobriety, developing a specific plan for maintaining sobriety until the next session, developing a back-up plan, and reminding the adolescent of reinforcers for sobriety
- Communication Skills: Includes a discussion of why positive communication is important, a description/review of the three positive communication elements, and role-plays to practice skills
- Problem-Solving Skills: Includes problem definition, brainstorming possible solutions, eliminating undesired suggestions, selecting a potential solution to try, generating and addressing possible obstacles, and deciding on a related homework assignment to be reviewed at the following session
- Caregiver Overview, Rapport Building, and Motivation: Begins with an overview of ***A-CRA***, sets positive expectations, reviews research regarding parenting practices for adolescent recovery, and keeps the discussion about the adolescent positive
- Adolescent-Caregiver Relationship Skills: Includes the use of several activities to help improve the relationship between the adolescent and the caregiver(s)
- Homework: To reinforce skills learned during sessions, adolescents and their clinician decide on a homework assignment, discuss anticipated obstacles, and review the homework at the start of the next session, where the clinician assesses the outcome, modifies the plan if necessary, and provides reinforcers
- Job-Seeking Skills: Uses multiple strategies to teach the adolescent how to obtain and maintain a job

- Anger Management Skills: Includes the identification of reinforcers to manage anger, assistance in recognizing anger, and techniques to manage anger.

The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment 2000
http://www.dldocs.stir.ac.uk/documents/ACRA_CYT_v4.pdf

https://www.cebc4cw.org/program/adolescent-community-reinforcement-approach/detailed

MOTIVATIONAL ENHANCEMET THERAPY

MET Therapies and Techniques: There are five critical elements of MET that patients and therapists will work through. These are strategies that have been found to encourage feelings of motivational change in those suffering from drug addiction.

- ✓ Developing and expressing empathy

Patients are encouraged to learn and develop empathy to learn how their actions affect others. This can be used as a motivational factor for change. Empathy also helps to establish a trusting relationship between a patient and therapist.

- ✓ Acknowledging the disparity between thoughts and reality

Patients often have some resistance to treatment, and must come to terms with the fact that there is a gap between where they think they are and where they actually are. Recognizing this gap can be eye-opening, and can help to elicit feelings of self-motivation to change.

- ✓ Avoiding arguments

Therapists won't argue with their patients about the degree of their drug or alcohol abuse. Patients are encouraged to have a positive response and outlook on MET.

- ✓ Accepting resistance as part of the process

MET helps addicted people work through their resistance to addiction treatment. Therapists engage recovering addicts on a personal level, helping them realize how their behaviors are impacting their goals and relationships.

- ✓ Supporting a recovering addict's self-efficacy

Recovering addicts must believe in their ability to achieve their goals. MET teaches patients they have the power to overcome addiction and to strive towards their life goals. Therapists encourage positive thoughts and behaviors that reinforce the concept of self-efficacy.

A MOTIVATIONAL ENHANCEMENT THERAPY SESSION

While variations are possible, MET is typically brief: It usually consists of about four sessions, preceded by an initial assessment that collects information on behaviors related to the presenting problem. In the first of the four MET sessions, the therapist will generally provide structured feedback based on the assessment. Feedback from the assessment allows individuals to see how their behavior compares to that of the wider

population, and it can allow a person to view any concerns in a new light. During the session, the therapist will likely encourage the person in therapy to address and explore any concerns they may have about a particular issue they are experiencing, including any observations that others have made about the person in therapy's behavior. The therapist may also ask an individual about short-term and long-term goals and evaluate any ways that a problem behavior may interfere with those goals.

Once a person in therapy has clarified any concerns, the therapist may focus on the options available for addressing those concerns. Treatment options are not prescribed; rather, they are elicited from the individual. For example, a therapist may ask, "What do you think you can do about this problem?" The therapist then works with an individual to create a change plan. This plan outlines desired changes, the reasons change is desired, and the steps the individual will take in order to achieve change. Some of this work might be carried over to the second session, which builds on the initial progress made. A significant other, such as a close relative or friend, may be included in the first few sessions. The last two sessions are intended to reinforce progress and further encourage an individual's efforts.

MET is both non-confrontational and nonjudgmental. Diagnostic labels that convey a sense of powerlessness over the problem are avoided, while personal choice and control are emphasized. Instead of guiding an individual through a process of change and teaching specific skills, in MET, a therapist typically assumes that the individual already has the resources needed for change and works instead to help an individual mobilize these resources in order to achieve the desired outcome.

WHO CAN MOTIVATIONAL ENHANCEMENT THERAPY BENEFIT?

Research has consistently demonstrated the efficacy of MET in increasing one's readiness to stop drug use, reducing the severity of substance use, and in lengthening periods of abstinence. Preliminary evidence also indicates that MET may be useful in enhancing the treatment of other conditions, such as anxiety, eating disorders, and problem gambling. This type of therapy may even be of help to persons who are at risk of developing these conditions. Studies further suggest that MET can help stimulate positive changes in health-risk behaviors among youth living with HIV.

MET can be used regardless of an individual's commitment level. It has been shown to be particularly effective when an individual has a strong resistance to change or is not strongly motivated to change. An example of this is in the case of substance abuse, as individuals who abuse drugs and alcohol may often find it difficult to stop using due to the reinforcing effects of these habits. MET's focus on rapid change also makes it suitable for cases where the therapist has only limited contact with an individual. The non-confrontational and nonjudgmental style adopted by therapists also makes MET an effective approach in the treatment of adolescents who may be experiencing identity issues and/or trying to assert their independence.

https://www.addictioncenter.com/treatment/motivational-enhancement-therapy/
https://www.goodtherapy.org/learn-about-therapy/types/motivational-enhancement-therapy

CONTINGENCY MANAGEMENT THERAPY

Contingency management is a behavioral therapy that uses motivational incentives and tangible rewards to help a person become abstinent from drugs or alcohol. To encourage sobriety and behaviors that support healthy living, clients receive rewards when they obtain positive goals and make lifestyle changes within their day-to-day lives. Examples include drug-free urine specimens or consistent treatment attendance.

An evidence-based treatment for alcohol, marijuana, opioids and stimulants, contingency management therapy may be used for other substance use disorders per a treatment clinician's discretion.

Contingency management can be especially beneficial for individuals who are unable to take certain medications for managing addiction or for those who only have limited success using these treatments. Used with medications and/or other addiction treatment therapies, contingency management can increase treatment retention rates and improve a client's chance of sobriety and recovery success.

Contingency Management Rewards Healthy, Sober Living
Humans, by nature, are wired to pursue activities and behaviors that create a sense of reward.

Reward, then, enforces these behaviors, encouraging a person to repeat it in the future. This is called positive reinforcement. This is largely why substance abuse becomes so attractive to a person once they abuse drugs or alcohol.

With healthy, natural rewards, such as wholesome food, water and nurturing, this reward system can be beneficial. However, in the case of substance abuse, activating this reward system can be devastating.
Drugs and alcohol stimulate the reward and pleasure centers of the brain by producing a chemical neurotransmitter called dopamine. Dopamine is responsible for producing the trademark buzz, euphoria, high, rush or other pleasurable feelings many drugs create.

In order to recreate these effects, many people consume the drug again. Eventually, as a tolerance occurs, the amount of drug needed to produce these feel-good effects climbs, circumstances which can push a person closer to addiction. For a person in treatment, or in the beginning stages of recovery, the absence of a drug-induced reward can be intimidating. In fact, the longing for reward sensations is a major factor in relapse.

Part of treating addiction revolves around normalizing brain function as best as possible and teaching a person to find healthier ways to experience reward and pleasure. After an addictive lifestyle, it can be difficult for a person newly in recovery to experience a sense of reward or pleasure while sober. Contingency management can be a useful tool in fighting this state.

Through a system of positive incentives, a person is taught to appreciate non-substance-related rewards. Not only do these rewards encourage abstinence and healthy behaviors, but they also boost self-confidence, a much-needed change after the poor morale caused by addiction.

What Is A Contingency Management Program?

Contingency management is founded on operant conditioning, a concept that people learn and change based upon rewards and punishments for their behaviors. People respond positively to incentives, and in the case of substance abuse treatment, this system of behavior modification has shown great success.

Contingency management uses rewards to reinforce behaviors that support both facility requirements and a person's individual recovery and sober living goals. Quite often these goals include negative urine tests or breathalyzer results, however, a program may also use incentives to reward treatment attendance or educational, social or vocational goals. One study even found that contingency management incentives increased the number of high-risk injection drug abusers who completed hepatitis B vaccination programs.

