

Introduction to Family Behavior Therapy

Overview

This chapter provides an overview of the application of Family Behavior Therapy (FBT) as applied to adolescents. First, the historical, theoretical, and empirical underpinnings of FBT are reviewed to assist in understanding its conceptualization and development during the past 20 years. We then describe youth and their families who are most likely to benefit from FBT, and offer recommendations in determining a method of assessment to assist in treatment planning. Although content of each of the FBT intervention components is extensively reviewed in Chapters 4 through 13, a summary of each intervention component is provided in this chapter. The method of using our relatively novel prompting checklists to guide treatment providers (TPs) in intervention implementation is reviewed, and procedures involved in the assessment of treatment integrity are underscored.

Chapter at a Glance

- Historical, theoretical, and empirical background of FBT
- Clinical populations and therapeutic contexts appropriate for FBT
- General structure of FBT
- Maintenance and assessment of FBT intervention integrity

Historical and Theoretical Background

The FBT that is reviewed in this book was initiated in 1989 by the authors and their colleagues with support from the National Institute on Drug

Abuse. During the time of FBT's initial development, very few evidence-supported interventions were available to treat adolescent drug abuse. Behavioral treatment programs for preadolescent conduct disorders were comparatively advanced due to the pioneering work of Sidney Bijou, Don Baer, Todd Risley, Mont Wolf, and others. Two behavioral programs that stood out to us in their emphasis on positive reinforcement, standardized method, and effectiveness included Constance Hanf's parent training program for noncompliant preadolescent children that was empirically validated in studies by Rex Forehand and his colleagues at the University of Georgia (see Forehand & McMahon, 1981); and Gerald Patterson's social learning approach to family therapy (e.g., Patterson, Reid, Jones, & Conger, 1975) that continues to be enhanced by his colleagues at the Oregon Social Learning Center. The scientific work of these esteemed investigators validated our desire to enhance drug-incompatible skills in youth through family-based reinforcement, while rejecting punishment-based interventions that were shown to result in numerous negative side effects.

Consistent with behavioral theory, we conceptualized substance use to be a strong inherent reinforcer (i.e., pleasurable sensations, peer support, elimination of aversive emotions). Although negative consequences occur as a result of substance use, the severity of these consequences is often minimized or suppressed, or the full impact is not realized until well after the habitual processes of drug use has begun. To assist youth in gaining long-term abstinence from illicit drugs, we hypothesized that FBT would need to (a) reinforce the development of skills that are incompatible with drug use (e.g., recognizing antecedents or "triggers" to drug use, controlling drug cravings, utilizing communication skills to decrease arguments and other stressful antecedents to drug use), (b) modify the environment to facilitate reinforcement for time spent in drug-incompatible activities (e.g., enrollment in school or work, changing driving routes to avoid drug use triggers, creating a social network of nonaddicted friends), and (c) reward actions that are incompatible with drug use.

We decided to base the development of FBT on the Community Reinforcement Approach (CRA) due to its consistency with the aforementioned model and because CRA had been shown to successfully treat the related problem of alcohol abuse in adults (e.g., Azrin, Sisson, Meyers, & Godley, 1982; Hunt & Azrin, 1973; Sisson & Azrin, 1989). Communication

skills training, a critical component in behavioral marital therapy (Stuart, 1969), had been successfully incorporated into Gerald Patterson's program with parents of conduct-disordered youth when marital problems were evidenced. Therefore, it made good sense to incorporate methods of facilitating family activities and communication skills training into FBT that were similar to CRA. As can be seen in Chapters 8 and 9, we made very few changes to the original CRA communication skills therapy protocols other than to emphasize youth/parent relationships.

To assist in managing youth who refused to go to school we modified another CRA component, the Job Club intervention for adults (Azrin, Flores, & Kaplan, 1975), to be developmentally appropriate in youth (see Chapter 12). For instance, shortly after we initiated our first controlled trial, it became apparent to us that, relative to adults, we needed to spend additional time motivating youth to wear appropriate clothing to job interviews, arranging transportation for them to attend interviews, and teaching them to speak respectfully during their job interviews. They also demonstrated relatively greater difficulties responding to questions that are commonly asked in job interviews. Therefore, the Job Club intervention was modified to train youth in these important areas.

It was initially anticipated that many adolescents would be unmotivated to desire abstinence from illicit drugs, and likely evidence frequent lapses in drug use throughout treatment. Therefore, relapse prevention strategies similar to those of Alan Marlatt (1985), and concepts of motivational interviewing methods similar to those formalized by William Miller (1983), were utilized to shape clinical style and general approach to therapy (see Chapters 3 and 5). The youth who were treated in our clinical trials were extremely responsive to these supportive methods, and our TPs found them to be consistent with their conceptualization to the addictions and enjoyable to implement. Relapse prevention strategies were also embedded within a newly developed stimulus control method in which youth learned to identify antecedents ("triggers") to drug use and non-drug use, and to implement skills to assist in managing these antecedent stimuli (see Chapters 10 and 11). We theorized that youth and parent motivation would be enhanced with external reinforcement through contingency contracting. We decided to establish a point system in which youth would be rewarded for behaviors that were incompatible with substance use. About the time we were developing this contracting procedure, Stephen Higgins and his colleagues (1991) had demonstrated

4 Treating Adolescent Substance Abuse Using Family Behavior Therapy

the efficacy of CRA and voucher-based contingency management in reducing drug abuse. The latter study demonstrated the importance of using objective methods of assessing drug abuse (i.e., urinalysis testing) in contingency management. Similar to their work, we made all rewards contingent on no signs of drug use through urinalysis and reports from others. The developed system included standardized methods of quickly determining target responses, and rewards from the participants' social ecology. The point system appeared to be relatively effective in our first randomized controlled trial with youth (Azrin, Donohue, Besalel, Kogan, & Acierno, 1994). However, some parents evidenced difficulties managing earned points, and it seemed more complicated than necessary. Therefore, in a subsequent trial (Azrin et al., 2001), this point system was replaced with a much easier to implement level system (Chapter 6). The developed level system was similar to those that are often utilized in state-of-the-art residential youth programs. However, the contingencies were managed by parents rather than staff.

