

**APT**

**ADOLESCENT PORTABLE THERAPY**

# **ADOLESCENT PORTABLE THERAPY:**

*A Practical Guide for Service Providers*

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*January 2005*

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## INTRODUCTION

### ***A. About this manual***

This manual is a practice and reference guide for service providers interested in implementing Adolescent Portable Therapy (APT), an intervention that targets substance-using adolescents involved in the justice system. The manual, which provides a theoretical framework as well as procedures and techniques, is designed to serve as a flexible resource for providers seeking to engage and motivate families throughout treatment. It covers parenting skills and techniques for improving family relationships; addressing substance abuse in individual and family therapy sessions; and curbing behavior problems such as school truancy and anti-social peer involvements. The manual also guides providers in how to help parents collaborate with post-release supervision systems.

For the most part, the manual is intended to serve as a starting point for program planners interested in implementing APT in their own jurisdictions. The manual is organized into several distinct sections, some of which overlap nonetheless. Its overall structure is intended, however, to present issues and interventions chronologically—in the order they will likely arise or need to be implemented by program planners or therapists.

### ***B. Acknowledgements and contact information***

The APT treatment program described in this manual was developed by the Vera Institute of Justice, a non-profit organization based in New York City that works closely with leaders in government and civil society to improve the services people rely on for safety and justice. Information about the Vera Institute and the APT program is available on the Vera Institute's website, [www.vera.org](http://www.vera.org).

This manual was conceived and written by APT Director Evan Elkin with contributions from Jean Callahan and Ben Roth. We would like to thank Kate Kraft, Michael Dennis, Aaron Hogue, Kevin Moore, Randy Muck, Laura Nissen, and Fiona True for their guidance and support over the years. APT would also like to thank the New York City Department of Juvenile Justice for their partnership with us on the project. Technical assistance, consultation services, and additional information about implementing or adapting APT may be obtained by contacting:

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## **C. Notes on terminology**

### **1) References to ‘family’ and ‘family members’**

Throughout this manual, the terms “family” and “family members” refer to the same thing: all individuals involved in APT treatment, including the adolescent whose behavior was the catalyst for treatment and all adults and other minors who may be living in the adolescent’s household.

### **2) References to parents, caregivers and other involved adults**

Most adults involved in APT treatment are parents of the adolescent. However, sometimes the adolescent is being raised by just one parent or by a grandparent or another adult who is not a parent. The APT model remains the same regardless of who the primary caregivers are. The authors of this manual are aware of the wide range of possible relationships that involved adults might have with adolescents in APT: for the sake of consistency, though, they decided to primarily use the words “parents” or “parent.” References to “parents” or “parent” throughout this manual should be considered applicable to all caregivers and adults involved in APT treatment.

### **3) How ‘juvenile’ is defined**

Most young people who enter APT with their families are between the ages of 13 and 18. Throughout this manual, the words “juvenile,” “adolescent,” “kid,” “child” and “client” are generally synonyms that refer to the young person who is involved in the juvenile justice system and is now seeking to reintegrate into the community. Plural forms of these words are also used frequently.

### **4) How ‘juvenile justice’ is defined.**

APT was created to serve adolescents who are arrested and become involved in the justice system. In New York State, that system is the “juvenile justice” system if the young person is under age 16 when he commits the crime; it becomes the “criminal justice” system at age 16, when that young person is treated as an adult. Different jurisdictions have different boundaries between these systems. APT does not see itself as limited to the juvenile justice system because that is where the treatment was first developed; instead, it treats substance-abusing adolescents of a certain age (from 13 through 18) whose arrest brings them into contact with the overall justice system. The authors’ use of the term “juvenile justice system” is not meant to exclude the criminal justice system if adolescents find themselves in that system.

### **5) Gender references**

APT has no gender restrictions or policies. Both boys and girls may be involved in APT therapy, as may both mothers and fathers and other adults of either gender. To reduce unwieldy phrases, the authors of this manual use “he,” “his” and “him” in instances when either gender may apply or the gender is otherwise not specified.

## **CHAPTER 1**

# **THE BASICS OF APT**

### **A. What is APT?**

Adolescent Portable Therapy (APT) is an intensive family- and community-based intervention developed to treat adolescents who are heavy substance abusers. APT was created to serve juvenile justice–involved adolescents and their families in New York City as the young people move through the justice system and re-enter the community. The APT model is designed to be flexible enough to be adapted to other environments where home-based family therapy intervention is needed.

APT’s planners based the model on growing evidence in the adolescent treatment community suggesting that intervention strategies are more likely to bring about lasting change in an adolescent’s drug use and problem behavior if they take a multi-target approach—with a primary emphasis on working with the entire family. Examples of similarly structured models include multisystemic therapy (MST),<sup>1</sup> multidimensional family therapy (MDFT),<sup>2</sup> Cannabis Youth Therapy (CYT),<sup>3</sup> Brief Strategic Family Therapy (BSFT),<sup>4</sup> and multidimensional therapeutic foster care (MDTFC).<sup>5</sup>

Intervention strategies in these treatment models vary, but all stress the critical importance of including all family members in the treatment process. Furthermore, most of these evidence-based models

- emphasize strength-based approaches;
- incorporate the principles of a behavioral or skill-based approach, like cognitive behavior therapy (CBT), to changing adolescent behavior; and
- stipulate that the intervention must take place where adolescent behavior is learned and reinforced: at school, in peer environments, in the home with family members and within other community settings.

Taken together, these various program elements represent the national blueprint for effective treatment for juvenile justice–involved adolescents with serious substance-abuse problems.

The APT model builds on the strengths of existing evidence-based programs and emphasizes strategies that closely meet the needs of juvenile justice–involved adolescents in an urban community like New York City. APT is unique in that it is based

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<sup>1</sup> See [www.mstservices.com/](http://www.mstservices.com/).

<sup>2</sup> See [http://phs.os.dhhs.gov/ophs/BestPractice/mdft\\_miami.htm](http://phs.os.dhhs.gov/ophs/BestPractice/mdft_miami.htm).

<sup>3</sup> Cannabis Youth Therapy is an initiative sponsored by the Substance Abuse & Mental Health Services Administration (SAMHSA), a division of the U.S. Department of Health and Human Services. Additional information may be found online at <http://www.samhsa.gov>.

<sup>4</sup> Brief Strategic Family Therapy was developed by the Family Therapy Institute of Miami. Additional information is available online at <http://www.brief-strategic-family-therapy.com/bsft>.

<sup>5</sup> For more information, see under “Foster Care Services” on the Oregon Youth Authority’s website at <http://www.oregon.gov/OYA/FIELD/services.shtml>.

on identifying adolescents when they are first detained and then working with them as they move through the juvenile justice system. No matter what happens in court, under the APT approach the case remains active and treatment is provided until the youth returns home. The model blends a family therapy approach with the most effective elements of cognitive behavior therapy rather than treating them as distinct arms of the treatment.

The following are the core principles of APT's treatment model:

- **APT is a continuity of care model with a strong emphasis on the adolescent's re-entry into the community and family.** APT consists of services for adolescents both during their direct involvement with the juvenile justice system and over a four-month period afterward as they re-enter the community.
- **APT is family-centered.** APT is based on the belief that strengthening family functioning and targeting family problems that influence an adolescent's behavior are essential elements in the effort to bring about lasting change.
- **APT treats adolescents and their families in their own environments.** Evidence indicates that treatment is more accessible, meaningful and effective if provided on an adolescent's familiar turf—his home, school and community.
- **APT is strength-based.** Treatment aims to capitalize on the existing strengths of the adolescent and other family members to bring about change.
- **APT is culturally sensitive.** APT's approach to family therapy recognizes culturally specific aspects of family structure and functioning such as parenting roles and practices, behavioral expectations and issues of acculturation with immigrant families.
- **APT treatment is developmentally relevant.** In recognition of the fact that adolescence is a time of rapid growth and change, APT adapts to the specific developmental needs of each client and helps family members integrate parenting practices that are in line with these needs.

## ***B. Does APT work?***

Many factors must be weighed when analyzing the effectiveness of a treatment model, especially since definitions of what constitutes success vary greatly among practitioners, parents and adolescents themselves. That being said, anecdotal accounts and scientifically rigorous analysis both indicate that in most cases, the treatment goals established under the APT model have been met consistently and satisfactorily.