In addition to being used in **inpatient drug rehab** programs, contingency management is frequently used in community-based treatment programs, including traditional outpatient, intensive outpatient, partial hospitalization and methadone maintenance programs. In this role, outpatient programs are generally best used as a step-down service from a residential treatment program.

What makes contingency management stand apart from other treatment approaches is the emphasis on positive reinforcement versus punishment. Some treatment facilities foster a negative environment by using confrontational techniques when a person doesn't adhere to program guidelines. These procedures can alienate a person from the therapeutic community of treatment, break their self-confidence and reduce their motivation for change.

Instead, contingency management uses a more supportive form of negative consequences.

Specifically, if a person fails to meet their goals or has a positive drug test they would not receive a voucher or prize. When compared to confrontational techniques or punishments, using rewards to support positive behaviors can have a more inspiring and lasting impact.

How Does Contingency Management Work?

Once individualized treatment goals are established and agreed upon, a written contract may be drawn up. This contract holds a person accountable and outlines the arrangements of the contingency management program.

Two forms of motivational incentives or rewards-based systems widely used in addiction treatment include:

Voucher-Based Reinforcement: In this method, participants receive a voucher for each drug-free urine sample or negative breathalyzer result. Each voucher has a cash value that may then be used to obtain various goods, services and/or retail items that can be part of a balanced, sober life. Examples include clothing, electronics, food, movie passes and

restaurant gift certificates. As a person continues to have negative test results, the value of the vouchers increase.

The National Institute on Drug Abuse (NIDA) reports that this method is beneficial for individuals addicted to opioids and stimulants, with particular benefit for people with a cocaine use disorder.

Prize Incentives: It's recommended that these programs last three months or more. In this time, at least once a week, clients draw from a "fishbowl" for a cash prize. Certain slips may offer words of encouragement only, while others have prizes ranging from a dollar to a hundred dollars or more.

According to the NIDA, research has shown that prize incentives do not encourage gambling behaviors in treatment participants.
Treatment providers may also offer extra privileges to clients as an additional way to reward healthy behaviors.

If there's a missing or positive sample, positive reinforcement is typically withheld, an action that is sometimes referred to as a punishment. For instance, if a person has a positive urine sample they would not receive a slip or chip for a cash prize drawing. In the voucher system, should a person test positive, they would start over at the lowest voucher value.

Contingency Management And Integrated Care

Like many forms of addiction treatment, especially other forms of behavioral therapy, an individual may have greater success when contingency management is coupled with other therapies.

While contingency management is effective, intensive psychotherapy sessions are often necessary to help a person overcome the root causes of addiction. This integrated approach typically includes additional behavioral therapies, such as **cognitive-behavioral therapy** and dialectical behavior therapy.

Alternative or complementary treatments may also be used to encourage mind-body-spirit wellness. Examples include mindfulness and stress management practices, equine therapy and Adventure Therapy.

In addition to addiction, contingency management has shown to be beneficial in treating other disorders or issues which may accompany substance abuse and complicate recovery.
Other disorders treated with contingency management include:

- eating disorders
- aggression
- smoking

Further, research shows that contingency management can be helpful for people struggling with a co-occurring disorder or dual diagnosis (when a person has both a mental health and

substance use disorder). Used this way, this therapy was shown to reduce psychiatric symptoms both during and after treatment.
Through hard work and perseverance, and when used as part of an individualized treatment plan, contingency management can help a person build a healthier and more stable, drug-free life.

Published on July 18, 2018
https://www.treehouserehab.org/treatment-programs/contingency-management-therapy/

TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY

For children and parents

Trauma-focused cognitive behavioral therapy (TF-CBT) for children and parents is an evidence based treatment approach for traumatized children. Evaluation of TF-CBT includes several randomized controlled trials, effectiveness studies and ongoing studies for children experiencing sexual abuse, domestic violence, traumatic grief, terrorism, disasters and multiple traumas. The model of TF-CBT described here is a flexible, components based model that provides children and parents with stress management skills prior to encouraging direct discussion and processing of children's traumatic experiences. TF-CBT components are summarized by the acronym PRACTICE: Psychoeducation, Parenting skills, Relaxation skills, Affective modulation skills, Cognitive coping skills, Trauma narrative and cognitive processing of the traumatic event(s), In vivo mastery of trauma reminders, Conjoint child-parent sessions, and Enhancing safety and future developmental trajectory. Currently this model of TF-CBT is being adapted and implemented both within the USA and internationally.

Introduction

All too often children experience traumatic events before reaching adulthood. International studies document that child sexual abuse, physical abuse or domestic violence affect up to 25% of children around the world, with potentially serious and negative effects lasting into adolescence and adulthood if left untreated (Ammar, 2006; Chen, Dunne, & Han, 2004; Nelson et al., 2002, Xu, Campbell, & Xhu, 2001). Natural disasters, motor vehicle accidents, community and school violence are also common, with many children being negatively impacted by such exposure. Although some children never experience war, terrorist acts or refugee status, many others do. These events are also potentially traumatic and can result in long lasting negative emotional squela. While most children are resilient following trauma exposure, some are not. Recent research suggests that genetic makeup influences how children respond to traumatic events (Caspi et al., 2002). Several other factors can serve as risk or protective factors following children's exposure to trauma. These include the degree of exposure to the index trauma, including threat to the childs life and threat to or loss of life of family members; the availability of social support; past history of other traumas; the childs preexisting history of anxiety disorder; parents history of psychiatric disorder; the presence of parental posttraumatic stress disorder (PTSD) in response to the index trauma; and the amount of time the child spends viewing television coverage of the index traumatic event (reviewed in Pine & Cohen, 2002).

The impact of trauma exposure Children may develop different types of emotional or behavioral problems in response to traumatic exposure. These can be divided into problems of affect, behavior, and cognition.

Affective problems may include sadness, fear, anxiety or anger. Some children may develop excessive moodiness, or develop difficulty in controlling or regulating their moods and emotional states (affective dysregulation). Affective dysregulation can arise from a variety of causes, and it is important for the therapist to critically analyze the source of the childs problems. For example, a child may feel sad because she is overly responsive to negative stimuli (her feelings are easily hurt), is underresponsive to positive stimuli or does not have adequate skills to access positive stimuli (she doesn't know how to take a compliment, she's too shy to approach new peers, etc.). These sound like similar problems but may require somewhat different interventions. Perhaps this child is happy sometimes but later reinterprets that experience more negatively (i.e. has fun at a friend's house but later says she hated it). In the above instances, the childs negative feelings were partly related to negative cognitions that are amenable to therapeutic interventions.

Behavioral problems may take the form of avoidance of trauma reminders (any person, place, thing or situation that reminds the child of the original trauma). Avoidance is a hallmark of PTSD, but it is also normal for children to want to avoid talking about painful or difficult subjects. Thus, it may be hard to distinguish PTSD avoidance from a childs normal reticence to discuss an upsetting topic, the irritability associated with depression, or another underlying difficulty. Following traumatic exposure children may also develop new oppositional behaviors (which may result from anger or feelings of betrayal in reaction to the unfairness of the traumatic event). Children may develop new difficulty in separating from adults (school refusal, wanting to sleep with parents), regressive behaviors, or other manifestations of anxiety. Adolescents may use substances as a way of coping with emotional distress or avoiding trauma reminders. Another symptom of PTSD is re-experiencing the original trauma. In some cases this may lead to sexualized behavior, bullying, or abuse of others.

Cognitive problems may include distorted ideas about why the traumatic event happened, who was responsible (including self-blame), shame or worthlessness, and/or a loss of trust. Children who blame themselves for what happened and feel that they are unworthy of being loved or of having good things happen to them may begin to behave in self-defeating ways. For example, they may begin to associate with peers who get into trouble, truant from school, or use drugs, and may start to engage in these behaviors themselves as they believe this is the kind of person I am now. As will be discussed below, TF-CBT is largely based on the idea that affect, behaviors and cognitions are interrelated. It should be clear from the brief discussion above that traumatic exposure can result in a wide variety of emotional and/or behavioral symptoms in children and adolescents. Some children will develop significant disorders such as PTSD, depression, or substance use disorders, while others will not. The potential impact of trauma on children is discussed in greater detail elsewhere (Cohen, Mannarino, & Deblinger, 2006a, pp 3–19).

Treatment components

Psychoeducation: Once the therapist, child and parent agree that TF-CBT is the right treatment, it is important to educate the family about this approach. Psychoeducation should

start from the first contact with the family. When a child has experienced a traumatic event, parents are understandably distressed, worried, or even overwhelmed about what this means for the childs long term prognosis.

Providing information in this regard (e.g. that many children have mostly transient symptoms and recover well following trauma exposure) can provide an important message of hope before the family even comes to the initial assessment. At the initial assessment, information about the childs diagnosis and the treatment plan (e.g. the TF-CBT treatment model) should be introduced.