One of the interventions we developed in our first trial of FBT was an Urge Control (Self-Control) intervention (see Chapter 11) to reduce drug cravings/urges. This intervention was based on Joseph Cautela's (1967) Covert Sensitization therapy. In Covert Sensitization, the person with the addiction is instructed to think of aversive stimuli just as alcohol use is about to occur during imagery trials. After repeated pairings of aversive and alcohol-related thoughts, desire for alcohol use diminishes. However, in our earlier pilot trials, youth were often resistant to extended imagination of aversive thoughts. Moreover, Covert Sensitization does not teach skills relevant to managing substance use. Therefore, we developed an Urge Control (or Self-Control) intervention to assist youth in identifying the earliest thought of drug use and very briefly imagining aversive stimuli when the urge is relatively low. This change permitted cravings and desires for drug use to be overshadowed easily and quickly by aversive thoughts and images. Once the urge was terminated in the imagined trial, youth were taught to engage in a series of skill sets culminating in a brief problem-solving exercise to identify drug-incompatible behaviors, and imagine escape from the drug use situation. The latter skill-based modifications were unique to the previous Covert Sensitization procedure. Because youth reported that they had a difficult time imagining themselves doing the non-drug-associated actions that were brainstormed, we had them verbally describe themselves doing responses that were incompatible with problem behavior. That is, they were prompted to complete

“practice” trials by describing themselves doing the desired behavioral sets aloud, and were subsequently praised for their efforts. Adolescents reported great satisfaction with these trials, probably because of the abundant encouragement and praise they received throughout.

Thus, FBT is consistent with the CRA and other behavioral therapies, but does differ in meaningful ways. Since our initial trial 2 decades ago, FBT has undergone continued enhancement. Standardized quality assurance programs specific to FBT have been originated to assist in managing infrastructural and administrative needs (see Donohue et al., 2009; Chapter 2), and the method of assessing treatment integrity that is described later in this chapter has been favorably evaluated in a community setting (Sheidow, Donohue, Hill, Henggeler, & Ford, 2008). Easy-to-follow prompting checklists that are described at the end of this chapter have been developed to guide TPs in efficient and effective administration of therapies during sessions (included at the end of each of Chapters 4 through 13), and standardized telephone therapies aimed at improving session attendance have been favorably examined in controlled trials involving youth to complement FBT (Donohue et al., 1998). Standardized agendas have also been developed to assist TPs in transitioning between treatment sessions (see Chapter 4), interventions have been tied directly to standardized treatment plans (see Chapter 7), and the treatment termination process is now clear and specific to future goal preparation (see Chapter 13). Relevant to dissemination, other standardized procedures have been developed to assist in determining readiness for FBT adoption in community agencies, and prompting checklists have been developed to guide trainers when implementing FBT workshops and ongoing training sessions (freely available from the first author).

Empirical Background

Relevant to outcome support, FBT is one of the few evidence-based treatments to demonstrate efficacy in controlled clinical trials involving both adults and adolescents who have been identified to abuse illicit drugs (see reviews, for example, by Bukstein & Horner, 2010; Carroll & Onken, 2005; Dutra et al., 2008; Macgowan & Engle, 2010). In the first randomized controlled trial of FBT (Azrin, McMahon, et al., 1994), adolescents and adults were randomly assigned to receive FBT (referred to as behavior therapy at that time) or a nondirective control group after completion of baseline data. Results indicated that, as

compared with control group participants, the participants assigned to FBT demonstrated significantly greater improvements throughout the year following baseline in drug and alcohol use frequency, conduct problems, family functioning/satisfaction, work/school attendance, depression, and parental satisfaction with the youth. The results were maintained at 9 months' follow-up (Azrin et al., 1996), with adolescents in FBT showing better outcomes than adults in FBT and adolescents and adults in the control group. Other randomized controlled trials that have explicitly examined dually diagnosed substance abusing adolescents and their parents (Azrin, Donohue, et al., 1994; Azrin et al., 2001) have shown similar positive effects. The studies of FBT have generally indicated favorable results regardless of gender, ethnicity, or type of substance used (i.e., alcohol, marijuana, hard drugs). Based on a meta-analysis of outcome studies conducted by an independent review group (Bender, Springer, & Kim, 2006), it was concluded that FBT was one of only two treatments to show large treatment effect sizes for dually diagnosed adolescents across substance use, and internalizing and externalizing behavior problems. Favorable substance abuse outcomes have also been indicated in the very similar Adolescent Community Reinforcement Approach (ACRA; Dennis et al., 2004; Godley, Godley, Dennis, Funk, & Passetti, 2007) and Community Reinforcement Approach in homeless adolescents (Slesnick, Prestopnik, Meyers, & Glassman, 2007). The dissemination of ACRA in 33 sites is particularly impressive (Godley, Garner, Smith, Meyers, & Godley, 2011). Relevant to family participation in FBT, we developed a brief telephone intervention that was shown to improve initial session attendance of youth and their parents by 29% in an outpatient setting (Donohue et al., 1998). More intensive CRA-like engagement programs, such as CRA Family Training (CRAFT) have been empirically developed by Bob Meyers and his colleagues (see review by Smith & Meyers, 2004). These programs have significantly enhanced family involvement in CRA (e.g., Meyers, Miller, Smith, & Tonigan, 2002; Miller, Meyers, & Tonigan, 1999).

These findings offer support for FBT in the treatment of adolescent substance abuse within community settings that are charged with the implementation of evidence-supported "best practices." For instance, FBT is now listed in national clearinghouses as an evidence-based therapy (e.g., Substance Abuse and Mental Health Service Administration's National Registry of Evidence-Based Practices, California Evidence-Based Clearinghouse for Child Welfare), and this treatment was one of the first behavioral programs reviewed in the National Institute on Drug Abuse's Principles of Drug Addiction Treatment

(National Institute on Drug Abuse, 1998). In Module 10, published by the National Institutes of Alcoholism and Alcohol Abuse (2005), this behavioral approach was said to be an “emerging developmentally sensitive approach” for drug use problems.