In the most extensive evaluation effort, the Vera Institute's research department in 2001 initiated a three-year analysis of APT's effectiveness in reducing substance abuse, improving family functioning, increasing school attendance and addressing related behavior problems and mental health symptoms. The evaluation was conducted using an experimental design comparing adolescents enrolled in APT with a randomly assigned control group whose members qualified for treatment but did not get APT



services. Baseline interviews were conducted at enrollment in APT and follow-up interviews were done at three, nine and 15 months after re-entry to the community. Though longitudinal follow ups are still in progress, it is clear from the research analyzed so far that improvements in substance abuse, family functioning and mental health indicators for adolescents enrolled in APT are significant compared with the control group. Current research updates for APT are available on the Vera website at [www.vera.org](http://www.vera.org).

### ***C. APT's portability across systems***

In a few cities and states, juvenile justice systems are integrated to ensure continuity of service. This is not the case in most jurisdictions, however, where juvenile justice systems consist of a web of agencies (local corrections, probation, state corrections, etc) that rarely coordinate activities and policies. A move between detention facilities within the same agency or from probation supervision to state custody often results in a complete termination of services for the youth. He is forced to “start again” with new counselors and caregivers.

APT is designed to be portable across systems, thus eliminating such disruptions in service. It offers continuity of care by creating a treatment provider with authority to follow adolescents from agency to agency and into the community.

APT is also portable in its delivery of services. Standard clinical treatment information emphasizes “meeting the clients where they are,” but rarely is this advice taken as literally as it is in the APT model. APT therapists do not deliver treatment from a fixed location; instead, they work with kids and families inside detention facilities, in family court and in their homes. The model seeks to make access to services as easy as possible for kids and their families.

## CHAPTER 2

### **COLLABORATING WITH GOVERNMENT PARTNERS**

Coordinating services with multiple agencies at multiple locations is a challenge that requires the provider to understand a complex set of inter-related systems and to appreciate the importance of relationship building at all levels. APT providers must navigate systems such as family or criminal court, residential facilities, probation departments and state agencies. Providers' success in collaborating with government agencies depends on their ability and willingness to build trust. The agencies must know that providers are allies who seek to provide quality services to their clients.

Establishing positive with government agencies can be difficult at first. Even under the best of circumstances, introducing new services to a system initially creates more work for the government agency. While the commissioner or other officials who run the systems may strongly support bringing APT into their agencies, line staff may have an entirely different view. Giving a new provider access to clients has one immediate consequence for them: more work. They may be expected to take on new tasks such as escorting kids to or participating in sessions, corresponding with APT therapists and cooperating with behavioral interventions. Given these potential additions to their regular tasks, it is not surprising that staff in facilities and in the courts might initially resent APT therapists' involvement.

Therapists might consider the following ways to overcome potential resentment from line staff and establish effective relationships with them:

- ***Be an asset***  
Therapists can find ways to help staff. For instance, if dealing with probation, they can do some of the leg work on school placement. If planning a session for a day when facility staff are going to be busy, it may be useful to ask staff what time work best for them.
- ***Let agency staff know that APT works***  
Although often overworked, most staff at facilities and supervisory agencies care deeply about the kids they serve and will make every effort to improve their lives. Taking the time to explain that APT is a proven method of helping kids will go a long way toward gaining staff cooperation.
- ***Help agency staff understand that success depends upon them***  
One of the most effective ways APT therapists can enlist the help of line staff is to simply let them know that they are counting on them. Staff should be aware that APT therapists recognize that the program will not work without their invaluable help.
- ***APT therapists must always be polite and helpful***  
Dealing with agencies that are not accustomed to change can be very frustrating, especially during initial implementation. APT therapists should be trained on how to maintain cordial relations even when they are not being treated well. They should bring back grievances to their supervisors rather than seek to address them with agency staff at the moment.

- ***Always have a contact higher up in the agency***  
No matter how polite APT therapists may be, there will be times when they need assistance breaking through an agency's culture. It is important to establish contacts at the high and middle management level; a well-placed phone call from a high-ranking agency official is often all that is needed to address the problem satisfactorily.
- ***Take time to get to know partners***  
APT therapists must have a thorough understanding of the agencies, including their structure, culture, leadership and organization. There is no substitute for simply spending time at the agency, for instance sitting in the intake area one evening, sitting in court for a day to watch cases being processed or organizing focus groups with kids and the staff who serve them.

## **CHAPTER 3**

### **HOW APT IDENTIFIES APPROPRIATE CLIENTS**

One of the unique features of APT as it was created is that clients are screened, assessed and initiated into treatment before therapists know what will happen with their cases. Some kids are released to the community immediately after APT intake is finished; others, meanwhile, are placed in state custody for up to a year.

Regardless of the expected outcome, services are provided immediately and are continued both in secure facilities and for four months after the youth is released to the community. APT's early intake system and willingness and ability to follow clients wherever they may be provides continuity of care in a system that often seems designed to prevent such continuous care.

#### ***A. Admissions criteria***

APT is an extremely intensive program that serves high-need kids. Therefore, the admission criteria are very high. APT only takes kids who report 30 uses of a substance in the 30 days prior to detention or those who meet criteria set for substance abuse or dependence by the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is issued by the American Psychiatric Association. While these criteria are not required to implement APT in another location, APT staff should recognize that it may not be appropriate to use such an intense level of service with kids who are not high risk.

#### ***B. Intake processes***

All APT kids have been through the juvenile justice system. In New York City, all newly detained youth, whether sent there by a judge or brought there by the police when the courts are closed, are taken to the central detention intake center in the Bronx. Most kids spend at least one night at the intake center, called Bridges. This is the place where they get a medical exam, their families are contacted, and they go through other intake processes. It is also a time of crisis for these kids. For many, it is the first time they have been away from home.

It is important to get good information from kids on their needs, but it is equally vital to spare them any unnecessary anxiety and protect their privacy. Initially it was thought that having detention staff do a face-to-face interview to look for kids who are heavy substance abusers would be optimal. However, it soon became clear that it was too difficult to control the quality of these interviews in a 24-hour-a-day operation. In addition, confidentiality was at risk due to the close quarters in which intake was being conducted. The APT model has since adopted a computer-based kiosk style interview because it is a more efficient and private way to do this first round of intake.

#### **1) The Drug Use Screening Inventory (DUSI)**

The Drug Use Screening Inventory (DUSI) is a validated, standardized screening

instrument that assesses a variety of domains of functioning in adolescents. APT uses only the drug-use section since drug use is the program's primary focus and this specific section works well as a stand-alone screening tool. Other domains are assessed in greater depth later in the intake process.

APT screens adolescents using a computer-administered, voice-guided version of the DUSI that is located in the admissions area of the primary intake point into NYC's juvenile justice system. During the intake process kids are asked by detention staff to sit at the computer and answer a brief set of questions from the DUSI. Kids are asked to wear headphones so that they can hear the questions as they appear on the screen. All questions can be answered by clicking a mouse. Kids with limited literacy can generally still do the interview since they are hearing the questions and are prompted verbally to select simple answers.

Confidentiality is maintained during the DUSI interview by setting the computer at an angle that prevents other people in the room from seeing the answers. In addition, each completed interview is automatically stored in the firewall-protected computer so that detention staff do not need to take any action to save the interview.

APT staff review the results of the DUSI interviews the day after they are completed. Based on responses to the DUSI, staff determine which kids should do a more in-depth, follow-up interview using the Global Appraisal of Individual Needs (*see below*). DUSI cutoff scores can be adjusted as criteria for follow-up interview depending on the desired severity level of clients. For example, APT currently interviews kids who report heavy drug or alcohol use within a day or two of screening and also exhibit symptoms indicative of substance abuse and dependence.

## **2) The Global Appraisal of Individual Needs (GAIN)**

The Global Appraisal of Individual Needs (GAIN) is a full psychosocial interview, also validated and standardized. It is widely used in the United States, which means that the data gathered can be compared against a national sample. The GAIN is an adaptable tool; a site can make a number of changes to it without affecting its validity. For example, there were questions in the original GAIN concerning use of heavy machinery found primarily in rural locations—such as cherry pickers and snowmobiles. APT ultimately created a customized version of the GAIN that used specific New York City terms and even common street names for drugs, while retaining the core diagnostic questions in the instrument.

Once the youth has completed the GAIN, the interviewer can immediately determine if he meets the program criteria. Intake staff then ask the youth for his consent to enter the APT program. His parents are contacted only if the youth agrees to participate and gives permission for intake staff to take that step. Admission is complete once parents have consented; family members are generally seen within a few days following parental consent.

## CHAPTER 4

### FAMILY THERAPY INTERVENTION

#### ***A. Contacting the parents***

The first contact between APT therapists and parents who have just enrolled a child in treatment is extremely important because it sets the tone for the therapeutic relationship and enables both therapists and parents to discuss certain critical issues from the very beginning. This contact, preferably by telephone, should happen as soon as possible following the family's enrollment in APT. Before placing the call, therapists should undertake advance preparation so they are confident, calm, empathetic and knowledgeable about the adolescent's situation and what the family is confronting as a result of the teenager's arrest and detention. Before contacting parents, therapists should review the Pre-call Checklist (*see box below*).