Psychoeducation continues throughout treatment by providing information about the impact of trauma on children and family members, the nature of PTSD or other diagnoses/symptoms the child is exhibiting, and information to normalize the childs and parents situation. For example, providing statistics about how many children have experienced the same type of traumatic event as the child (one out of every four girls experience sexual abuse) may help to decrease the childs and parents sense of stigmatization. Education about the criminal justice system and where to apply for victim's assistance may also be important means of engaging families in the early stages of treatment.

- Parenting component as noted above, parents receive parallel sessions that address each of the PRACTICE components. In addition, they receive interventions to optimize parenting skills, since parenting practices may change following children's exposure to traumatic events. For example, parents may become overly protective or more permissive about maintaining routines. Alternatively, parents may never have had adequate parenting skills to address behavioral difficulties and now may have even more problems as children develop traumarelated behaviors such as enuresis, aggression or noncompliance. In any of these cases parents can benefit from learning basic parenting skills such as the use of praise, selective attention (selectively attending to children's positive behaviors), the appropriate use of time out, and contingency reinforcement programs (behavior charts). Therapists collaborate with parents to individualize each of these interventions for the particular child and parent, keeping in mind that one might work more optimally for a given child, family or culture.

Relaxation skills: Relaxation skills are also individualized for each child and parent. These skills aim to both reverse any physiologic changes that may have resulted from their traumatic experiences (DeBellis et al., 1999) and to help children gain mastery over their subjectively stressful experiences. Having a number of options, or tools in the toolkit to select from when stressful situations arise allows children to try an array of different methods to self-soothe when they feel either physically or psychologically stressed. This provides a sense of control, which children (and often parents as well) were deprived of during the original traumatic experiences.

These relaxation skills may include deep breathing and progressive muscle relaxation, blowing bubbles (for younger children), yoga and mindfulness exercises (for older children and teens), listening to music, sports, knitting, singing, reading funny stories, praying, or listening to relaxation tapes. Therapists work with each family to create several options that will work for the child in each of several settings (school, home, on the playground, at

friend's homes). Children practice these and report back on how they worked between treatment sessions. If they didn't work, therapists work with the family to fine tune the relaxation skills and the child and parent practice them again the following week until they are working well.

Affective modulation skills: Affective modulation skills are similarly tailored for each individual family. Some severely traumatized children are affectively constricted so therapists may initially work with such children to expand their range of affective expression by playing a variety of feeling games. Therapists then work with children and parents to develop individualized affective modulation skills, by first identifying areas in which the child has difficulties (e.g. is the child overly responsive to negative affective cues, or under responsive to positive ones? Does she/he need help with social skills or problem solving skills in order to improve affective modulation?)

Therapists assist children and parents in strengthening these skills to add to children's toolkits and encourage them to practice these skills between sessions.

Cognitive coping skills: Therapists also assist children and parents in gaining cognitive coping skills, which is, recognizing connections among thoughts, feelings and behaviors as they relate to everyday situations.

Therapists encourage children and parents to identify thoughts related to upsetting events, to determine the feelings and behaviors they had associated with those thoughts, and to evaluate whether these thoughts are accurate and helpful. Alternatively, children and parents can be encouraged to generate alternative thoughts for each situation, and then to explore what feelings and behaviors would be associated with these thoughts and whether these would be more soothing/prosocial than the original ones they experienced. In this manner, children and parents learn that they have control over their own thoughts, and consequently over their feelings and behaviors and thus have another tool for the toolbox for self-soothing of negative affective states, upsetting situations and trauma reminders.

The trauma narrative and cognitive processing trauma experiences: After completion of the skill-building components of TF-CBT, therapists move to the trauma-specific components. Children develop a trauma narrative by gradually telling the story of what occurred during their traumatic experience(s), most often through the writing of a book, poem, song or other written narrative. The reasons for creating a trauma narrative include the following:
1) Overcoming avoidance of traumatic memories;
2) Identifying cognitive distortions through the childs telling of the story in his or her own words; 3) Contextualizing the childs traumatic experiences into the larger framework of the childs whole life: through telling the story in context (before, when, since this happened to me…), the child is able to see that he or she is more than just a victim of trauma. Some children choose to create the narrative on a computer while others prefer to write their stories or dictate them to the therapist.

Occasionally, children will want to tell their stories through art, dance, song or other creative techniques. If possible it is helpful to preserve the childs narrative in a permanent manner so

that it can be reviewed from one session to the next. As the child is writing the narrative, it is shared with the parent in separate parent sessions (with the childs permission) so that the parent has the opportunity to prepare for later conjoint child-parent sessions. Once the child has created the narrative (including the childs thoughts, feelings, body sensations and the worst moments of the traumatic experience), the therapist assists the child in cognitively processing any cognitive distortions that are contributing to negative affective states (such as self-blame, shame, feeling damaged, low self-esteem, related to the traumatic event).

Cognitive processing utilizes the techniques mastered earlier during the cognitive coping components (learning to change thoughts to more accurate and helpful ones as described above). It is not uncommon for parents to hear some aspects of the childs traumatic experience for the first time through the childs narrative, and to experience difficult emotions (such as self-blame) that need to be worked through. Therefore parents may need to cognitively process some parts of the childs narrative during individual parent sessions prior to the later conjoint child-parent sessions.

In vivo mastery of trauma reminders: In vivo mastery of trauma reminders involves developing a graduated exposure program for children who have developed generalized avoidance of innocuous cues. For example, a child who was sexually abused in a bathroom might now be afraid of all bathrooms, and be unable to use bathrooms at school. This might eventually lead to school refusal, which may impair the childs functioning. In order to help this child return to school, the child needs to learn that not all bathrooms are dangerous, and that school is a safe place. In vivo mastery of generalized trauma reminders follows the same general principles as other graduated exposure programs, which are described elsewhere (Kendall, 1990).

Conjoint child-parent sessions: Conjoint child-parent sessions are an important component of our model of TF-CBT for families where a parent is available to participate in treatment. TF-CBT has been provided for children alone, but children experience added benefits when parents participate (Deblinger, Lippmann, & Steer, 1996; King et al., 2000). During the joint sessions, the communication shifts from children talking directly about their traumatic experiences with the therapist, to sharing this information with the parent while the therapist moves to the background. During these sessions children typically share their trauma narratives directly with parents (parents have already heard these in individual sessions with therapists and accommodated to the emotional content adequately to be supportive and praising of children during the retelling of the narrative).

Children and parents also build on their ability to talk about other aspects of the children's traumatic experience; for example, by asking each other questions they may not have felt able to ask previously (Are you mad at me for what happened? Do you think I should have been able to stop it from happening?).

This allows parents to provide reassurance and praise to children for discussing any ongoing fears and cognitive distortions, with appropriate modeling/guidance from therapists. These sessions may also be used to enhance parent's roles as a reliable resource for trauma-related information through enjoyable joint activities. For example, the child and parent might work together to develop a Public Service Announcement about domestic violence, or a child who

had experienced sexual abuse might quiz the parent about healthy sexuality (the therapist will have previously prepared the parent for these projects during individual parent sessions).

Enhancing safety and future developmental trajectory: Many traumatized children need additional skills in order to remain safe in the future. Safety skills are individualized to each childs and family's particular situation, and provided and practiced either during individual or joint child-parent sessions. Some examples of safety skills we provide include: healthy sexuality for sexually abused children, including prevention of sexually inappropriate behaviors; no, go, tell (sexual abuse safety skills for younger children); domestic violence safety plan development (individualized for each childs developmental level and the family's specific circumstances); bullying safety skills; and drug refusal skills. We encourage children and parents to apply the skills learned during TF-CBT treatment to other difficult situations they may encounter after therapy ends, as these do not only apply to traumatic circumstances.

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FAMILY INTERVENTIONS

STRUCTURAL/STRATEGIC FAMILY THERAPY

Theoretical basis

Structural/strategic family therapy assumes that (1) family structure—meaning repeated, predictable patterns of interaction—determines individual behavior to a great extent, and (2) the power of the system is greater than the ability of the individual to resist. The system can often override any family member's attempt at non-engagement (Stanton 1981*a* ; Stanton et al. 1978).

Roles, boundaries, and power establish the order of a family and determine whether the family system works. For example, a child may assume a parental role because a parent is too impaired to fulfill that role. In this situation, the boundary that ought to exist between children and parents is violated. Structural/strategic family therapy would attempt to decrease the impaired parent's substance abuse and return that person to a parenting role.