Appropriate Intervention Settings and Referrals

Settings

Evidence-based treatments (EBTs) are experimentally evaluated in specified clinical settings, most often including inpatient and outpatient mental health facilities, hospitals, homes, and school environments. Since outcome studies of FBT in adolescent samples have been conducted in outpatient mental health facilities, this is the preferred venue in which to implement FBT with targeted youth and their families. Outcomes resulting from the implementation of FBT have yet to be formally examined within the context of inpatient therapeutic milieus, peer group, multifamily, or exclusive individual applications. We are aware that at least some community-based agencies have been funded to implement FBT in home and inpatient mental health settings, and that their anecdotal findings appear to indicate positive results. However, it is important to emphasize that these programs have reportedly maintained the integrity of FBT implementation while treating families in private rooms as consistent with outpatient implementation. It may be that inpatient settings offer certain advantages over outpatient settings in the treatment of substance abusing youth. For instance, inpatient facilities assure easy access to FBT, prohibit drug use opportunities, and provide opportunities to implement FBT intensively. Nevertheless, in considering FBT for use in inpatient facilities, it is important to ensure that (a) significant others will be able to visit the facility to participate in FBT sessions, (b) patients will have sufficient time in the facility to learn the interventions, (c) treatment providers (TPs) will be able to engage participants in outpatient care subsequent to discharge, and (d) patients will be provided opportunities to practice newly learned skill sets during brief excursions from the facility.

Referrals

The exclusionary criteria in controlled clinical trials involving FBT in youth have been relatively relaxed to permit referrals from a variety of sources, including judges, juvenile justice probation and parole officers, school

8 Treating Adolescent Substance Abuse Using Family Behavior Therapy

administrators, and community TPs. Self-referrals are rare, with referrals from family members often occurring in response to pressure from court systems. FBT has demonstrated favorable outcomes with marijuana and hard drug abuse, alcohol abuse and various coexisting problems, such as depression, family dysfunction, stress, incarceration, unemployment, behavior problems, and school attendance. Youth who have been formally diagnosed with mental retardation, severe cognitive impairments, and psychosis have generally been excluded from our controlled trials of FBT. However, when persons with severe cognitive disabilities have been treated with FBT, or other treatments for that matter, the outcomes appear to be relatively poor (see Burgard, Donohue, Azrin, & Teichner, 2000).

General Approach and Structure to Treatment

Outcome Assessment

It is generally recommended that evaluation of FBT include the administration of assessment measures before, during, and after treatment. Sometimes primary measures (e.g., urinalysis) are administered throughout treatment. Assessing treatment outcomes is important because the derived data may be used to guide treatment, assist in determining the adequacy of fit between FBT and the treatment provider, demonstrate program improvements, and justify costs to funding agencies.

In determining which measures to administer, several factors should be considered. First, required consent and assent forms should be obtained consistent with state and federal licensing requirements, and the person administering, interpreting, and recording the respective measures and analyzing this data should be legally and ethically qualified to do so. The measures should be relevant to the presenting concerns.

The gold standard in drug abuse assessment is biological testing. Broad-screen urinalysis testing may be utilized to assess illicit drug use that may have occurred during the past few days, hair follicle tests are ideal to assess illicit drug use that may have occurred during the past several months, and Breathalyzer tests may be used to assess alcohol use that may have occurred within the past day. Our experiences have led us to conclude that biological testing procedures (i.e., urinalysis, Breathalyzer) should occur during treatment when there is reason to suspect drug use, and when contingency management is being implemented (i.e., rewards are provided when youth

are drug free as per urinalysis and reports of others). Broad screen or multiple-panel tests (i.e., each panel represents a substance) are recommended instead of select tests of specific substances because youth often experiment with various substances, and their substance use patterns are often irregular. Some TPs do not administer biological testing when youth admit to using substances. However, the administration of broad-screen urinalysis assists in determining if substances that were not reported may have been used. If youth disagree with the results of biological testing, it is important to simply indicate the testing procedures are the best objective estimate of drug use, and subsequently facilitate implementation of consequences that may have been established with the parent through contingency management. Sometimes youth report that biological testing may have come up positive for illicit drugs because something had been “slipped” into a drink at a party or that they were in a room with marijuana smokers and they inhaled the secondhand smoke. In such cases, it is important to initiate any consequences that may have been negotiated during the establishment of contingency contracting, and emphasize that goals should be set to avoid such risky situations in the future. Standardized procedures involving biological testing procedures may be obtained by the companies that sell these products. For instance, Redwood Toxicologies Inc. has a Web-based program relevant to learning to implement biological testing procedures that includes free certification.

Retrospective reports from youth and significant others regarding adolescents' number of days using illicit drugs and alcohol, as well as other problem behaviors (e.g., work and school attendance, days incarcerated), appear to be valid and reliable up to 6 months in retrospect when formal assessment methods are utilized, such as the Timeline Followback method (TLFB) developed by Mark and Linda Sobell. The Sobells maintain a web site at Nova Southeastern University that includes freely accessible information relevant to TLFB implementation.

Satisfaction scales offer utility in achieving goals for treatment. These include the Life Satisfaction (Donohue et al., 2003) and Youth Satisfaction With Parent Scale (DeCato, Donohue, Azrin, & Teichner, 2001) completed by youth and the Parent Satisfaction Scale (Donohue, Decato, Azrin, & Teichner, 2001) completed by parents. Each of these scales may be utilized to determine the respondent's satisfaction in a number of areas that have been validated to be relevant to improvements in substance abuse and conduct disorders (e.g., communication, school, work, chores). Utilizing a 0 to 100% scale, respondents

indicate for each of the domains their extent of happiness. Upon scale completion, respondents are queried to indicate how happiness may be improved in specific domains. These scales may be obtained from Dr. Donohue or the immediately aforementioned source articles free of charge.

Depending on various characteristics of the population receiving FBT, other assessment measures may be warranted, particularly measures of psychiatric symptoms and mental health diagnoses, family functioning, satisfaction with treatment, service utilization, and risk of contracting HIV. More information regarding specific assessment procedures used to evaluate the effects of FBT and other EBTs are reviewed in Allen, Donohue, Sutton, Haderlie, and LaPota (2009). In determining assessment procedures to utilize, it is important to ensure that they are standardized; evidence good psychometric properties; and are quick and easy to administer, score, and interpret. Depending on the specific setting in which FBT is implemented, assessment measures vary to accommodate the unique aspects of program referral sources, funding agencies, and state laws.