#### **1) Key tasks to accomplish during initial phone call**

##### **Pre-Call Checklist**

Before making initial contact with family members, APT therapists should

- review intake materials carefully with an eye for any special circumstances that may be affecting family members;
- know which APT intake worker enrolled the family in the program;
- review information about the child's legal situation;
- know where and when the teen was detained;
- know the teen's current charge and also his arrest and detention history; and
- know who the teen's lawyer is and attempt to talk with the lawyer before contacting the parents.

The duration and quality of an initial phone call with parents can vary widely depending on where and under what circumstances they are reached. Even during brief conversations therapists should try to accomplish certain key tasks, including

- clearly identifying who they are and why they are calling;
- communicating an ability and readiness to help;
- acknowledging and supporting the parents' decision to use their current crisis as an opportunity to address longstanding family issues; and
- making an appointment for a face-to-face meeting.

The first two tasks are discussed in detail below.

#### ***1) (a) The need for therapists to clearly identify who they are and why they are calling***

When parents have a child involved in the juvenile justice system, they are likely to be in contact with staff from a number of different agencies, including court-appointed lawyers and social workers, investigating probation officers and intake staff from any number of private agencies. It is therefore crucial that APT therapists make sure family members understand who they are and that the call represents the beginning of APT's response to the parents' request for treatment. Referencing the name of the intake interviewer who

signed up the parents with APT is an easy and effective way to remind parents about APT and their commitment to the program.

**1) (b) The need to communicate an ability and readiness to help**

Parents are under a great deal of stress and have many demands placed on their time because of their child’s involvement in the juvenile justice system. They have to appear in court, meet with lawyers and visit their kids in detention centers. Many parents’ jobs are in jeopardy because of repeated absences from work. They must believe that therapists empathize with what they are going through and have the ability to help them. To convey those important messages, therapists might first focus on asking parents how they are feeling or coping with the situation and then, based on their responses, discussing some potentially useful information or ideas.

The example below shows how an initial phone call might play out.

*Parent:* “Hello?”

*Therapist:* “Hi. This is Krista from APT, the family program you and Tyrell signed up for the other day in family court.”

*Parent:* “Which one is that again?”

*Therapist:* “Do you remember Mario our intake worker who came to your home on Friday? I’m the therapist he said would be calling you.”

*Parent:* “Oh yeah.”

*Therapist:* “I’m really happy you signed up, and I’m excited to begin helping you and your family. How have you been doing since Mario came to see you?”

*Parent:* “I’d be feeling better if I knew where they moved my son to. He isn’t at the place where they were holding him yesterday, and I don’t know where his is now. I want to see him and I can’t get the lawyer to return my calls.”

*Therapist:* “Well it’s a good thing I called because I’ve spoken to the lawyer and just found out where they moved Tyrell. He was placed in a non-secure group home until the judge sees him next Tuesday. I’ve been there a number of times before. I can take you there and that way you can introduce me to your son. I know you must be very busy, so tell me when you would like to go.”

*Parent:* “I don’t know if I should take any more time off of work. My boss is not so patient with me because of all the time I have taken off recently.”

*Therapist:* “It sounds like all this running around really has you feeling



stressed out and worried about your job. How about if we try to go after work tomorrow? I can get us special permission to visit him in the evening.”

**Parent:** “That would work much better for me because I don’t want to have to tell my boss why I’ve missed so much work.”

**Therapist:** “Great, how about I meet you after you finish work and we’ll travel to facility together to see your son?”

**Post-Call Checklist**

After making initial contact with family members, APT therapists should ask themselves the following questions:

- Did I clearly identify myself as the therapist for the program they signed up for?
- Did I express empathy for the situation they are in?
- Did I demonstrate that I am knowledgeable about the family’s juvenile justice situation and capable of helping them?
- Did I make an appointment for an initial face-to-face visit with the family?

After the initial phone call, therapists should review the Post-Call Checklist to confirm that they accomplished the key tasks (see box this page).

**B. Engaging the family in therapy**

Therapists’ efforts to engage family members in treatment begins with the initial contact with each member and continues throughout treatment.

Keeping family members engaged in the therapeutic process for even four months—the average duration of APT’s intensive treatment in the community—is a challenge. The parents’ and child’s interest in the process and their motivation to stay engaged usually

fluctuates greatly over these 12 weeks, and family members are often not at similar points in terms of their engagement in and openness to therapy. Additionally, it is normal and expected for individuals to resist the kind of changes that family therapy is designed to bring about.

Establishing a “therapeutic alliance”—a working agreement and a feeling of trust with the adolescent—is the most important ingredient of any type of treatment and the greatest predictor of success. However, to promote and sustain engagement, therapists must strive to nurture and maintain good working relationships with all other involved family members as well.

**1) Useful techniques for therapy engagement**

**1) (a) Get buy-in from the adolescent**

Adolescents rarely seek treatment on their own or see themselves as collaborators in the therapeutic process with authority to help shape the agenda. Instead, they usually view therapy as something their parents want for them and something that is *done to them*. Even when adolescents sign up for treatment voluntarily, as most APT clients do, they are likely to assume therapists are allied with their parents against them. Therapists have a responsibility to act in ways that reassure the adolescent that this assumption is incorrect. Among the strategies that therapists should consider when seeking to engage the adolescent in treatment are the following:



- emphasizing the role of ally to, and collaborator with, the adolescent. Therapists might say, for example:  
 “I’ve heard quite a bit from your mom and grandma about what they think, and I want to make sure that our sessions are a place where your side of the story always gets listened to.”
- showing a genuine interest in the adolescent by asking for details about his life outside the home and then validating or empathizing with his responses. Therapists might say, for example:  
 “It seems like hanging out in the courtyard with your friends feels like the only way you can avoid all the stress you are feeling at home.”
- eliciting, shaping and validating goals that are meaningful to the adolescent. Therapists might say, for example:  
 “Do you think we can use the therapy sessions to help you communicate with your mom better so she understands that you are not simply avoiding your responsibilities at home, but that you are also trying to manage your anger by going outside when you get upset?”
- challenging hopeless attitudes and communicating a belief in the adolescent’s power to change his own behavior. Therapists might say, for example:  
 “I know it seems like nobody believes you can do well in the community, but if we can show your parents and the judge the potential that you have shown me then I think things will go really well for you in court next week.”

**1) (b) Get buy-in from parents or caregivers**

Motivating parents to become active participants in a family therapy process is very challenging, particularly because most families enroll with APT at a time when parents have reached the end of their rope and feel hopeless about their ability to be effective. They simply want therapists or the juvenile justice system to “fix” their child. To cultivate hope and a desire to collaborate in the therapy process, therapists must

- empathize with parents’ frustration and stress. Therapists might say, for example:  
 “I’m sure Robert’s arrest was just what you needed given everything else you’re dealing with right now, trying to hold down a job and take care of your two younger kids.”
- help parents understand that their child cannot change without them. Therapists might say, for example:  
 “We’re going to really have to put our heads together to figure out how to help your son. I’m going to help you however I can, but I need you on my team here.”

- convey faith in the parents' ability to influence their child and become closer to him. Therapists might say, for example:  
 "I know you sometimes think you've lost control of him and that he's not listening to you, but I've been watching him during our sessions and he really is taking in what you're saying."
- focus on strengths in the parenting repertoire and evidence of past parenting success. Therapists might say, for example:  
 "I see that you and your husband really know how to present a unified front when you talk to Carlos about his behavior. Continuing to do that more consistently will really pay off."

### **1) (c) *Balance relationships with parents and the child***

Therapists' ability to maintain strong alliances with each family member is difficult because different sets of skills are needed to develop and maintain each relationship. The two central challenges for therapists are

- keeping the trust and motivation of the adolescent while helping parents improve their parental authority and
- protecting alliances with parents while pushing them to change their parenting approach to become more sensitive to the adolescent's developmental experience and positive attributes.

When seeking to balance their relationships with parents and the adolescent, therapists might consider the following:

- telling the adolescent early on that an important treatment goal is to help his parents become better parents;
- continually pointing out to both parents and the child the value of discovering and understanding each other's perspectives. Therapists must seek to ensure that this effort fosters curiosity and emotional closeness rather than argument and blaming;
- openly acknowledging when one family member feels "ganged up on" by the therapist or by another family member; and
- giving parents and the adolescent equal time to speak and be heard during counseling sessions

### **1) (d) *'Break the ice' and seek to bring families closer together***

Starting family therapy is extremely difficult for most parents and kids, especially when there is extreme tension or anger between family members—and this is often the case at the time of enrollment in APT. All involved may exhibit a paralyzing sense of uncertainty and anxiety about what to do about their problems. In initial counseling sessions, therefore, therapists should seek to establish conditions conducive to constructive communications between family members. The first session should focus on activities

that do one or more of the following:

- “break the ice” and help family members interact comfortably in initial sessions (*see sample “ice-breaking” exercise below*);
- capitalize on the universal desire for closeness and connection; and
- focus on strengths and past family successes.