Whenever family structure is improperly balanced with respect to hierarchy, power, boundaries, and family rules and roles, structural/strategic family therapy can be used to realign the family's structural relationships. This type of treatment is often used to reduce or eliminate substance abuse problems. As McCrady and Epstein (1996) explain, the family systems model can be used to (1) identify the function that substance abuse serves in maintaining family stability and (2) guide appropriate changes in family structure.

Integrated Structural/Strategic Family Therapy for Substance Abuse

Therapy begins with an assessment of substance abuse, individual psychopathology, and family systems. If chemical dependence or serious substance abuse is discovered, therapy begins by working with the family to achieve abstinence. In the next phase, abstinence is consolidated by resolving dysfunctional rules, roles, and alliances. Then developmental

issues and personal psychopathology are treated as part of the family contract. For example, an adolescent client's trouble accepting responsibility and a parent's depression can be part of what the family contracts to change. With that in place, a family plan for relapse prevention is incorporated. Finally, in the abstinence phase, intimacy deepens as families learn to appropriately express feelings, including hostility and mourning of losses.

Techniques and strategies

In this treatment model, the counselor uses structural/strategic family therapy to help families change behavior patterns that support substance abuse and other family problems. Because these patterns in dysfunctional families are typically rigid, the counselor must take a directive role and have family members develop, then practice, different patterns of interaction. Counselors using this treatment model require extensive training and supervision to direct families effectively.

One modification that flows from structural/strategic family therapy is strategic/structural systems engagement (SSSE). In SSSE, the family is helped to exchange one set of interactions that maintains drug use for another set of interactions that reduces it. In particular, SSSE targets the interactions linked to specific behaviors that, if changed, will no longer support the presenting problem behavior. Once the family, including the person with a substance use disorder, agrees to participate in therapy, the counselor can refocus the intervention on removing problem behaviors and substance abuse.

One of the specific techniques used in structural/strategic family therapy is illustrated below.

Structural/Strategic Family Therapy's Technique of Joining and Establishing Boundaries

Family: The client is a 22-year-old Caucasian female who abuses prescribed medication and has problems with depression and a thought disorder. She is the younger of two children whose parents divorced when she was 3. She stayed with her mother, while her brother (age 7 at the time) went with their father. Both parents remarried within a few years. Initially, the families lived near each other, and both parents were actively involved with both children, despite ill feelings between the parents. When the client was 7, her stepfather was transferred to a location 4 hours away, and the client's interactions with her father and stepmother were curtailed. Animosity between the parents escalated. When the client was 8, she chose to live with her father, brother, and stepmother, and the mother agreed. The arrangement almost completely severed ties between the parents.

At the time the client entered a psychiatric unit for detoxification, the parents had no communication at all. The initial family contact was with the father and stepmother. As the story unfolded, it became clear that the client had constructed different stories for the two family subsystems of parents. She had artfully played one against the other. This was possible because the birth parents did not communicate.

Treatment: The first task was to persuade the father to contact the mother and request that she attend a family meeting. He, along with the stepmother, agreed, though it took great courage to make the request because the father believed his daughter's negative stories about her relationship with the mother. In the next session, the older brother (the intermediary for the past 4 years) and his wife also attended.

Because the relationship between the counselor and the paternal subsystem had already been established, it was critical to also join with the maternal subsystem before attempting any family system work. The counselor knew that nothing could be accomplished until the mother and stepfather felt an equal parental status in the group. This goal was reached, granting the mother free rein to tell the story as she saw it and express her beliefs about what was happening.

A second task was to establish appropriate boundaries in the family system.

Specifically, the counselor sought to join the separate parental subsystems into a single system of adult parents and to remove the client's brother and sister-in-law as a part of that subsystem. This exclusion was accomplished by leaving them and the client out of the first part of the meeting. This procedural action realigned the family boundaries, placing the client and her brother in a subsystem different from that of the parents.

This activity proved to be positive and productive. By the end of the first hour of a 3-hour session, the parents were comparing information, routing incorrect assumptions about each other's beliefs and behaviors, and forming a healthy, reliable, and cooperative support system that would work for the good of their daughter.

This outcome would have been impossible without taking the time to join with the mother and father in a way that allowed them to feel equal as parents. Removing the brother from the parental subsystem required the client to deal directly with the parents, who had committed themselves to communicating with each other and to speaking to their daughter in a single voice.

Source: Consensus Panel.

While structural/strategic family therapy has been shown to be effective for substance abuse treatment, counselors must carefully consider using this approach with multiproblem families and families from particular cultures. Some points to consider are

- *Culture.* Counselors should become familiar with the roles, boundaries, and power of families from cultures different from their own. These will influence the techniques and strategies that will be most effective in therapy.
- *Age and gender.* Cultural attitudes toward younger people and women can affect how the counselor can best assume the directive role that structural/strategic family therapy requires.
- *Hierarchies.* Certain cultures are very attuned to relative positions in the family hierarchy. Sometimes, children may not ask questions of the parent. Other children will remove themselves from the situation until the parent notices they are not there. The professional needs to be attentive to who is who in the family. Who is revered? Who are friends? What is its history? Place of origin? All these are clues to understanding a family's hierarchy.

Counselors who use structural/strategic family therapy need to appreciate how a particular intervention might be experienced by family members. If family members experience the intervention as duplicitous, manipulative, or deceitful, the counselor may have broached a possible ethical line. As discussed in the section on informed consent in chapter 6, family

therapists or substance abuse counselors might wish to explain in advance that such interventions could be part of the therapeutic process and obtain the client's informed consent for their possible inclusion. If clients have questions about the use of such interventions, they should be answered ahead of time and included as part of the informed consent.

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BEHAVIORAL FAMILY THERAPY AND COGNITIVE–BEHAVIORAL FAMILY THERAPY

Theoretical basis of behavioral family therapy

Behavioral family therapy (BFT) combines individual interventions within a family problemsolving framework (Falloon 1991). BFT helps each family member set individual goals since the approach assumes that

- Families of people abusing substances may have problemsolving skill deficits.
- The reactions of other family members influence behavior.
- Distorted beliefs lead to dysfunctional and distorted behaviors (Walitzer 1999).
- Therapy helps family members develop behaviors that support nonusing and nondrinking. Over time, these new behaviors become more and more rewarding, leading to abstinence.

Theoretical basis of cognitive–behavioral family therapy

This approach integrates traditional family systems therapy with principles and techniques of BFT. The cognitive–behavioral combination views substance abuse as a conditioned behavioral response, one which family cues and contingencies reinforce (Azrin et al. 1994). The approach is also based on a conviction that distorted and dysfunctional beliefs about oneself or others can lead people to substance abuse and interfere with recovery. Cognitive–behavioral therapy is useful in treating adolescents for substance abuse (Azrin et al. 1994; Waldron et al. 2000).

Techniques and strategies of behavioral family therapy

To facilitate behavioral change within a family to support abstinence from substance use, the counselor can use the following techniques:

- *Contingency contracting.* These agreements stipulate what each member will do in exchange for rewarding behavior from other family members. For example, a teenager may agree to call home regularly while attending a concert in exchange for her parents' permission to attend it.
- *Skills training.* The counselor may start with general education about communication or conflict resolution skills, then move to skills practice during therapy, and end with the family's agreement to use the skills at home.

- *Cognitive restructuring.* The counselor helps family members voice unrealistic or self-limiting beliefs that contribute to substance abuse or other family problems. Family members are encouraged to see how such beliefs threaten ongoing recovery and family tranquility. Finally, the family is helped to replace these self-defeating beliefs with those that facilitate recovery and individual and family strengths.

Techniques and strategies of cognitive–behavioral family therapy

In addition to the behavioral techniques mentioned above, one effective cognitive technique is to find and correct the client's or the family's distorted thoughts or beliefs. Distorted personal beliefs may be an idea such as "In order to fit in (or to cope), I have to use drugs." Distorted messages from the family might be, "He uses drugs because he doesn't care about us," or, "He's irresponsible. He'll never change." Such messages can be exposed as incorrect and more accurate statements substituted.

Example of Behavioral and Cognitive–Behavioral Family Therapy

Family: Peter, a 17-year-old white male, was referred for substance abuse treatment. He acknowledged that he drank and smoked marijuana, but minimized his substance use. Peter's parents reported he had come home 1 week earlier with a strong smell of alcohol on his breath. The following morning, when the parents confronted Peter about drinking and drug use he denied using marijuana steadily, declaring, "It's not a big deal. I just tried marijuana once."

Despite Peter's denial, his parents found three marijuana cigarettes in his bedroom. For at least a year, they had suspected Peter was abusing drugs. Their concern was based on Peter's falling grades (from a B to a C student), his appearance (from meticulous grooming to poor hygiene), and unprecedented borrowing (he had borrowed a lot of money from relatives and friends, most of the time without repaying it).