Orientation Session

Of course, immediately after the initial pretreatment assessment battery is scored and interpreted, an orientation to FBT should be provided to youth and adult significant others that includes opportunities for the youth and family to review the basic treatment structure and approach, review feelings about the referral, receive and provide feedback relevant to the assessment findings, and provide an opportunity to solicit commitments from youth and participating family members to follow established program guidelines (e.g., attend sessions, participate in session exercises and therapy assignments, engage in appropriate communication such as speaking calmly and briefly). To assist in this endeavor, an Orientation Prompting Checklist (Exhibit 1.1) and Communication Guidelines Handout (Exhibit 1.2) are included at the end of this chapter. It is recommended that administrators in community treatment programs review these orientation materials to determine the extent to which their content should be customized to accommodate the unique needs, laws, and culture of the treatment agency. The Orientation session precedes the formal implementation of treatment (see the following Treatment section). As indicated in the previous section, the satisfaction scales that are reviewed in the Orientation session are fully described and freely available in either peer-reviewed journals (DeCato

et al., 2001; Donohue et al., 2001, Donohue et al., 2003) or from Dr. Donohue directly.

Treatment

Number of Treatment Sessions FBT for adolescents usually includes up to 16 treatment sessions, and each session is approximately 60 to 90 minutes in duration. All scheduled sessions are usually implemented within 4 to 6 months, depending on the setting, presenting problems, available funding, and response of youth to treatment. Sessions fade in frequency and duration as therapeutic goals are accomplished.

Persons to Include in Treatment Sessions The youth referred to the treatment facility for substance abuse is considered to be the identified client in the FBT model. FBT is focused on assisting the youth client in maintaining long-term abstinence from illicit drugs, and accomplishing goals that are consistent with a healthy and prosperous lifestyle. Primary significant others are the legal guardians of the youth client (almost always a parent). At least one primary significant other, and both if available, is expected to attend each session and sign legal consent forms. Secondary significant others include family members and sometimes close friends. Significant others are recruited from the adolescents' social ecology to assist youth in attending their therapy sessions, completing their homework assignments, and providing encouragement and rewards to them when treatment goals are accomplished.

During sessions, significant others can model exemplary skills during role-playing exercises, encourage youth to participate in role-plays or discuss difficult situations, provide insights that are relevant to recovery, and provide youth empathy and support. Adolescent friends and family of youth may be involved in therapy as significant others. However, TPs need to be careful not to involve adolescents in age-inappropriate content, and these young significant others must be committed to facilitating sobriety and other therapeutic goals. Indeed, all significant others should ideally be sober (or evidence a desire to remain sober), have an interest in the youth's well-being, and be relatively well adjusted. Recruiting more than one of these individuals is helpful, although this is often difficult to achieve because youth often have strained relationships with appropriate adults and have established close friendships with other drug users.

Bob Meyers and Jane Ellen Smith detail an evidence-based method of recruiting appropriate significant others of substance abusers into therapy and successfully resolving issues that sometimes come up in this process (see Smith & Meyers, 2004).

Adolescent friends of youth clients who use illicit drugs and alcohol may be valuable to incorporate into treatment, provided they are interested in eliminating their own use of substances. Indeed, the inclusion of these individuals permits TPs to closely monitor their behavior and encourage and assist them in accomplishing a healthy lifestyle that does not include problem behavior. However, these persons must be carefully screened and monitored to ensure that their inclusion in therapy is likely to put youth at relatively less risk of harm than their being excluded from therapy. Of course, recruited significant others must be committed to ameliorate problem behaviors that have the potential to negatively influence youth clients. When significant others are deemed to be appropriate, it is important to tell them that although they may indirectly benefit from FBT, their role in therapy is to aid youth clients in accomplishing treatment goals. Our experiences have generally shown friends of youth clients are especially compliant during treatment sessions so parents feel comfortable permitting their children to spend time with them. Although this compliance may appear disingenuous, such behavior permits practice learning to occur and should be encouraged in therapy.

The role of small children is limited to reviewing the scheduled family activity during the Environmental (Stimulus) Control intervention (see Chapter 10), and providing and receiving positive statements during Reciprocity Awareness and Positive Request interventions (see Chapters 8 and 9, respectively), and the last session (i.e., see Chapter 13).

In each of the remaining chapters, recommendations are provided for TPs to consider in regards to how and when to involve significant others in therapy. Of course, ethical, legal, and programmatic issues will need to be considered in the inclusion of significant others. These issues are customarily reviewed in state and federal laws, and state licensing boards may be queried when relevant laws are unclear. However, legal consultation is highly recommended in the initial development of family-based treatment programming to assist in originating consent procedures and guidelines to review with youth and their participating significant others, such as how various issues that are influenced by relationships will be managed (i.e., establishing firm guidelines

in the prevention of “secrets” [e.g., infidelity], reviewing how significant others will be included in record-keeping procedures, consent for treatment, confidentiality).

Content of Therapy Following the aforementioned orientation, there are eight FBT intervention components that are commonly utilized in adolescent-focused FBT. The youth intervention components include:

1. **Consequence Review:** A structured activity in which youth are prompted to extensively review negative consequences of substance use and associated problem behaviors and positive consequences associated with living a drug-free lifestyle. Support and encouragement are provided within the context of motivational techniques.
2. **Level System:** A contingency management program in which primary adult significant others (usually parents) provide contingent rewards for desired behaviors that facilitate youth abstinence from illicit drugs and alcohol and accomplish problem-free behavior.
3. **Treatment Planning:** Involves the youth and the youth’s primary adult significant others’ choosing the order and extent to which specific FBT intervention components should be prioritized in therapy.
4. **Reciprocity Awareness:** Involves youth and youth’s significant others’ disclosing things they appreciate about each other, and expressing desired actions.
5. **Positive Request:** Involves the youth and youth’s significant others’ learning to positively request desired actions from one another.
6. **Environmental (Stimulus) Control:** Involves the youth and youth’s significant others’ learning to restructure their environment to facilitate interaction with people and activities that are associated with a substance-free lifestyle, while eliminating or managing emotions, people, and activities in the environment that increase risk of drug use and other problem behaviors. Pleasant family activities are also planned and subsequently reviewed.
7. **Self-Control:** Involves teaching the youth and youth’s significant others’ to identify and manage antecedents (triggers) to substance use and other troublesome behaviors.