### **C. Strength-based family assessment**

#### **1) Overall keys to successful strength-based assessment**

Most mental health assessments focus primarily—or even exclusively—on describing and diagnosing problems. APT therapists do not minimize the problems that bring clients into treatment. However, they seek to go further during the assessment stage by uncovering existing strengths that family members can use to move past their problems and achieve their goals for change. This section outlines APT’s strength-based family assessment strategies and explains how to use this approach.

The keys to a strength-based family assessment include the following:

#### **Ice breaker: Sharing photos**

A common “ice breaker” that can achieve all three goals necessary for engaging the whole family in therapy is to ask members to show and discuss family photos—either by looking through a photo album or focusing on the gallery of pictures adorning the walls of many family homes. This relaxed activity often gives family members a way to interact without directly addressing their problems, putting anyone on the spot or forcing too much eye contact. Looking at baby pictures and photos taken during less stressful times may provide family members with an opportunity to celebrate their shared history and closeness, and it can trigger feelings of parental pride. It can also prompt laughter and general levity.

Furthermore, by asking to see family photos and to hear the stories behind them, therapists demonstrate that they are interested in more than just the family’s current problems.

- **Therapists should present themselves as collaborators rather than as experts.** The strength-based approach differs from other approaches to assessment because it operates from the assumption that the resources and strengths necessary for making positive change reside within the family, not from therapists. This approach considers family members to be active, not passive, agents of change. It also establishes an environment in which therapists and family members begin the treatment process on equal footing as collaborators.
- **The most productive activity in a strength-based assessment is goal-setting.** It is more important for family members to set goals for the future rather than to focus on an in-depth exploration of the reasons behind a problem. A goal-centered assessment also translates more effectively into action and change because it deals directly with what motivates family members.
- **Therapists should minimize blaming by reframing problems into goals for treatment.** Blaming can undermine motivation for treatment. A strength-

based family assessment is one that recognizes the underlying anger and frustration felt by both parents and adolescents and then minimizes blaming and scapegoating. The focus is on the positive attributes of the family and the goals its members share for making changes in their lives together.

- **Therapists should seek to generate a sense of hope, pride and motivation.** During times of crisis, family members often find it difficult to avoid fixating on problems. Therapists' role during the initial stage of treatment should be to help all members recall positive attributes and strengths by reframing complaints as attainable goals for change—and then helping members uncover the tools they have to make those changes.

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### **Case Study: Strength-based approach in initial encounter**

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The following is a sample dialogue between a therapist, an adolescent client and his mother during an initial family session. This example illustrates some of the key principles of a strength-based approach in an initial encounter with a family.

- Therapist:* “So, I wondered if we can talk a bit about how you think APT can help out.”
- Mother:* “He won’t talk to me, he just does his thing in the street and he’s completely out of control. I only find out what’s going on with him when I get a call from the precinct.”
- Jamal:* “That’s because you don’t ask me nothing. You don’t know anything about what I’m dealing with—you act like I’m some wild little kid.”
- Therapist:* “I hear that in some ways you both want the same thing here. Mom, you do seem to really want to know what Jamal’s life is like lately and Jamal, you want your mom to really get what you’re dealing with but it sounds like she might need some help in learning to ask you the right questions.”
- Mother:* “Well of course I know he’s not a little kid anymore. Maybe he’s right, maybe I’m not approaching him the right way, but he’s got to promise not to give me the usual one word answers.”
- Therapist:* “In some ways what you’re both saying is that you share a goal of wanting to figure out better ways of communicating with each other.... In fact you’ve both just proven in this session that you are able to talk to each other effectively to get to the bottom of a problem and agree on trying to improve things.”

*NOTE: In this example the therapist, by re-reframing problem language into the language of goals and by pointing out existing strengths, helped the mother and adolescent move from mutual blaming and a breakdown in*

*communication toward an agreement that a major effort during therapy will be to work on a solution together.*

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## **2) Assessment strategies**

### **2) (a) Assessing the family system**

Therapists' efforts to help family members make the changes necessary to overcome problems depend on gaining an understanding of

- how the family is structured and
- how this structure operates in terms of competency in parenting, communication styles, responsibilities and behavioral expectations.

Early on in treatment, therefore, therapists must observe and inquire about a number of aspects regarding the family's present functioning as well as its members' history.

### **2) (b) Assessing 'multi-systemically'**

APT therapists should consider the family to be a self-contained system embedded within other systems such as schools, peer groups, social services agencies and juvenile justice agencies. Knowing how family members interact with these key systems is critical to therapists' ability to plan how to help them to interact more effectively in the future.

Assessing the family system and its relationship with outside systems can be difficult. To do so, therapists must formulate a number of key assessment questions. *(See the box on page 19 for a list of key assessment questions that therapists should feel comfortable answering after their initial meetings with the family.)*

## **3) Using a genogram to take a family history**

In addition to paying attention to systemic and structural factors during the assessment period, therapists should also gather family history and information about previous generations—paying particular attention to recurrent themes that may impact on how members have addressed difficulties in the past and as well as how they view the current problem that brought them into treatment. One useful tool for gathering this type of information is the construction of a family genogram.

A genogram, or family tree, is an important tool for APT therapists and serves a number of key functions. If constructed early in treatment, a genogram is an excellent way to break the ice with family members, build rapport and demonstrate the emphasis APT places on the family and on family relationships. Drawing a genogram allows therapists to express curiosity about each family member and to gather information in a systematic way about family history, the quality of relationships between family members, resources and sources of social support and the strengths and qualities of each family member. While a genogram is no substitute for observing family members in action, it does

provide an initial snapshot of the family system and structure and helps therapists to formulate initial hypotheses about how to help the family. (See Appendix 1 for detailed instructions on how to construct a genogram.)

#### **4) Using a structured goal-setting exercise**

Some families will naturally gravitate toward setting constructive goals that capitalize on their strengths as a family; in fact, one of the main reasons they may have signed up for family therapy is because they are confident of their ability to bring about change. Most families, however, are overwhelmed by the crises that prompt them to enter treatment. Family members frequently believe they are incapable of solving the problems they face and have lost any sense of hope in the future. In such cases it can be very helpful for therapists to guide family members into a process of setting goals by using exercises that specifically focus members' attention on past successes and positive hopes for the future.

One exercise that might be useful, the "miracle question," is discussed below.

##### **4) (a) The 'miracle question'**

The "miracle question" is a simple and effective exercise in which all family members are asked to imagine a future time when all the problems that brought them into treatment have been resolved and things in the family are exactly the way they would like them to be. There are many variations of this exercise, but therapists might consider using the following basic introductory script:

"I would like you each to imagine that you have woken up in the morning and realized that a miracle has taken place which results in things being exactly as you would like them to be with your family. Relations between family members are as you would like them and problems which have caused strain on the family have disappeared. Describe to me a day in the life of your family after this miracle has taken place."

In this exercise each family member is asked to take a turn and describe his post-miracle "day in the life." Other family members are asked to listen without interrupting or commenting.

The resulting narratives invariably contain hopeful statements about improvements in family functioning. The "miracle" narratives generally include some combination of better communication, more closeness, more trust, more quality time spent at home, more respect for authority, less conflict, more fun, etc. When common themes emerge from multiple family members, therapists may point out that there is consensus among family members as to their goals and then seek to outline concrete objectives based on these areas of common desire for improvement. When family members differ on what constitutes a "miracle," therapists can encourage curiosity about the diverse, but equally positive goals that are priorities for individual family members.

The miracle question is also an excellent strength-based assessment because it almost always triggers narratives that contain elements of functioning where the family already



has some degree of satisfaction or competence. Therapists are encouraged to make such observations, which can be quite empowering for family members, during the miracle question exercise.

*Alternative option:* For family members who have trouble relating to the miracle question, another technique that yields similar results can be substituted. In this exercise, therapists ask each family member to “recall and describe a time when things were going well for the family.” The procedure is the same as with the miracle question: Each family member takes a turn and the resulting narratives are used as a springboard

for therapists to highlight strengths in family functioning and to help family members develop consensual goals regarding which aspects of the peak family functioning they would like to re-capture.