For the first two family sessions, Peter, his older sister Nancy, 18, and their parents attended. During the sessions, Peter revealed that he resented his father's overt favoritism toward Nancy, who was an honor student and popular athlete in her school, and the related conflict between the parents about the unequal treatment of Peter and Nancy. In fact, the father often was sarcastic and sometimes hostile toward Peter, disparaging his attitude and problems. Peter viewed himself as a failure and experienced depression, frustration, anger, and low self-esteem. Furthermore, Peter wanted to retaliate against his father by causing problems in the family. In this respect, Peter was succeeding. His substance abuse and falling grades had created a hostile environment at home.

Treatment: The counselor used cognitive–behavioral therapy to focus on Peter's irrational thoughts (such as viewing himself as a total failure) and to teach Peter and other family members communication and problemsolving skills. The counselor also used behavioral family therapy to strengthen the marital relationship between Peter's parents and to resolve conflicts between family members. Although the family terminated treatment prematurely after eight sessions, some positive treatment outcomes were realized. They included an improved relationship between Peter and his father, improved academic performance, and an apparent cessation of drug use (a belief based on negative urine test results).

Source: Consensus Panel.

Below is an example of a technique used in behavioral family therapy to improve communication.

Behavioral Family Therapy: Improving Communication

Family: Delbert, a 49-year-old man with alcohol dependence, had stopped drinking during a 28-day inpatient treatment program, which he entered after a DUI arrest. He attended Alcoholics Anonymous (AA), worked every day, and saw his probation officer regularly. In many ways, Delbert was progressing well in his recovery. However, he and his wife, Renee, continued to have daily arguments that upset their children and left both Delbert and Renee thinking that divorce might be their only option. Delbert had even begun to wonder whether his efforts toward abstinence were worthwhile.

Treatment: Delbert and Renee finally sought help from the continuing care program at the substance abuse treatment facility where Delbert was a client. Their counselor, using a behavioral family therapy approach, met with them and began to assess their difficulty.

What became obvious was that their prerecovery communication style was still in place, despite the fact that Delbert was no longer drinking. Their communication style had developed over the many years of Delbert's drinking—and years of Renee's threatening and criticizing to get his attention. Whenever Renee tried to raise any concern of hers, Delbert reacted first by getting angry with her for "nagging all the time" and then by withdrawing. The counselor, realizing the couple lacked the skills to communicate differently, began to teach them new communication skills. Each partner learned to listen and summarize what their partner had said to make sure the point was understood prior to response.

To eliminate the overuse of blaming, the couple instead learned to report how their partner's actions affected them. For example, they learned to say, "I feel anxious when you don't come home on time," rather than to impugn their partner's character or motivation with invectives such as, "You are still as irresponsible as ever; that's why I can't trust you."

In addition, since both Delbert and Renee were focused on the negative aspects of their interactions, the therapist suggested they try a technique known as "Catch Your Partner Doing Something Nice." Each day, both Delbert and Renee were asked to notice one pleasing thing that their partner did. As they were able to do so, their views of each other slowly changed. After 15 sessions of marital therapy, their arguing had decreased, and both saw enough positive aspects of their relationship to merit trying to save it.

Source: Consensus Panel.

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SOLUTION-FOCUSED BRIEF THERAPY

Theoretical basis

Solution-focused brief therapy (SFBT) replaces the traditional expert-directed approach aimed at correcting pathology with a collaborative, solution-seeking relationship between the counselor and client. Rather than focusing on an extensive description of the problem, SFBT

encourages client and therapist to focus instead on what life will be like when the problem is solved. The emphasis is on the development of a solution in the future, rather than on understanding the development of the problem in the past or its maintenance in the present. Exceptions to the problem—that is, times when the problem does not happen and a piece of the future solution is present—are elicited and built on. This counters the client's view that the problem is always present at the same intensity and helps build a sense of hope about the future.

Rooted in the strategic therapy model, de Shazer and Berg, along with colleagues at the Brief Family Therapy Center in Milwaukee, shifted solution-focused brief therapy away from its original focus, which was how problems are maintained (Watzlawick et al. 1974; Zeig 1985), to its current emphasis on how solutions develop (de Shazer 1988, 1991 1997). SFBT has been increasingly used to treat substance use disorders since the publication of *Working with the Problem Drinker: A Solution-Focused Approach* (Berg and Miller 1992). Berg and Miller challenged the assumptions that problem drinkers want to keep drinking, are unaware of the damage drinking causes, and require an expert's help and information if they are to recover. Quite the contrary, SFBT counselors insist, people who abuse substances can direct their own treatment, provided they participate in the process of developing goals for therapy that have meaning for them and that they believe will make significant change in their lives.

SFBT is consistent with research that stresses the importance of collaborative, nonconfrontational therapeutic relationships in substance abuse treatment (Miller et al. 1993) and treatment matching as a means of increasing motivation for change (Prochaska et al. 1992). In fact, even substance abuse counselors who firmly believe in the disease model also accept and use SFBT as one component of substance abuse treatment (Osborn 1997). Further, McCollum and Trepper (2001) have put forth a system-based variation of the therapy specifically for use with families of people with substance use disorders.

As yet, however, little definitive research has confirmed the effectiveness of SFBT for substance abuse. Gingerich and Eisengart (2000) found and evaluated 15 studies on the outcome of SFBT in treating various problems. They concluded that "the 15 studies provide preliminary support for the efficacy of SFBT, but do not permit a definitive conclusion" (Gingerich and Eisengart 2000, p. 477), especially for substance abuse. Of the 15 studies, only two poorly controlled ones looked at the substance abuse population. One of them described a man with a 10-year drinking history. He achieved more days abstinent and more days at work per week during treatment as compared to before treatment (Polk 1996). The other study involved a therapist who used SFBT with 27 clients in treatment for substance use disorders. A larger percentage of the SFBT clients recovered (by study definitions) after two sessions and after seven sessions than did the comparison clients, but no details were given about the severity of the cases or specific client outcomes (Lambert et al. 1998).

Techniques and strategies

In SFBT, the counselor helps the client develop a detailed, carefully articulated vision of what the world would be like if the presenting problem were solved. The counselor then helps the client take the necessary steps to realize that vision.

In addition, the counselor encourages clients to recall exceptions to problems, that is, times when the problem did not occur, and to examine and increase those exceptions. In this way, the client moves closer to the problem-free vision.

The techniques of solution-focused brief therapy are designed to be quite simple. They include the miracle question, exception questions, scaling questions, relational questions, and problem definition questions.

The miracle question. Perhaps the most representative of the SFBT techniques, the miracle question elicits clients' vision of life without the problems that brought them to therapy. The miracle question traditionally takes this form:

- I want to ask you a strange question. Suppose that while you are sleeping tonight and the entire house is quiet, a miracle happens. The miracle is that the problem that brought you here is solved. Because you are sleeping, however, you don't know that the miracle has happened. When you wake up tomorrow morning, what will be different that will tell you a miracle has happened, and the problem that brought you here has been solved? (De Jong and Berg 1997).

The miracle question serves several purposes. It helps the client imagine what life would be like if his problems were solved, gives hope of change, and previews the benefits of that change. Its most important feature, however, is its transfer of power to clients. It permits them to create their own vision of the change they want. It does not require them to accept a vision composed or suggested by an expert (Berg 1995).

Asking the Miracle Question

If the answer to the miracle question is "I don't know," as it often is, the client should be encouraged to take all the time needed before answering. The client can also be prompted, if necessary, with questions such as, "As you were lying in bed, what would you notice that would tell you a miracle had occurred? What would you notice during breakfast? What would you notice when you got to work?" Then the therapist should

- Expand on each change noticed. For example, the therapist might ask, "How would that make a difference in your life?" If the client answered that he would not wake up thinking about drinking, ask, "What would you think about? How would that make a difference?"
- Accept the client's answer without narrowing it. Some clients say their miracle would be to win the lottery. The counselor should not narrow the response by saying, "Think of a different miracle." Instead expand the response by asking questions such as, "What would be different in your life if you won the lottery?" "What would be different if you paid all your bills on time?"
- Make the vision interpersonal. Ask, "As your miracle starts to come true, what would other people notice about you?"
- Help the client see that elements of the miracle are already part of life. Even if those elements are small, ask, "How can you expand the influence of those small parts of the miracle?"

Exception questions. Sometimes a continual problem is less severe or even absent. Hence, the substance abuse counselor might inquire, "Tell me about the times when you decided not to use, even though your cravings were strong." The answer will set the stage for examining how the client's own actions have helped lead to that different outcome.