8. *Job-Getting Skills Training*: Involves teaching the youth and youth's significant others' how to solicit and do well in job interviews.

Determining the Order and Extent to Which Intervention Components Are Implemented The order and extent to which the intervention components are implemented in therapy is fully described in Chapter 4 (Establishing Effective Agendas for Treatment Sessions). However, in short, after the Orientation session is conducted, the Consequence Review (see Chapter 5) and Level System (see Chapter 6) are sequentially implemented to assist in gaining motivation for treatment. Treatment Planning is implemented next. The order in which the remaining intervention components are implemented for the first time is mutually determined by the youth and parents during Treatment Planning (see Chapter 7). The extent to which treatments are subsequently implemented, with the exception of Treatment Planning because it is implemented only once, will depend on their effectiveness as determined mutually among the youth, the youth's parents, and the TP. Treatments that appear to be effective are implemented more often than ineffective interventions.

Method of Transitioning Between Treatment Sessions An agenda is provided by the TP at the start of each session (see Chapter 4). In doing so, TPs initiate agendas by pointing out positive efforts that may have occurred during the most recent session, and briefly mentioning interventions that are intended for review in the current session (including estimated times to complete each intervention). Youth and family members are invited by TPs to modify agendas based on unanticipated circumstances that may have arisen since the last treatment session (e.g., severe arguments, youth wanting to withdraw from school).

Structure of Intervention Chapters Details regarding how to implement each of the primary interventions are described in Chapters 5 through 12. Each of these chapters include (a) an overview of the intervention approach; (b) goals for the intervention; (c) materials needed to implement the intervention; (d) the specific treatment procedures, including implementation dialogues among youth, TP, and family members; (e) initial and future prompting checklists to guide TPs during treatment implementation; and (f) worksheets and handouts to assist in treatment delivery.

Prompting Checklists Guide Treatment Providers in Sessions The Consequence Review and Treatment Planning interventions each include a single prompting checklist, while each of the remaining interventions include two prompting checklists (initial, future sessions). The initial checklist is specific to the first session the respective intervention component is implemented (e.g., Initial Session Prompting Checklist for Self-Control, Initial Session Prompting Checklist for Environmental Control). The other prompting checklist is used when the respective intervention is implemented in subsequent treatment sessions (e.g., Future Session Prompting Checklist for Self Control). Prompting checklists are included at the end of each of the chapters. Prompting checklists are basically summaries of the specific procedures or steps required to implement the treatments. Because prompting checklists are designed to be used by TPs during sessions, each checklist item is a succinct instructional prompt written in shorthand so TPs can quickly glance at the instruction during treatment and consequently implement what is being prompted. The instructions are listed in the order in which TPs should implement them. During implementation, TPs put the respective checklist on their lap or nearby desk. They briefly glance at the checklist, look up, and proceed to implement what is being prompted with the family. Treatment providers then respond to youth and their significant others as they feel appropriate, implement the next instruction, and so on until all intervention steps in the prompting checklist are complete. Of course, comfort, confidence, and skill in utilizing the prompting checklists is enhanced with continued practice and preparation. Most TPs experience some anxiety in utilizing the checklists initially. However, these anxieties will eventually be overshadowed with successful implementation. Each of these checklists have undergone hundreds of revisions based on the input of TPs in community-based treatment centers and scientists in controlled trials to encourage therapeutic freedom in responding to the concerns of clients. Using these prompting checklists is the best way to ensure that TPs implement all critical components of each intervention and, in this way, assist in ensuring treatment integrity. Until TPs are familiar with the implementation of FBT, they should utilize the prompting checklists faithfully.

The general content or “meat” of each *initial* intervention session prompting checklist pertains to: (a) providing family members a rationale for the treatment (i.e., problem behavior that is expected to be addressed, brief description of intervention, why intervention is likely to work); (b) developing the skill

set through participation in simulated role-play scenarios and structured exercises; and (c) assigning homework to practice the learned skill set.

The general format of each *future* intervention session includes: (a) discussing homework assigned during the last therapy session, (b) practicing or behaviorally enacting skill sets that were assigned during the last therapy session, and (c) assigning homework to continue practicing the skill set (if necessary). The number of future sessions implemented for each intervention component is determined mutually between the youth, participating significant others, and TP. Use of these prompting checklists assists in maintaining the integrity of the intervention so that all needed components are implemented, thereby increasing the effectiveness in treatment. For these reasons, TPs are encouraged to closely follow the protocols, but in doing so are also encouraged to use nonprescribed procedures whenever indicated between the prescribed steps.

It is important to emphasize that treatment sessions may include the implementation of several interventions, and that intervention components may be temporarily suspended or abandoned to permit timely implementation of other intervention components. For instance, if the Environmental (Stimulus) Control intervention were being implemented during a treatment session, and a client spontaneously indicated that she wanted to learn to be assertive when talking with her father, the TP could put down her prompting checklist for Environmental (Stimulus) Control, and take out a prompting checklist for the Positive Request procedure (as well as other requisite handouts) to teach her to be assertive. After the Positive Request procedure was implemented, the TP could return to the Environmental (Stimulus) Control intervention if time permitted, end the session, or proceed to another intervention component. This approach to treatment encourages treatment integrity while being flexible to address contemporaneous concerns. In the latter example, the TP's integrity for Environmental (Stimulus) Control would be based on the steps she did or did not complete up to the point at which she stopped administering the respective treatment components (see Treatment Integrity section below).