**What Therapists Should Ask Themselves After the Initial Meeting**

- What are members’ strengths in communication?
- How do members explain why they sought family therapy?
- Do they use blame to explain the problem(s) they want help with?
- How do members deal with anger and conflict?
- Are parents emotionally available to the adolescent?
- How do members interact with other systems?
- How do members maintain closeness, cohesion and safety—if they do so at all?
- How are roles defined?
- How are discipline and limit-setting handled?
- Who makes important decisions and through what process?
- How can the family hierarchy be described?
- Do caregivers collaborate and present a unified front?

**D. Translating goals into action**

After family members have articulated their goals for treatment (through exercises like the “miracle question”) and therapists have had the opportunity to assess key aspects of how the family system operates, it is time for the next step: seeking to achieve the goals through direct action. First of all, therapists must play an active role in helping family members to narrow an often broad set of goals into a list of specific objectives that seem manageable over the four-month timeframe of APT treatment.

Therapists are encouraged to focus on six primary activities that can help prompt effective moves from goals into action. These activities, which should take place simultaneously, include

- 1) helping family members choose and prioritize attainable goals;
- 2) helping members reach consensus on what goals they are working on;
- 3) mobilizing hopefulness about reaching goals;
- 4) reframing goals so they are future-oriented and are stated in positive terms;
- 5) defining measurable steps and objectives; and
- 6) establishing and sharing working hypotheses about the family.

Each of these six priority activities is discussed in detail below.

**1) Choosing and prioritizing attainable goals**

It is not uncommon for family members to begin treatment with a wide range of goals for treatment—all of which feel equally urgent. Among the pressing issues that members want improvement in, for example, are loss of parental control, breakdowns in

communication, frequent escalations of conflict and lack of closeness and trust.

Without guidance by therapists, the natural response for family members entering treatment with so many areas of need is to express goals that are overly broad in nature, such as “I just want things to be like they used to be.” These kinds of goals can be paralyzing rather than motivating, however. At this stage of treatment, therefore, APT therapists should focus on helping family members break down broad goals into smaller, more attainable parts and decide which to prioritize.

Some guidelines for therapists to consider when prioritizing goals include

- working with the most accessible areas first;
- selecting an initial goal that is likely to lead to success;
- determining if some goals are prerequisites to achieving other goals; and
- approaching more difficult or most avoided goal areas later in the process.

For example, when considering the goal “I just want things to be like they used to be,” therapists may discover that “a feeling of family togetherness” and “we’re sick of our arguments immediately getting out of control” are important elements of the bigger goal. Family togetherness is an accessible, fairly easy first goal to tackle that has a strong chance for success. Therapists can literally give family members a homework assignment to plan for a special family dinner or outing. Helping them to spend time together can be a prerequisite to focusing on something more difficult like learning to manage conflict without it escalating.

## **2) Establishing consensus on goals**

In most cases, individual family members come to the table with very different goals and conflicting perceptions about the causes of and possible solutions to family problems. These differences are often fueled by anger, disappointment and lack of communication. Therapists need to take the lead in helping family members come together as a group and take ownership of the problem and reach consensus about what they would like to change. Among the ways therapists can do this are by

- making sure all family members have a chance to voice their opinions about goals;
- pointing out, whenever possible, common elements to each family member’s goals; and
- taking the lead in helping members to democratically choose goals to work on.



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### **Case Study: Reaching a consensus on treatment goals**

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The following excerpt from a family session illustrates how therapists can help family members work toward a consensus on treatment goals.

- Ms. Sanchez:* “Well you know he’s just gotta stay off the corner where those thug friends of his are hanging out—the ones who got him arrested.”
- Darius:* “You don’t have no idea what you’re talking about. They’re not thugs and you don’t even know who my friends are.”
- Therapist:* “Okay mom, you would like Darius to work on making better choices about which kids he gets involved with, but it sounds like Darius has something to add to that goal.”
- Darius:* “Yeah, you never even let me have any of my friends over so how do you know who’s a thug and who’s not a thug?”
- Therapist:* “So you guys are sort of on the same page with this. Mom, you want to know that Darius is hanging out with positive friends, and Darius would like to be able to show you who his friends are by being allowed to invite them over.”
- 

### **3) Mobilizing hopefulness**

Therapists should seek to set a tone of optimism and certainty that family members can meet the goals they have articulated previously in therapy. Among the rules of thumb for therapists to focus on to maintain hopefulness at this stage of treatment include

- referencing the APT program’s success in helping other families reach similar goals;
- reminding families of past successes and liberally doling out positive reinforcement and praise for strengths in functioning;
- taking control of interpreting outcomes by, for instance, accepting a wide range of outcomes as indicative of progress and success; and
- normalizing regressions and perceptions of slow progress.

Here are some examples of statements therapists can make that mobilize hopefulness:

“The problems you want to work on are just the sort of things our program is designed to help with.”

“It may not seem like it to you sometimes, but you are already communicating a lot better.”

“The way you all handled that last disagreement was fantastic—everybody listened to what everybody had to say.”

“It’s completely normal to slip back to how you used to fight; it’s a sign that you are working hard on this.”

#### 4) Reframing goals in positive and future-oriented terms

Early in treatment, kids and other family members are likely to be angry and stressed. They will often express goals in very negative terms and need help from therapists to articulate their goals in more positive terms. For example, when a father whose ultimate goal is to improve communication with his son says, “he’s got do something about that attitude of his and show more respect,” this immediately makes his son feel criticized for behavior that has occurred in the past that he no longer has control over. As a result, the kid will likely feel no motivation or guidance for what alternative behavior he is being asked to show his father.

In instances like this, therapists must play a very active role and use “reframing” techniques to flesh out the positive goal that is embedded in this statement. For example, therapists might say in response, “You’d like for you and your son to establish a more respectful tone when you talk to each other so you can work on better communication. That sounds like a really good goal for you.”

#### 5) Defining measurable steps and objectives

Therapists play an active role in defining goals in ways that progress can be observed and tracked by the family. Even though family members may be very motivated for a particular behavior change to occur, this does not mean that they will be motivated to notice, or even to know where to look for, evidence of progress toward the goal. For example, when family members are particularly angry or frustrated about an adolescent’s behavior, such as the use of vulgar and disrespectful language at home, they may be so sensitive to this behavior that they neglect to notice when it *doesn’t* occur. In such situations therapists should

- **start small** and help family members to accept gradual change. For example, a child who uses vulgar language regularly might only be capable of five minutes of expletive-free conversation at first, then 15 minutes, then 30 minutes, etc.;
- **define things in concrete behavioral terms.** Goals like “respect” and “trust” are very vague, but they can be translated into specific actions that serve as evidence of progress. For example, an adolescent calling home when he is running late can be defined as respect;
- **shape.** Highlighting and reinforcing even small instances of improved behavior is the best way to shape behavior. For example, praising a kid for calling home to let his mom know he is running late, even though he has already missed his curfew by an hour, will increase the likelihood that he will call again; and

- **define and facilitate steps.** It may be useful to create a verbal or written contract with family members that outlines which step each member is going to take toward making the desired changes. Including steps for everyone in the family provides another opportunity to reinforce the important point that each member can play a role in reaching a goal even when the issue seems to be just one family member's behavior.

## **6) Establishing and sharing working hypotheses about the family**

After the assessment and goal-setting stage of treatment, APT therapists should work with family members to develop a set of "working treatment hypotheses" about how to best help to meet their goals. These hypotheses include

- themes and patterns that therapists believe will be important to focus on;
- strengths and resources that can be capitalized on; and
- risks and negative factors to be minimized.

Working hypotheses are intended to be *transparent*, to share with family members; *flexible*, responsive to feedback from all members; and *respectful* of each member's strengths and goals.

### **6) (a) Generating hypotheses**

The technique for generating working hypotheses is a four-step process that is carried out with members of the treatment team and supervisors and then tested and revised during therapy sessions. The four steps are described below.

#### **6) (a) i. Step 1: Draw a family genogram**

After the genogram is complete (see *Appendix for instructions on how to draw a genogram*), participants should closely examine and describe key patterns within the family. Special attention should be paid to

- parental roles;
- quality of relationships between family members;
- communication strengths and weaknesses;
- sources of support within and outside the family system; and
- family members' understanding of the problem and goals for treatment.

#### **6) (a) ii. Step 2: Make an exhaustive list of the risk and protective factors**

*Protective factors* are the strengths, resources, adaptive qualities and supports within the family and the community that can help family members make positive changes and attain their goals. *Risk factors*, meanwhile, represent obstacles to positive change; they too are found within the family, among its individual members and in the local environment.

The following is an example of a risk and protective factor list from a case illustration that will be discussed further below [see below, 7) Case Example: Moving from goals to action with the Mendez family].