Scaling questions. As a clear vision of change emerges, techniques begin to focus on helping the client make change happen. At this point, one especially useful technique is the scaling question. It might ask, On a scale of 1 to 10, where 1 means one of your goals is met and 10 means all your goals are completely met, where would you rate yourself today? A good follow-up question is, What would it take for you to move from a 4 to a 5 on our 10-point scale? Such questions help clients gauge their own progress toward their goals and see change as a process rather than an event.

Relational questions. Helping clients set goals that take the views of important others into account can extend the benefits of change into the client's environment. A good relational question is, What will other people notice about you as you move closer and closer to your goal? For instance, an adolescent client might declare that he is completely confident that he will not relapse. In reply, he might be asked, "Do you think your father is that confident?" Being urged to look at his situation from the perspective of the parent, who might only be somewhat confident that the client will not relapse, motivates the client to think about how he must behave to instill more confidence in this important other figure.

Problem definition questions. This technique, used with the families of people with substance use disorders, defines the steps that each person takes to produce an outcome that is not a problem (McCollum and Trepper 2001). The therapist helps the family define a problem it would like to solve, and then constructs the part each member plays in the sequence of behaviors leading up to that problem. Next, the therapist helps the family examine exceptions to the problem sequence and uses the exceptions to construct a solution sequence.

Case Study of Exceptions to Problem

Family: Darcy had been diagnosed with an alcohol use disorder. In family therapy, she and her husband Steve came to recognize a problem sequence known as a pursuer–distancer pattern. When Steve sensed Darcy distancing from him emotionally, he would begin to worry that she was in danger of going on another drinking binge. His response to this fear was to suggest that Darcy call her sponsor or go to extra AA meetings.

Steve's concern made Darcy feel her independence was threatened. She would get angry, refuse to take Steve's advice, and distance herself even more. Steve would then insist that she call her sponsor, and the tension between them would escalate into an argument. The quarrel often ended when Darcy stormed out of the house to spend the night with her sister, who was not a healthful influence. She would suggest a drink to calm Darcy's nerves—and then join her in a binge.

Treatment: After Darcy and Steve defined this sequence, the therapist helped them look for exceptions to it—times when the sequence started, but did not end in a binge. Both Darcy and Steve were able to identify a solution sequence. Darcy remembered a time when Steve was pestering her. Instead of going to her sister's house, she spent an hour online reading passages and trading messages and suggestions with the online recovery community. Then she called and had lunch with her sponsor before going to an AA meeting where her sponsor was the speaker that day. When she came home, she was able to reassure Steve that she was not tempted to drink at that point and suggested they go to a movie together. Steve recalled an occasion when he was getting anxious about Darcy, but instead of pestering Darcy, he mowed the lawn. The physical activity dissipated his anxiety, and he was then able to talk to Darcy calmly about his concerns without pressuring her to take any specific action. The

therapist helped Darcy and Steve to build on these successful times, identifying ways to more positive sequences of behavior.

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Center for Substance Abuse Treatment.
Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2004
https://www.ncbi.nlm.nih.gov/books/NBK64266/

MULTIDIMENSIONAL FAMILY THERAPY

Theoretical basis

The multidimensional family therapy (MDFT) approach was developed as a stand-alone, outpatient therapy to treat adolescent substance abuse and associated behavioral problems of clinically referred teenagers. MDFT has been applied in several geographically distinct settings with a range of populations, targeting ethnically diverse adolescents at risk for abuse and/or abusing substances and their families. The majority of families treated have been from disadvantaged inner-city communities. Adolescents in MDFT trials have ranged from high-risk early adolescents to multiproblem, juvenile justice-involved, dually diagnosed female and male adolescents with substance use problems.

As a developmentally and ecologically oriented treatment, MDFT takes into account the interlocking environmental and individual systems in which clinically referred teenagers reside (Liddle 1999). The clinical outcomes achieved in the four completed controlled trials include adolescent and family change in functional areas that have been found to be causative in creating dysfunction, including drug use, peer deviance factors, and externalizing and internalizing variables. The cost of this treatment relative to contemporary estimates of similar outpatient treatment favors MDFT. The clinical trials have not included any treatment as usual or weak control conditions. They have all tested MDFT against other manualized, commonly used interventions. The approach is manualized (Liddle 2002), training materials and adherence scales have been developed, and have demonstrated that the treatment can be taught to clinic therapists with a high degree of fidelity to the model (Hogue et al. 1998).

Research basis

MDFT has been developed and refined over the past 17 years (Liddle and Hogue 2001). MDFT has been recognized as one of the most promising interventions for adolescent drug abuse in a new generation of comprehensive, multicomponent, theoretically-derived and empirically-supported treatments (*c* Center for Substance Abuse Treatment [CSAT] 1999*c* ; NIDA 1999*a* ; Waldron 1997). MDFT has demonstrated efficacy in four randomized clinical trials, including three treatment studies (one of which was a multisite trial) and one prevention study. Investigators have also conducted a series of treatment development and process studies illuminating core mechanisms of change.

Techniques and strategies

Targeted outcomes in MDFT include reducing the impact of negative factors as well as promoting protective processes in as many areas of the teen's life as possible. Some of these risk and protective factors include improved overall family functioning and a healthy interdependence among family members, as well as a reduction in substance abuse, drastically reduced delinquency and involvement with antisocial peers, and improved school

performance. Objectives for the adolescent include transformation of a drug using lifestyle into a developmentally normative lifestyle and improved functioning in several developmental domains, including positive peer relations, healthy identity formation, bonding to school and other prosocial institutions, and autonomy within the parent–adolescent relationship. For the parent(s), objectives include increasing parental commitment and preventing parental abdication, improved relationship and communication between parent and adolescent, and increased knowledge about parenting practices (e.g., limit-setting, monitoring, appropriate autonomy granting).

Core components

MDFT is an outpatient family-based drug abuse treatment for teenagers who abuse substances (Liddle 2002). From the perspective of MDFT, adolescent drug use is understood in terms of a network of influences (i.e., individual, family, peer, community). This multidimensional approach suggests that reductions in target symptoms and increases in prosocial target behaviors occur via multiple pathways, in differing contexts, and through different mechanisms. The therapeutic process is thought of as retracking the adolescent's development in the multiple ecologies of his or her life. The therapy is organized according to stage of treatment, and it relies on success in one phase of the therapy before moving on to the next. Knowledge of normal development and developmental psychopathology guides the overall therapeutic strategy and specific interventions.

The MDFT treatment format includes individual and family sessions, sessions with various family members, and extrafamilial sessions. Sessions are held in the clinic, in the home, or with family members at the court, school, or other relevant community locations. Change for the adolescents and parents is intrapersonal and interpersonal, with neither more important than the other. The therapist helps to organize treatment by introducing several generic themes. These are different for the parents (e.g., feeling abused and without ways to influence their child) and adolescents (e.g., feeling disconnected and angry with their parents). The therapist uses these themes of parent–child conflict as assessment tools and as a way to identify workable content in the sessions.

The format of MDFT has been modified to suit the clinical needs of different clinical populations. A full course of MDFT ranges between 16 and 25 sessions over 4 to 6 months, depending on the target population and individual needs of the adolescent and family. Sessions may occur multiple times during the week in a variety of contexts including in-home, in-clinic, or by phone. The MDFT approach is organized according to five assessment and intervention modules, and the content and foci of sessions vary by the stage of treatment.

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BRIEF STRATEGIC FAMILY THERAPY

BSFT evolved from more than 25 years of research and practice at the University of Miami. The structural orientation of BSFT draws on the work of Minuchin (Minuchin, 1974; Minuchin and Fishman, 1981; and Minuchin, Rosman, and Baker, 1978), and the strategic

aspects of BSFT are influenced by Haley (1976) and Madanes (1981). By integrating theory, research findings, and clinical practice, BSFT has been continuously refined to improve its effectiveness with youth with behavior problem.

BSFT recognizes that the family itself is part of a larger social system and—as a child is influenced by her or his family—the family is influenced by the larger social system in which it exists. Sensitivity to contextual factors begins with an understanding of the influence of peers, schools, and neighborhoods on the development of children's behavior problems. However, BSFT also focuses on parents' relationships with children's peers, schools, and neighborhoods and on the unique relationships that parents have with individuals and systems outside the family (e.g., work or groups such as Alcoholics Anonymous).

Program Objectives

BSFT has been revised to respond to the unique strengths and weaknesses minority youth and families in Miami bring to therapy. Several of these risk and protective factors are described below.