Treatment Integrity Although there are a number of ways to define *treatment integrity* or *protocol adherence*, these terms generally concern the extent to which TPs implement a given intervention in a manner that is consistent with the way it was determined to be efficacious. Importantly, programs

that utilize standardized manuals and evaluate treatment integrity are consistently rated better than those programs that do not (Moyer, Finney, & Swearingen, 2002). As emphasized by Power et al. (2005), it is imperative that treatment programs conduct comprehensive assessment of intervention integrity or protocol adherence. The methods of measuring treatment integrity vary, although there is some evidence to suggest that examining audiotapes or videotapes of therapy sessions appears to be the most accurate way to assess TPs' adherence to therapeutic protocols (Del Boca & Darkes, 2007).

Therapists utilize two approaches to ensure treatment integrity, with the first focusing on overall adherence in completing the steps necessary to implement the intervention, and the second addressing skill of the TP. Research demonstrates that these methods of assessing protocol adherence in FBT are both valid and reliable in TPs participating in controlled treatment outcome studies (e.g., Azrin et al., 2001) and in community-based TPs (Sheidow et al., 2008). Family Behavior Therapy is especially amenable to the assessment of treatment integrity because all FBT intervention components are specified in the initial and future session therapist prompting checklists. These steps are unambiguous, easy-to-understand instructions that are listed sequentially, permitting TPs to use them as prompts during treatment implementation, and permitting trainers to easily and objectively monitor them during their audio or video reviews of sessions. The prompting checklist method of treatment administration also has practical utility. That is, it encourages TPs to achieve a high degree of treatment integrity (implementation of one step prompts the next step, and so on), while permitting them to compute their own assessment of protocol adherence (their own completed checklist may be used to estimate adherence).

The Treatment Integrity Review Form (Exhibit 1.3) is used to record the results of protocol adherence assessments. In assessing protocol adherence for FBT, TPs examine their completed prompting checklist after the therapy session and divide the number of steps completed by the number of steps that were possible in the sections that were said to be implemented. They then multiply the resulting dividend by 100. The resulting score represents the percentage of steps completed for the respective intervention. Scores above 80% are generally considered to indicate good treatment adherence, while scores between 70% and 79% are considered adequate. Trainers (or other persons or raters examining treatment adherence, such as supervisors) independently complete their own prompting checklists while listening to the session audiotapes, and compute their assessment of protocol adherence in the same way

as the TP. Thus, protocol adherence scores may be derived for both the TP and trainer (or other persons or raters examining treatment adherence).

Reliability is determined by dividing the number of agreements between the TP and trainer (number of items or steps both the TP and trainer agreed were either completed or not completed) by the number of disagreements between the TP and trainer (number of items or steps the TP and trainer disagreed were either completed or not completed) *and* agreements between them. The resulting number is multiplied by 100 to yield the percentage agreement score. Eighty percent or higher means reliability between the TP and trainer in assessing treatment integrity is good, while 70% to 79% is adequate.

For example, in the Self-Control Intervention Prompting Checklist for Future Sessions, there are 24 items or steps. If the TP indicated that 24 items were completed, the TP's estimate of treatment integrity would be 100%. If the trainer indicated that 22 of the 24 steps were completed, the trainer's estimate of treatment integrity would be 92%. In computing their reliability, if the TP and trainer agreed that the first 21 items and the last item were performed, there would be 22 agreements. If the trainer stated that the 22nd and 23rd items were not performed, and the TP stated that the 22nd and 23rd items were performed, they would have two disagreements. Thus, reliability would be computed as agreements (22) divided by agreements (22) + disagreements (2) multiplied by 100, or in this case, $22/24 \times 100 = 91.7\%$. Thus, the percentage agreement score would be 91.7 percent, indicating excellent reliability.

In both community and research settings, it is recommended that all therapy session audiotapes be submitted to an appropriate administrator, and that only approximately 10% of these session audiotapes be randomly selected for review by the trainer (or other rater) to enhance feasibility. To assist in the provision of feedback from the trainer to the TP, and enhance treatment integrity, the Treatment Integrity Review Form includes a section where the TP's overall "skill level" can be recorded by the trainer (or rater) utilizing a 1 to 7 Likert-scale: 7 = extremely skilled, 6 = very skilled, 5 = somewhat skilled, 4 = neutral, 3 = somewhat unskilled, 2 = very unskilled, 1 = extremely unskilled. The top of each prompting checklist includes a spot where the name of the trainer may be recorded, as well as the date of the review. Finally, there is a spot at the bottom of each prompting checklist to write notes about the intervention to facilitate qualitative comments about the delivery of therapy.

This highly reliable and valid method of measuring treatment integrity has a number of unique advantages. Indeed, it is psychometrically reliable

and valid, administratively feasible, and facilitates learning as TPs use the checklists both as instructional prompts during therapy and to score their own adherence to therapy.

Consumer Satisfaction and Compliance Ratings

After each intervention component is implemented, the youth client is asked to rate the extent to which the intervention was perceived to be helpful (on a 7-point scale), and the TP rates the extent to which the client was compliant (on a 7-point scale; see Table 1.1). These ratings are recorded at the end of each of the prompting checklists, thus permitting an examination of consumer satisfaction (i.e., youth helpfulness) and TP assessed compliance with the family each time a treatment component is implemented. As exemplified below, TPs are prompted to assess these ratings, and to facilitate discussion about how these ratings were derived, and how the intervention component can be improved in the future for the family.

Consumer satisfaction ratings are important to obtain because high scores are indicative of future interest in the respective therapy, whereas low scores may demonstrate a lack of confidence and enthusiasm in the intervention. Of course, assessing consumer satisfaction is also likely to show youth that

Table 1.1. Method of Assessing Consumer Satisfaction and Compliance of Family in Treatment.

Helpfulness Ratings

___a. Solicit youth's rating of helpfulness for the respective treatment component on the following 7-point scale after stating the youth should not feel obligated to provide high scores because an honest assessment helps the treatment provider better address youth needs.

(7 = extremely helpful, 6 = very helpful, 5 = somewhat helpful, 4 = not sure, 3 = somewhat unhelpful, 2 = very unhelpful, 1 = extremely unhelpful). Youth's Rating: ____.