**Risk and protective factor list for the Mendez family**

<b>Risk Factors</b>	<b>Protective Factors</b>
<ul style="list-style-type: none"> <li>• Carlos is involved with a gang and his parents are not aware of his involvement.</li> <li>• Carlos was smoking marijuana five times a day.</li> <li>• Carlos’ father is disabled and has serious mobility problems.</li> <li>• Carlos’ mother just returned to the family from rehab after two years of living on the street and using crack.</li> <li>• Carlos has difficulty reading and has not gotten the extra help he needs in school.</li> <li>• Recent events have placed enormous stress on family members, and they complain of not “feeling like a family” any more.</li> </ul>	<ul style="list-style-type: none"> <li>• Carlos’ dad is a feisty advocate with the school.</li> <li>• Family members have a history of being supportive and affectionate with each other during rough times.</li> <li>• Carlos’ adult siblings sometimes help with parenting tasks around the house.</li> <li>• Carlos’ grandmother has begun spending more time in the home, helping out with the younger kids.</li> </ul>

**6) (a) iii. Step 3: Develop a set of working hypotheses**

These hypotheses should be based on family members’ goals, the assessment of the family system and the strengths and areas of risk. For example, after reviewing the family’s treatment goals and the list of risk and protective factors, the Mendez family therapist might propose the following hypothesis:

“Helping the family to celebrate their history of being supportive of each other during tough times will be a key first step in helping Carlos discuss openly his gang involvement. Reviving this family strength toward the end of helping Carlos will also serve to bring the family closer together.”

In this example, the therapist has identified an existing family strength which he feels will be important both in moving family members toward their goal of returning to a time

when they feel like a family again, but also in addressing a specific risk factor—that Carlos has maintained gang involvement outside of other family members' awareness.

#### *6) (a) iv. Step 4: Bring the hypotheses into the family sessions*

When communicating the hypotheses to family members during family sessions, therapists should pay attention to

- **timing.** Wait until a particular topic, conflict or goal relevant to a particular hypothesis is being discussed before introducing it to the family;
- **readiness.** Decide whether family members are ready to hear feedback. If they are upset and defensive or in middle of a live conflict, they may not be prepared to hear a working hypothesis; and
- **logic.** Has there been enough groundwork and information exchanged on the theme of the hypothesis so that it will seem logical to the family?

Therapists might use the following basic techniques for bringing hypotheses into the therapy process:

- communicating about hypotheses using “tentative language.” For example, therapists might say: “I had a thought after our last session that I wanted to get your opinion on...”
- avoiding the use of labels or blaming language;
- reflecting both sides of a conflict. For example the therapist might say, “The thought of Joshua moving to go live with his father makes you feel relieved, but also concerned that you will not be able to take care of him.”
- presenting the hypothesis as “one way to look at a complicated situation” instead of as the “correct” answer or interpretation; and
- using the language and metaphors the family uses, not psychological jargon.

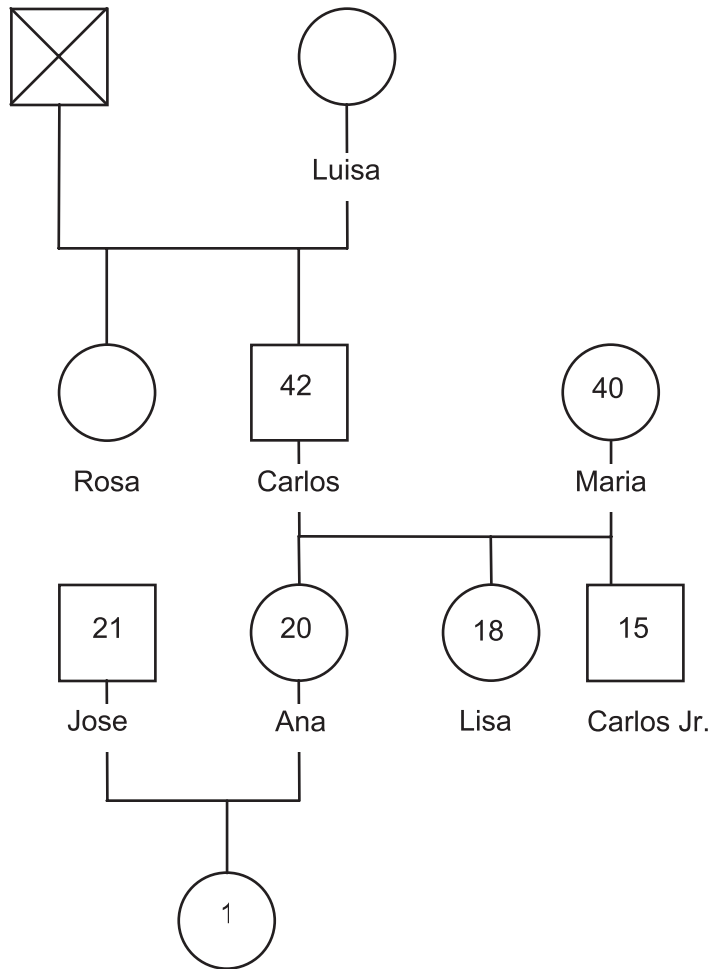
### **7) Case Example: Moving from goals to action with the Mendez family**

The following is a composite case example with excerpts from family sessions that illustrate many of the techniques and principles of moving from goals to action. Included in the example are a genogram, some salient background information and the results of the APT team's planning session where hypotheses were developed.

#### **7) (a) Background**

The Mendez family was struggling to adjust to the recent return of the mother from drug rehabilitation after two years of active crack use. Shortly after the mother's drug problem caused her to leave home and live in the streets, the adolescent boy in the family stopped attending school regularly, began smoking marijuana and was placed on probation for a series of fights in school. Family members were very welcoming of the mother's return, but many of them struggled with quite a bit of unresolved anger at her for abandoning the family. They were understandably tentative about what parenting

### Mendez Family Genogram



role she might be able to play with her son after such a long absence from his life.

During the “miracle question” exercise [see above, 4] (a) *The ‘miracle question’*, family members expressed a strong sense of longing for a time when the whole family was together and the boy, Carlos, was not engaging in delinquent behavior. In defining their goal for treatment, they fixated on something the grandmother said: “I want us to feel like a family again.” The parents and Carlos agreed with her but were reluctant to elaborate because they were all tactfully trying to avoid claiming that the mother’s absence from the home and the son’s delinquent behavior had been factors contributing to the family not feeling like a family in recent years.

“Feeling like a family” is a valid goal, so the therapist took care not to minimize it. However, the goal was clearly too big and vague—and thus needed to be broken down into a series of attainable smaller goals and steps sorted into a workable order of priority as described in the section on prioritizing goals [see above, 1] *Choosing and prioritizing attainable goals*. The most difficult step—confronting the fears, anger and disappointment that family members were feeling—could not be taken until some smaller

goals were achieved. The therapist helped family members draw out some workable components of this big goal while maintaining their level of motivation and minimizing scapegoating.

**7) (b) Therapist's hypotheses**

The therapist sought to defer a discussion of the mother's troubles until later by sharing the following key working hypothesis in a way that was comfortable for the family to hear.

- Family members want very much to accept mom back into the home and to feel like a family again. But they first need help finding a comfortable way to express their anger and disappointment about her abandonment of the family.
- Other family members, including grandma and older siblings, filled in the parenting gap very well during mom's absence. They may feel less valued if mom steps back into the parenting role.

**7) (c) Session excerpt # 1**

The first excerpt from a family session, outlined below, shows how a therapist can

- work with family members to break down a larger goal into meaningful components;
- prioritize an effective first step so that they can more easily work on their problems in therapy; and
- in the process help them to take collective responsibility and establish a feeling of consensus and hopefulness about making the desired changes.

*Therapist:* "I'm hearing that it's pretty much unanimous that what everybody really wants most is to feel like a family again. Coming together and signing up for APT tells me that you are already starting to work together like a family again."

*Grandmother:* "Yeah, but it's not like we would be sitting down like this if it wasn't a therapy session."

*Therapist:* "That's exactly what I mean, you've all already taken the first step toward your goal of feeling like a family again by making the effort to all be here as a family. I think it might be nice to hear what people think the next steps should be."

*Grandmother:* (Pointing at Carlos Jr.) "It's not going to matter if this one here stays out on the street until all hours."

*Carlos Jr.:* "We never do nothing fun any more, why should I come home?"

*NOTE: The therapist intentionally ignored grandma's comment, which was both blaming and derailing of the tone of the session, and instead decided to focus on Carlos Jr.'s*



*response—thus reframing it as a possible first step toward the family’s goal.*

*Therapist:* “Does anyone else agree with Carlos that doing some fun things together might motivate him to spend time at home *and* help people feel like a family again?”