Mitigating Risk Factors Immigration. Many of the families served by the Spanish Family Guidance Center have recently immigrated to the United States. The immigration process creates specific problems that must be addressed in treatment. For example, many families emigrate in stages; it is not uncommon for one parent, usually the mother, to come to the United States alone to establish a place and economic means for the family, and then bring the children to this country. For many families, this process is protracted, and they are separated for many years. Moreover, the reunification process often fails to meet family members' expectations. Children are often disappointed when they arrive in the United States and see that they are living in an impoverished, dangerous, inner-city community. Likewise, parents are often disappointed when they are confronted with angry and emotionally detached children. As a result, treatment often involves attempting to reestablish parent-child bonds and create new family structures that include the parent who was separated from the family.

High conflict. Intense and persistent conflict is a common characteristic of families of youth with behavior problems. High levels of conflict interfere with parents' ability to resolve problems, communicate effectively, nurture, and guide their children. BSFT focuses on assessing the family's conflict resolution style and developing specific interventions to help families negotiate and resolve their differences more effectively.

Inner city. The powerful influence of neighborhoods cannot be ignored when working with inner-city youth and families. In fact, accumulating evidence shows that the positive changes made in family therapy are often overwhelmed by the harsh and deteriorated conditions of the inner city. As a result, the focus of BSFT has expanded from individual families to include the relationship between families and the multiple systems that influence children. Developments in the clinical model have been heavily influenced by the theoretical work of Urie Bronfenbrenner (1977, 1979, 1986) and the groundbreaking clinical work of Scott Henggeler and his colleagues (Henggeler and Borduin, 1990; Henggeler, Melton, and Smith, 1992). In particular, BSFT has expanded to include attention to the relationship between families, on one hand, and schools, peers, juvenile justice agencies, and neighborhoods, on the other.

Theoretical Underpinnings The goal of BSFT is to improve youth behavior by:

◆ Improving family relationships that are presumed to be directly related to youth behavior problems.

◆ Improving relationships between the family and other important systems that influence the youth (e.g., school, peers).

To understand the specific way in which BSFT produces changes in these relationships and subsequent changes in behavior problems, it is necessary to understand some of the basic principles on which BSFT is based. Systems BSFT assumes that each family has its own unique characteristics and properties that emerge and are apparent only when family members interact. This family "system" influences all members of the family. Thus, the family must be viewed as a whole organism rather than merely as the composite sum of the individuals or groups that compose it. In BSFT, this view of the family system is evident in the following assumptions:

◆ The family is a system with interdependent/interrelated parts.

◆ The behavior of one family member can only be understood by examining the context (i.e., family) in which it occurs.

◆ Interventions must be implemented at the family level and must take into account the complex relationships within the family system. Structure BSFT also focuses on "structure." While the concept of a system is useful, one must understand the system's basic structure to recognize the mechanism through which it operates. Thus, as noted above, the existence of a system explains how the behaviors of family members are interdependent. These interdependent or linked behavioral interactions among individuals tend to recur and create patterns of interactions among family members. In BSFT, these repetitive patterns compose a family system's structure. This view of structure is evident in the following assumptions:

Structure: refers to the repetitive patterns of interactions that characterize the family system.

◆ Repetitive interactions (i.e., ways family members behave with one another) are either successful or unsuccessful in achieving the goals of the family or its individual members.

◆ BSFT targets repetitive patterns of interaction (i.e., the habitual ways in which family members behave with one another) that are directly related to the youth's behavior problems.

Strategy: BSFT believes in a strategic approach that uses pragmatic, problem-focused, and planned interventions. This strategic approach emerged from an explicit focus on developing an intervention that was quick and effective in eliminating symptoms. In BSFT, this strategic approach is evident in the following assumptions:

◆ Interventions are practical. That is, interventions are tailored to the unique characteristics of families and are implemented to achieve attainable treatment goals.

◆ Interventions are problem focused. A problem-focused approach targets first those patterns of interactions that most directly influence the youth's psychosocial adjustment and antisocial behaviors and targets one problem at a time.

◆ Interventions are well planned, meaning that the therapist determines what seem to be the maladaptive interactions (i.e., interactions that are directly related to the youth's behavior problems), determines which of these might be targeted, and establishes a plan to help the family develop more effective patterns of interaction.

Process versus Content: As noted above, BSFT is primarily concerned with identifying and ameliorating patterns of interaction in the family system that are presumed to be directly related to behavioral symptoms. This focus on patterns of interactions is also referred to as a "process" focus. Rather than focusing simply on what happens in the family (e.g., what dad said when he yelled at the children), BSFT focuses on how interactions occur (e.g., who was involved in the conflict, when it occurred, who responded to whom, what preceded and followed the 4 incident). This important distinction between process (patterns of interaction) and content (specific and concrete information) is a fundamental concept of BSFT. This process focus is evident in the following assumptions:

◆ Process refers to what behaviors are involved in an interaction and how they occur. Secondarily, process refers to the message that is communicated by the nature of interactions or by the style of communication, including all that is communicated nonverbally, such as emotion, tone, and the underlying power relationship.

◆ Content refers to the specific and concrete facts used in the communication. Content includes such things as the reasons that family members offer for a given interaction.

◆ BSFT is process oriented at all times. The emphasis is on identifying the nature of the interactions in the family and changing those interactions that are maladaptive.

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Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention, April 2000
https://www.ncjrs.gov/pdffiles1/ojjdp/179285.pdf

FAMILY BEHAVIOR THERAPY FOR SUBSTANCE ABUSE FAMILY BEHAVIOR THERAPY (FBT)

Is a robust intervention approach that, in addition to substance abuse and dependence, is capable of addressing a wide-array of problems, including conduct disorders, child maltreatment, depression, family discord, and unemployment.

FBT has demonstrated efficacy in both adolescents and adults (see reviews by Carroll & Onken, 2005; Dutra, Stathopoulou et al., 2008; Waldron & Turner, 2008). Its component interventions are also demonstrating great promise in substance abusing parents within the child welfare system (see initial study by Donohue & Van Hasselt, 1999). FBT includes up to 20 treatment sessions ranging from 60 minutes to 2 hours. Sessions are usually scheduled to occur between 6 months and a year. One therapist usually implements FBT in outpatient settings, whereas two therapists implement

FBT in client homes when substance abuse and other comorbid problems are especially severe and children are involved (e.g., child maltreatment). When therapy is initiated in homes, one therapist assumes primary responsibilities with adults, while the other treats children. Therapists utilize checklists to prompt implementation of prescribed protocols, as well as intervention handouts and assignment sheets to assist in generalizing skill acquisition to the home environment. All treatments are skill-oriented, and therapy is initiated with a semistructured program Orientation to engage patients. Clients are then assisted in developing Behavioral Goals that are incompatible with antecedents to substance use and

HIV infection, and anchored to a Contingency Management system. When substance abusers are parents, particularly those involved in child welfare systems, they are prompted to set goals that are relevant to effective parenting behaviors. Behavioral goals are reviewed during each session, and contingent rewards are provided by significant others when goals are accomplished.

Following establishment of Behavioral Goals, Treatment Planning is initiated wherein clients choose the order and extent to which specified interventions are implemented from a menu of treatment options consisting of the various FBT interventions. All sessions are initiated with the client completing a checklist to assure Basic Necessities in the home are being met (e.g., bills are paid, violence is absent), and when Basic Necessities are absent, such problems are resolved expeditiously utilizing a structured problem-solving method that borrows from the tenants of Self Control (see below). FBT interventions include strategies to avoid substance use and HIV infection.

For example, Stimulus Control involves teaching clients to avoid, and escape from, stimuli that precede substance use and other problem behaviors (e.g., child neglect), and teaching skills that facilitate more time with stimuli that are incompatible with substance use and HIV while promoting goal-oriented behavior. When reviewing antecedent stimuli (i.e., "triggers") in Stimulus Control, clients are taught to utilize other FBT interventions to resolve problems that are spontaneously indicated. There is a Self Control intervention that may be utilized to reduce the intensity of problematic impulsive behaviors (e.g., unprotected sexual activity) and generate opportunities to engage in behaviors that are incompatible with substance use (e.g., use of condoms).

Communication Skills Training may be utilized to positively request nondrug using people to engage in "clean" activities or resolve conflicts that often end in substance use or other problem behaviors (e.g., child neglect, domestic violence). There are therapies to assist in obtaining desired employment (i.e., Job Club methods) and maintaining effective Financial Management. Family members are taught to acknowledge reinforcing positive attributes and behaviors of one another in "I've Got a Great Family." When substance abusers are parents, children receive child-focused treatments while adults receive treatment in another room. The childfocused treatments are designed to increase the reinforcement value of children, thereby decreasing their risk of child neglect and increasing desire of parents to spend more time in nondrug associated activities with their children.