___b. Solicit how rating was derived & methods of improving the intervention component in the future.

Compliance Ratings

___a. Disclose therapist's rating of the youth and family's compliance on the following 7-point scale (7 = extremely compliant, 6 = very compliant, 5 = somewhat compliant, 4 = neutral, 3 = somewhat noncompliant, 2 = very noncompliant, 1 = extremely noncompliant). Therapist's Rating: ____

Factors that contribute to compliance ratings are:

Attendance

Participation & conduct in session

Homework completion

___b. Explain how the rating was derived and methods of improving performance in future.

the TPs are interested in the youths' opinions about their treatment plan, and this procedure provides opportunities to modify treatment planning to be commensurate with youths' interests. Indeed, low scores may suggest that a treatment is not working or that a treatment is not desired in its current method of implementation and may need to be adjusted. The compliance ratings include three process measures that have consistently been predictive of treatment outcome (i.e., attendance, participation, and homework completion). TPs are also encouraged to consider significant others when compliance ratings are assessed. Providing youth positive feedback lets them know these things are valued. Indeed, with permission from youth, the compliance ratings are provided to referral agents (see Monthly Progress Reports in the appendix of this chapter), thus enhancing the meaningfulness of these ratings and potentially motivating youth to do well.

Concluding Remarks

This chapter provided a general background of FBT, including its historical, theoretical, and empirical underpinnings in youth who have been afflicted with substance abuse and dependence; outcome support to assist in determining appropriate referrals; and strategies to maintain and assess treatment integrity. As indicated, FBT is clearly a robust, empirically supported intervention capable of managing a wide range of problem behaviors. In addition to being relatively easy to learn and monitor, it is exciting to implement. Whereas most of this chapter was focused on the general structure of FBT, the remaining chapters will focus on therapeutic strategies and specific content involved in the effective implementation of this approach.

Supporting Materials for Chapter 1: Introduction to Family Behavior Therapy

Exhibit 1.1. Orientation Prompting Checklist.

<div style="border: 1px solid black; padding: 10px; display: inline-block;"> <h2 style="margin: 0;">ORIENTATION PROMPTING CHECKLIST</h2> </div>	
Youth ID#: _____	Treatment Provider: _____
Session #: _____	Date of Session: _____
Reviewer (if person completing checklist is different from treatment provider): _____	
Materials Required:	
<ul style="list-style-type: none"> • Summaries of the assessments that were administered pretreatment. • Completed Satisfaction Scales (e.g., Parent Satisfaction With Youth, Youth Satisfaction With Parent, Youth Life Satisfaction Scale). • Communication Guidelines Handout. 	
Begin Time: _____	
Program Policies	
Review of General Issues Relevant to FBT Context (Youth and Appropriate Significant Others):	
<p>___ a. Sessions may be audio-recorded so supervisors can monitor therapy for treatment integrity.</p> <ul style="list-style-type: none"> • Sessions usually: <ul style="list-style-type: none"> ___ 1. Last 60 to 90 min. ___ 2. Occur once per week. ___ 3. Last 4 to 6 months. 	
<p>___ b. Explain how prompting checklists will be used during sessions to assure optimum care.</p> <ul style="list-style-type: none"> • Show copy of a protocol checklist. 	
<p>___ c. No smoking, alcohol use, or intoxication is permitted during sessions.</p>	
<p>___ d. Phone calls should be avoided during sessions unless emergency or special circumstance.</p> <ul style="list-style-type: none"> • Check-up calls may occur each week between sessions so treatment provider may: <ul style="list-style-type: none"> ___ 1. Ensure youth’s needs are met. ___ 2. Answer questions. ___ 3. Assist in obtaining referrals for additional support. ___ 4. Assist w/ implementation of interventions. ___ 5. Assist w/ practice assignments. ___ 6. Develop plans in working w/ court or other professionals. • Review the following program policy issues relevant to missing sessions: 	

- ___ 1. With consent, others may be notified of missed/late sessions.
- ___ 2. Treatment provider should be contacted 24 hrs. in advance to reschedule.
- ___ 3. Provide appointment card w/ scheduled day and times of future sessions (tell to put in conspicuous place).
- ___ e. Assure telephone or other methods of contacting therapist are available.
- ___ f. Assure all persons understand relevant State and federal laws, including confidentiality, and its limits.

Case Review

Review of Youth Experiences and Feelings About Referral (Youth and Appropriate Significant Others)

- ___ a. Review reasons for referral.
 - Empathize w/expressed concerns.
 - Generate solutions to expressed concerns.
- ___ b. Solicit problems experienced, or expected to occur w/ person/agency making referral.
- ___ c. Solicit things that can be done to support family w/person/agency responsible for referral.
- ___ d. Solicit general goals for therapy.
 - Provide support/empathy, and clarify inaccuracies.

Review of Pretreatment Assessment (Usually Youth and Appropriate Significant Others)

- ___ a. Solicit potential concerns w/ pretreatment assessment.
 - Empathize and/or generate solutions to manage expressed concerns.
 - For each target drug that was assessed to occur, do the following (**may need to review w/ youth only**).
 - ___ 1. Solicit age and circumstances associated with first use.
 - ___ 2. Solicit current circumstances that appear to be associated with higher rates of substance use.
 - ___ 3. Solicit current circumstances that appear to be associated with lower rates of substance use.
 - ___ 4. Solicit positive and negative consequences of use.
- ___ b. Attempt to obtain commitment from youth to eliminate drug and alcohol use and other identified problem behaviors.
 - If abstinence from substances is refused, attempt to obtain commitment from youth to reduce use.
- ___ c. Show youth completed Life Sat. Scale and Youth Sat. w/Parent Scale (**may need to review w/ youth only**)
 - ___ 1. Query why areas that are rated relatively high are rated so.
 - ___ 2. Query why areas that are rated relatively low are rated so.
 - ___ 3. Query what would need to happen to bring about 100% satisfaction in low areas.
- ___ d. Show parent completed Parent Satisfaction with Youth Scale (**may need to review with appropriate significant others only**).
 - ___ 1. Query why areas that are rated relatively high are rated so.
 - ___ 2. Query why areas that are rated relatively low are rated so.
 - ___ 3. Query what would need to happen to bring about 100% satisfaction in low areas.
- ___ e. Attempt to obtain commitment from significant others to help youth reduce drug use or maintain abstinence.