*Carlos Sr. and older sister both nod in agreement.*

*Therapist:* (To the mother) “How about you, Mrs. Mendez, we haven’t heard from you. Does that sound like a good first step?”

*Mom:* “It’s really up to them, but I think it sounds good.”

### **7) (d) Session excerpt #2**

Realizing that mom repeatedly deferred to the rest of the family quite a number of times in this and previous sessions, the therapist decided that the time was right and that the family might be ready to reflect on a working hypothesis she had developed. The therapist’s decision, and subsequent steps exhibited in the excerpt below, shows how she paid attention to the guidelines for presenting the hypothesis.

*Therapist:* “If it’s okay with everyone, I’d like to share something I’ve been thinking about during the session. It’s just an idea and I’m interested to get your reactions to it. Two natural things seem to be happening at the same time. First, I have noticed how welcoming everyone has been toward mom and how good it feels to have her back home. But I’ve also noticed everyone walking on eggshells with each other and I wonder if that’s because the welcoming feeling is mixed with some other feelings people must have about mom’s having being out touch for so long?”

*Mom:* “I’m glad you said that because I want them to feel like it’s okay for them to tell me how mad they are.”

*Therapist:* “What do other people think?”

*Grandma:* “I think she knows how we feel. Things are different now and she’s gonna have to earn our trust again.”

*Therapist:* “I’m sure she has an idea of how you feel, but I bet it was helpful for her to hear from you just now that you feel that you want her to work on building trust with you again and I think it would be useful for you to explain a little about how things are different.”

*NOTE: In the excerpt above, the therapist used respectful and tentative language to communicate the hypothesis about family members’ need to communicate their unexpressed anger with mom. She also balanced the hypothesis with the observation that in spite of their anger, members wants to welcome mom back in the family.*



*Communicated in this way, the hypothesis immediately opened lines of communication about the unspoken issue.*

## **E. Creating a structure for treatment**

Integrating the APT treatment experience into the daily lives of families can make it particularly powerful and effective. In their efforts to maintain motivation for the treatment process among family members, therapists should focus on

- managing expectations;
- establishing a routine;
- paying attention to boundaries;
- creating continuity between sessions; and
- tracking progress.

Each of these five issues is described in detail below.

### **1) Managing expectations: ‘You are actually coming to my house?!’**

From the very first contact with family members, therapists should be explicit when preparing them for the type and frequency of contact they should expect during APT treatment. APT has specific ideas about treatment intensity, and these should be spelled out clearly from the outset. Therapists certainly do not want to increase apprehension among family members by warning that they will be “in their face” every day during treatment, but at the same time it is important to be clear and unapologetic about APT’s belief in the necessity of intensive contact. Expectations are best managed by framing this information in a way that also conveys therapists’ accessibility, their hopes for positive change and their responsiveness to family members’ scheduling needs.

### **2) Establishing a routine**

Many families that APT works with have been discharged from other treatment settings and labeled as “non-compliant” because of missed appointments or other “failures.” APT therapists must seek to understand and accept high levels of chaos and stress in family members’ lives and not be judgmental in any circumstance. Therapists should take responsibility for traveling to the family rather than expecting clients and their family members to come to them. Furthermore, therapists should seek to

- **be consistent.** From the beginning, therapists must model the sort of consistency that they expect from family members, including immediately returning phone calls, showing up on time and calling when they are late.
- **get into a routine.** Balancing flexibility with the need to establish a routine can be a challenge. Regular standing appointments are a good strategy; at the same time, it is important to get the family into the habit of rescheduling, if necessary, rather than waiting for the next appointment to cycle around. This avoids potential setbacks due to long gaps without face-to-face contact.

### **3) Establishing boundaries**

The APT model of treatment is different from most other therapy experiences that clients will have had. This can pose challenges for therapists, especially in terms of appropriate boundaries to establish and uphold. Therapists may address these challenges by clearly defining their roles and establishing a therapeutic “frame.”

#### **3) (a) *Defining therapists’ role***

Clients who have never had a therapist may not understand the nature of the relationship without some explicit discussion of what it entails. Common misconceptions are that APT therapists are like child-welfare agency workers or probation officers. The best strategy for handling such perceptions is to ask the adolescent directly what his thoughts are as to his therapist’s role and the nature of the therapeutic relationship. Teenagers, particularly boys in detention who have female therapists, will at times experience some confusion about the meaning of the interest and empathy shown by their therapists and may romanticize the relationship. In such instances, therapists should clarify the nature of the treatment relationship in a respectful way, appreciating the positive elements of the young person’s feelings toward his therapist.

#### **3) (b) *Establishing a therapeutic ‘frame’***

The “frame” refers both to logistics—how, where and when the therapy is to take place (for example, in the adolescent’s home twice a week)—and to family members’ understanding of the therapeutic relationship. Therapists should be aware of and appreciate certain cultural issues that may influence the structure of the frame.

For example, Latino family members uncomfortable with sharing intimate details of their problems may invite a therapist to share a family meal during or after a session. This invitation does not necessarily mean that family members are confusing the boundary between “therapist” and “family dinner guest,” but instead represents their contribution to negotiating a therapeutic frame with the therapist. In this situation the therapist’s willingness to participate in a family meal may have important symbolic value for family members and enable them to participate more openly in a therapeutic dialogue. Therapists faced with this situation therefore should look for ways to structure the therapeutic interaction in a way that accommodates family members’ request; therapists might, for example, ask if it is possible to begin the therapy session at the conclusion of dinner or perhaps during dinner.

### **4) Creating continuity between sessions**

#### **4) (a) *Frequent contact***

In a short-term intensive treatment model, the frequency of contact with family members is very important in maintaining continuity and intensity. Frequent phone contact ensures that clients get the most out of treatment by helping them process what is discussed during therapy sessions and integrate changes into their daily lives. It can also prepare them for upcoming sessions.

Between-session preparation is particularly important early in treatment when family members may still be experiencing a great deal of anger and frustration with each other and may not have begun to develop or strengthen the communication skills necessary to make family therapy productive. In such cases APT therapists can communicate by phone and in person with individual family members to prepare them for family therapy by engaging in what is referred to as “shuttle diplomacy.”

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### **Case Study: ‘Shuttle diplomacy’**

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Nelson is 15-year-old boy who is currently in detention awaiting his next appearance in family court. In Nelson’s first court appearance, the judge said he was inclined to send Nelson home on probation if his mother agreed. Nelson’s mother flew off the handle in front of the judge, telling him that she did not want Nelson home because he was completely out of control and disrespectful. The judge was taken aback and delayed a decision until the next court date. Although both Nelson and his mother had signed up for APT and were motivated to do family therapy, both parties refused at this point to participate in a session when the other person would be in the room. At this point the therapist engaged in some “shuttle diplomacy” by speaking to each party separately in order to break the ice and get both of them to the table.

*The therapist first spoke to mother in her home the evening after the court date:*

*Therapist:* “I think everyone really heard how upset you are and how concerned you are about Nelson’s readiness to come home—and that you’ll be ready for him to come home if understands that you want him to show more respect and begin to get his behavior under control.”

*Mother:* “He don’t show me no respect and he needed to hear that.”

*Therapist:* “I could tell from watching him that he heard that message loud and clear, don’t you think?”

*Mother:* “We’ll see.”

*Therapist:* “One way to see, I think, is for you to let him know specifically what you need from him in terms of respect before you’ll tell the judge you want him home.”

*Mother:* “Yeah, if he promises to try harder I do want him home, I miss him...but he don’t want to talk to me now.”

*Therapist:* “Well, I bet if he knew how you felt about him being home he would. If it’s okay with you, I’d like to tell Nelson some of what we just discussed and get back to you.”

*The therapist then met with Nelson, who is in detention:*

- Therapist:** “How are you doing? I know you were very upset in court yesterday.”
- Nelson:** “Yeah, she don’t care about me, she just wants me locked up.”
- Therapist:** “Well, the judge certainly wanted to be sure you and your mom were ready for you to come home. I think from what your mom said to me when I talked to her last night that despite what happened yesterday, she does care about you and she does want you home.”
- Nelson:** “You talked to her, what she said?”
- Therapist:** “Well, she said she misses you and wants you home, but would like to really begin working on the respect and behavior issues. She knows that means meeting with you but is concerned that you might be too angry to meet just yet.”
- Nelson:** “Nah, I’ll meet with her to talk about all that.”
- 

As noted in the case study above, “shuttle diplomacy” can enable therapists to gather and convey information about the perspectives each family member is bringing to the table. It gives therapists the freedom to begin to reframe issues so that family members feel a greater sense of common understanding and goals when they arrive at the next family session. This process is most effective early on in treatment, in preparation for initial family sessions, but can be useful throughout.