These treatments include teaching children to differentially reinforce desired parental behaviors (i.e., Catching My Parents Being Good), teaching them to increase rate and quality of assistance to their parents (i.e., Offering to Help My Parents), performing talent shows and activities to "show-off" positive personal qualities and skills taught in therapy (Showing My Parent How I'm Special), and teaching them home safety skills (Safety Skills Stories). There are treatments available to teach parents how to differentially reinforce desired behaviors and ignore undesired behaviors (i.e., Catching My Children Being Good), and manage noncompliance of children through clearly stated directions and consequences (i.e., Child Compliance Training). Parents learn a nonaversive discipline strategy (i.e., Positive Practice) to utilize when their children perform undesired behaviors. When therapy is implemented in the home, home tours are utilized to identify and remove home hazards and encourage

cleanliness and aesthetic enhancements (i.e., Home Safety and Beautification), thus making family home activities more reinforcing and safe. Once implemented, skill-based interventions are usually reviewed in all remaining sessions to a progressively lesser extent, and involve therapy assignments between sessions to enhance generalization of skill acquisition. Role-playing and behavioral rehearsal are also utilized extensively to improve the confidence of clients, and prepare them for difficult in vivo situations. That is, after 1 intervention skill is implemented, it is usually implemented in all remaining sessions.

FBT Intervention Components

This section describes the FBT treatment components, including a brief rationale and overview of each method. First, the core foundation interventions will be described, as these treatments are initially implemented with all types of substance abusers in the following order:

(a) Program Orientation
(b) Development of Behavioral Goals and Contingency Management
(c) Standardized Treatment Plan
(d) Assurance of Basic Necessities
(e) Stimulus Control. Skill-specific treatments are subsequently implemented based on preference ratings completed by clients from a menu of therapy options.

Most of the skill-based treatments are applicable to all types of substance abuse (i.e., Self Control, I've Got a Great Family, Positive Request, Arousal Management, Job Getting Skills Training, and Financial Management).

However, when parents are the ones abusing substances, there are several additional treatments available, including Catching My Child Being Good, Child Compliance Training, Positive Practice, Home Safety and Beautification tours (the latter intervention is available only if therapy is provided in the client's home), Catching My Parents Being Good, Offering to Help My Parents, Showing My Parents How I'm Special and Safety Skill Stories.

Family Behavior Therapy for Substance Abuse and Other Associated Problems
A Review of Its Intervention Components and Applicability
Behavior Modification Volume 33 Number 5 September 2009
https://pdfs.semanticscholar.org/00e5/48cba4eded4abbd6b520cb7a47e64109aa69.pdf

FUNCTIONAL FAMILY THERAPY (FFT)

Is a family-based prevention and intervention program that has been applied successfully in a variety of contexts to treat a range of these high-risk youth and their families. As such, FFT is a good example of the current generation of family-based treatments for adolescent behavior problems (Mendel, 2000; Sexton and Alexander, 1999). It combines and integrates the following elements into a clear and comprehensive clinical model: established clinical theory, empirically supported principles, and extensive clinical experience. The FFT model allows for successful intervention in complex and multidimensional problems through clinical practice that is flexibly structured and culturally sensitive—and also accountable to youth, their families, and the community.

Although commonly used as an intervention program, FFT is also an effective prevention program for at-risk adolescents and their families. Whether implemented as an intervention or a prevention program, FFT may include diversion, probation, alternatives to incarceration, and/or reentry programs for youth returning to the community following release from a high-security, severely restrictive institutional setting. Based on the results of extensive independent reviews, FFT has been designated variously as a "blueprint program" (Alexander et al., 2000), an "exemplary model" program (Alexander, Robbins, and Sexton, 1999), and a "family based empirically supported treatment" (Alexander, Sexton, and Robbins, 2000).

These designations reflect FFT's 30 years of clinical and research experience and its use at a wide range of intervention sites in the United States and other countries. FFT targets youth between the ages of 11 and 18 from a variety of ethnic and cultural groups. It also provides treatment to the younger siblings of referred adolescents. FFT is a short-term intervention—including, on average, 8 to 12 sessions for mild cases and up to 30 hours of direct service (e.g., clinical sessions, telephone calls, and meetings involving community resources) for more difficult cases. In most cases, sessions are spread over a 3-month period. Regardless of the target population, FFT emphasizes the importance of respecting all family members on their own terms (i.e., as they experience the intervention process).

Data from numerous studies of FFT outcomes suggest that when applied as intended, FFT reduces recidivism and/or the onset of offending between 25 and 60 percent more effectively than other programs (Alexander et al., 2000). Other studies indicate that FFT reduces treatment costs to levels well below those of traditional services and other interventions (Alexander et al., 2000). As FFT has evolved, it has adopted a set of guiding principles, goals, and techniques that can be used even when resources are limited—for example, in managed care and similar contexts that restrict open-ended and non-outcome-based resource funding.

Core Principles, Goals, and Techniques

Functional Family Therapy is so named to identify the primary focus of intervention (the family) and reflect an understanding that positive and negative behaviors both influence and are influenced by multiple relational systems (i.e., are functional).

FFT is a multisystemic prevention program, meaning that it focuses on the multiple domains and systems within which adolescents and their families live. FFT is also multisystemic and multilevel as an intervention in that it focuses on the treatment system, family and individual functioning, and the therapist as major components. Within this context, FFT works first to develop family members' inner strengths and sense of being able to improve their situations—even if modestly at first. These characteristics provide the family with a platform for change and future functioning that extends beyond the direct support of the therapist and other social systems. In the long run, the FFT philosophy leads to greater selfsufficiency, fewer total treatment needs, and considerably lower costs.

At the level of clinical practice, FFT includes a systematic and multiphase intervention map—Phase Task Analysis— that forms the basis for responsive clinical decisions. This map gives FFT a flexible structure by identifying treatment strategies with a high probability of success and facilitating therapists' clinical options. FFT's flexibility extends to all family

members and thereby results in effective moment-by-moment decisions in the intervention setting. Thus, FFT practice is both systematic and individualized.

The following sections describe the intervention phases and the model of FFT clinical assessment. As the clinical map presented in the table on page 3 reflects, FFT is a multiphase, goal-directed, and systematic program.

Intervention Phases

FFT's three specific intervention phases— engagement and motivation, behavior change, and generalization—are interdependent and sequentially linked. Each has distinct goals and assessment objectives, each addresses different risk and protective factors, and each calls for particular skills from the interventionist or therapist providing treatment. The interventions in each phase are organized coherently, which allows clinicians to maintain focus in contexts that often involve considerable family and individual disruption. The three intervention phases are described in the sections that follow.

Phase 1: Engagement and Motivation: This phase places primary emphasis on maximizing factors that enhance intervention credibility (i.e., the perception that positive change might occur) and minimizing factors likely to decrease that perception (e.g., poor program image, difficult location, insensitive referrals, personal and/or cultural insensitivity, and inadequate resources). In particular, therapists apply reattribution (e.g., reframing, developing positive themes) and related techniques to address maladaptive perceptions, beliefs, and emotions. Use of such techniques establishes a family-focused perception of the presenting problem that serves to increase families' hope and expectation of change, decrease resistance, improve alliance and trust between family and therapist, reduce oppressive negativity within families and between families and the community, and help build respect for individual differences and values.

Phase 2: Behavior Change: During this phase, FFT clinicians develop and implement intermediate and, ultimately, long-term behavior change plans that are culturally appropriate, context sensitive, and tailored to the unique characteristics of each family member. The assessment focus in this phase includes cognitive (e.g., attributional processes and coping strategies), interactive (e.g., reciprocity of positive rather than negative behaviors, competent parenting, and understanding of behavior sequences involved in delinquency), and emotional components (e.g., blaming and negativity). Clinicians provide concrete behavioral intervention to guide and model specific behavior changes (e.g., parenting, communication, and conflict management). Particular emphasis is placed on using individualized and developmentally appropriate techniques that fit the family relational system.

Phase 3: Generalization: This FFT phase is guided by the need to apply (i.e., generalize) positive family change to other problem areas and/or situations. FFT clinicians help families maintain change and prevent relapses. To ensure long-term support of changes, FFT links families with available community resources. The primary goal of the generalization phase is to improve a family's ability to affect the multiple systems in which it is embedded (e.g., school, juvenile justice system, community), thereby allowing the family to mobilize community support systems and modify deteriorated family-system relationships. If

necessary, FFT clinicians intervene directly with the systems in which a family is embedded until the family develops the ability to do so itself.

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https://www.ncjrs.gov/pdffiles1/ojjdp/184743.pdf