- ___ f. Provide results for other assessment measures & solicit/answer questions.
 - If disagreements occur, query reasons for disagreement, empathize, and mention other areas will be emphasized in treatment.
- ___ g. Query how youth can be supported in life.
 - ___ 1. Show how treatment provider will attempt to provide assistance in these areas.
 - State other youths have indicated therapists have supported in the following ways:
 - ___ a. Supportive letters to person or agency responsible for referral, if relevant.
 - ___ i. Explain youth performance ratings will occur after each treatment is implemented and summarized in letters of support.
 - ___ ii. Explain ratings based on performance of caregivers and youth.
 - ___ iii. Explain letters will emphasize youth's progress in accomplishing treatment goals.
 - ___ iv. State effort will be made to show youth letters before they're sent.
 - ___ a. Solicit how supportive letters will be helpful.
 - If a referral agent is not involved, explain information about the youth's participation in treatment may help if future problems occur.
 - ___ b. Assistance in maintaining family unity (i.e., keep family together, calm home environment).
 - ___ i. Solicit how this would be helpful.
 - ___ c. Assistance gaining better jobs w/ greater income.
 - ___ i. Solicit how this would be helpful.
 - ___ d. Assistance maintaining or "getting out" of trouble (e.g., court, school suspensions) by promoting efforts of youth.
 - ___ i. Solicit how this would be helpful.
- ___ h. Solicit greatest motive for being involved in treatment.
- ___ i. Solicit how youth and significant others will be able to motivate themselves to accomplish goals.
- ___ j. Explain success of FBT.
- ___ k. Explain how FBT is expected to be particularly beneficial to youth and significant others.

Communication Policy

Rationale for Communication Policy (Youth and Significant Others)

- Explain the following:
 - ___ a. Lots of material to cover in upcoming sessions.
 - ___ b. Important to review guidelines to maintain good communication and get through session material quickly.
 - ___ c. Guidelines apply to all family members.
 - ___ d. If a guideline is broken, person will be instructed to correct guideline.
 - ___ e. Other families have found these guidelines to be effective
 - ___ f. Solicit questions.

Review Communication Policy (Youth and Significant Others)

- ___ a. Give participants a copy of Communication Guidelines Handout
 - State the following guidelines and obtain commitments from each family member to comply w/ each one:

- ___ 1. Avoid interruptions; instead, wait for person to pause or ask if it is O.K. to speak
- ___ 2. Avoid talking for more than a minute.
- ___ 3. Avoid saying "no" when someone asks for something, instead say the part you can do.
- ___ 4. Avoid rolling eyes back or using other negative facial expressions.
- ___ 5. Avoid swearing, shouting, use of sarcasm, spite, or statements that are hurtful.
- ___ 6. Avoid talking about past problems or weaknesses; instead, suggest solutions and build on strengths.
- ___ 7. Stay focused on specific desired actions, not overall criticisms of what negative attitudes are disliked.
- ___ 8. Speak in a soft and conversational tone of voice.

Helpfulness Ratings

- ___ a. Solicit youth's rating of helpfulness for the respective treatment component on the following 7-point scale after stating the youth should not feel obligated to provide high scores because an honest assessment helps the treatment provider better address youth needs.
(7 = extremely helpful, 6 = very helpful, 5 = somewhat helpful, 4 = not sure, 3 = somewhat unhelpful, 2 = very unhelpful, 1 = extremely unhelpful). Youth's Rating: ____.
- ___ b. Solicit how rating was derived and methods of improving the intervention component in the future.

Compliance Ratings

- ___ a. Disclose therapist's rating of the youth and family's compliance on the following 7-point scale (7 = extremely compliant, 6 = very compliant, 5 = somewhat compliant, 4 = neutral, 3 = somewhat noncompliant, 2 = very noncompliant, 1 = extremely noncompliant).
Therapist's Rating: ____
 - Factors that contribute to compliance ratings are:
 1. Attendance
 2. Participation and conduct in session
 3. Homework completion
- ___ b. Explain how the rating was derived and methods of improving performance in future.

End Time: _____ **Reviewer notes:**

Exhibit 1.2. Communication Guidelines Handout.

COMMUNICATION GUIDELINES HANDOUT

1. **Avoid interruptions.** Instead, wait for the person to pause, or ask if it is O.K. to speak.
2. **Avoid talking for more than a minute.**
3. **Avoid saying "no" when someone asks for something.** Instead, tell the person what you can do.
4. **Avoid rolling eyes or using negative facial expressions.**
5. **Avoid swearing, shouting, sarcasm, or statements that are hurtful.**
6. **Avoid talking about past problems or weaknesses.** Instead, suggest solutions and talk about strengths.
7. **Talk about things you want, do not give criticisms about the negative attitudes you dislike.**
8. **Speak in a soft and conversational tone of voice.**

Exhibit 1.4. Method of Assessing Consumer Satisfaction and Compliance of Family in Treatment.

ASSESSING CONSUMER SATISFACTION AND COMPLIANCE OF FAMILY IN TREATMENT

Helpfulness Ratings

- ___ a. Solicit youth's rating of helpfulness for the respective treatment component on the following 7-point scale after stating the youth should not feel obligated to provide high scores because an honest assessment helps the treatment provider better address youth needs.
(7 = extremely helpful, 6 = very helpful, 5 = somewhat helpful, 4 = not sure, 3 = somewhat unhelpful, 2 = very unhelpful, 1 = extremely unhelpful). Youth's Rating: ____.
- ___ b. Solicit how rating was derived and methods of improving the intervention component in the future.

Compliance Ratings

- ___ a. Disclose therapist's rating of the youth and family's compliance on the following 7-point scale (7 = extremely compliant, 6 = very compliant, 5 = somewhat compliant, 4 = neutral, 3 = somewhat noncompliant, 2 = very noncompliant, 1 = extremely noncompliant).
Therapist's Rating: ____
- Factors that contribute to compliance ratings are:
 1. Attendance
 2. Participation and conduct in session
 3. Homework completion
- ___ b. Explain how the rating was derived and methods of improving performance in future.