#### **4) (b) Between-session check-ins**

Check-ins before and after a session are helpful for therapists to

- support clients after a difficult session;
- provide encouragement and positive reinforcement; and
- get progress reports on things that family members agreed to try at home between sessions.

Face-to-face contact with adolescents or other family members is ideal, but scheduling issues and other time constraints mean that most check-ins are done over the phone. On occasion, therapists or family members may seek to organize a *telephone session* to discuss and work on issues in greater depth than is possible during regular check-ins. These sessions, which can be conducted via conference call with kids, parents and other family members, can be an efficient and powerful way to maintain intensity and continuity.

#### **5) Motivating by tracking progress**

“Tracking” is an important part of APT treatment. It consists of therapists monitoring and communicating with family members about their treatment goals and helping them see and appreciate the progress they are making. The key elements of tracking are

- **keeping family members focused on their treatment goals.** It is the therapists' responsibility to refer back to the goals set by family members at the beginning of treatment. As treatment progresses, therapists should take the lead when it seems appropriate to revise goals;
- **giving feedback on progress toward meeting goals.** A useful motivator for treatment is often the use of positive feedback about the progress family members are making toward their goal. Noting even small positive changes can keep members motivated;
- **“reframing” instances of regression, drug use slips or slow progress as normal parts of the therapy process.** Therapists should play an active role in defining and framing for the family what constitutes progress, especially when apparently negative behavior becomes an issue. For instance, therapists might say something like, “It’s actually quite normal for you all to return to fighting as you used to—it takes time to learn new ways of handling conflict;” and
- **helping the family reach a satisfying “graduation” from APT.** Finally, the tracking process involves helping prepare family members for the end of treatment. Therapists should steer them toward appreciating the gains they have made and accepting that the skills they have acquired will allow them to move forward even if they have not achieved all of their goals in the intensive phase of treatment.

## **CHAPTER 5**

### **INCORPORATING UNIVERSAL GOALS INTO FAMILY THERAPY**

As noted throughout the manual, the APT treatment model emphasizes identifying and working toward family therapy goals that are unique to each family. In addition to developing a unique family therapy treatment plan, APT therapists may also incorporate a broader set of objectives for improving family functioning using a structure that applies generally to all families. This structure comprises universal elements of good family functioning that should be incorporated as therapy goals. For example, throughout treatment all APT therapists should seek to

- a. foster a sense of closeness and family cohesiveness;**
- b. improve family communication;**
- c. reinforce family roles;**
- d. improve family members' relationships with key outside systems; and**
- e. encourage strength-based parenting.**

There is no recommended blueprint as to the order in which therapists should address these universal elements over the course of APT treatment. Also, it is important to be aware that not all of these universal goals will come into play with every case and that, in some cases, two or more goals may overlap. Regardless, therapists should keep in mind all five universal elements listed above as they move through the treatment process. This chapter contains extensive information about each of them.

#### ***A. Fostering a sense of closeness and family cohesiveness***

Family members participating in APT treatment can be disengaged from each other. Helping them re-establish—or even establish for the first time—a feeling of closeness is a prerequisite to moving to a point at which they are able and willing to focus on behavior change. This effort therefore should be a top priority at the outset of treatment. Whenever appropriate, therapists should seek to

- 1) validate instances of emotional warmth and connectedness;
- 2) build a family alliance;
- 3) openly address old conflicts and grudges;
- 4) foster an atmosphere of playfulness in sessions;
- 5) help family members express what they value about one another; and
- 6) help the family to access available support systems.

Each of these six issues is discussed in detail below.

### **1) Validate instances of emotional warmth and connectedness**

Regardless of the degree of stress and tension within a family, most members strive to feel emotionally connected with each other. That sense of closeness does not always exist within families in crisis, so therapists may find it necessary to help bring out positive feelings that family members have suppressed or hidden. Observing and appreciating instances of warmth and closeness are very useful to the family. Here are two examples of how therapists might approach this effort:

*Therapist:* “I notice how your mom looks at you with that ‘proud mom smile’ when you talk about how you want to improve your grades.”

*Therapist:* “In spite of all you’ve been through I see you two have really stuck together.”

### **2) Build a family alliance**

A good way to begin this process is to give credit to parents for the fact that their child has reached out for help. When speaking with parents, therapists should regularly observe that their child must trust them—otherwise he probably would not have reached out for help knowing that the parents will be integral to the treatment process. Here is an example of how therapists might approach this effort:

*Therapist:* “It really shows what a great job you’ve done with him that he knows when he needs help and has chosen to be involved in family therapy.”

### **3) Openly address old conflicts and grudges**

Helping families move on is crucial. Unresolved conflicts and old emotional injuries can be barriers to establishing or re-establishing closeness. Playing a “mediator” role, eliciting apologies and establishing terms under which family members will allow “bygones to be bygones” can help move families forward. Here are two examples of how therapists might approach this effort:

*Therapist:* “Your mom wasn’t ready to ask the judge to release you then, but she clearly wants you home now. Are we ready to let this be ‘water under the bridge’ and move forward from here?”

*Therapist:* “It is clear to me that you feel sorry for what happened, but I have a sense that your mom feels an apology from you would mean a lot to her and would allow her to start to trust you again.”

### **4) Foster an atmosphere of playfulness in sessions**

Helping family members enjoy and appreciate each other’s company helps them bond, thus enabling them to work together as a family again. It may also be helpful to remind them of what they have in common. Here is an example of how therapists might approach this effort:



*Therapist:* “You and your mom both have the same wise-guy sense of humor.”

### **5) Help family members express what they value about one another**

Family members sometimes need to be reminded of the positive qualities that they appreciate in each other. Helping them to communicate directly about these qualities can strengthen family relationships. Here are two examples of how therapists might approach this effort:

*Therapist:* “Mom, do you think Sheila knows how much you appreciate the effort she puts into being a good big sister to the younger ones?”

*Therapist:* “What are some qualities that your dad has that you’d also like to have when you are an adult?”

### **6) Help the family to access available support systems**

The first step is often to simply help explore who in an extended family might be a resource. This effort can be initiated by drawing a genogram (family tree) and inquiring as to who has been helpful in the past, who has had a positive influence on the child and who might offer appropriate support in the future. Therapists should seek to bring important family members together to “collaborate” on finding solutions to the problems that brought the family into treatment. Among other steps, therapists can

- invite key extended family members and adult family friends to participate in sessions and
- get permission from parents and the child to speak to these key individuals in person or by phone about how they can help, if they are able and willing.

## ***B. Improving family communication***

Several key universal aspects of family communication should be prioritized by therapists as part of APT treatment. Among them are

- 1) helping the family use developmentally appropriate ways of communicating;
- 2) increasing the emotional availability of parents;
- 3) assisting the family in creating an environment where drug use and abstinence efforts can be discussed openly;
- 4) assisting the family in using strength-based language to work toward behavior change; and
- 5) using good communication to de-escalate conflict and problem-solve as a family.

Each of these five issues is discussed in detail below.



## 1) Helping the family use developmentally appropriate ways of communicating

As a child makes the transition into adolescence, parents often fail to change communication strategies that were effective in early childhood but may have little impact at this new stage of development. For example, commanding kids to change their behavior is less effective in adolescence than in early childhood. Some ways in which APT therapists can help parents to be more developmentally in tune are to coach them to

- communicate in ways that validate and show respect for the adolescent even if his behavior seems silly and “typical” for a teenager;
- avoid communications that lead directly into power struggles;
- assume the adolescent has perspectives and opinions on topics that parents are not aware of, which makes it important to solicit his thoughts on important matters;
- include the adolescent in decision-making as a way of empowering him, a strategy that would not necessarily be appropriate for a younger child; and
- understand that it is normal for an adolescent to become more concerned with privacy as he grows up.

Here are three examples of how therapists might convey these messages to parents:

*Therapist:* “Adolescence is a time when kids are just learning to appreciate how other people feel—this actually takes time to develop. So, telling them repeatedly how they have made you feel may not sink in because of where they are in development.”

*Therapist:* “You know your kid is at the age where he is more likely to cooperate with you if his opinions are solicited. It’s the time in adolescent development where feeling heard and respected is a big motivator.”

*Therapist:* “When he was little you pretty much knew every thought and feeling he had and that helped you to know how to parent him. It’s really tough on parents when their kids reach adolescence and the need for privacy and their own space becomes so important to their development.”

## 2) Increasing the emotional availability of parents

Parents often need help creating an atmosphere in which a child feels comfortable approaching them with information or problems that are related to “bad” behaviors. Being open, curious and non-judgmental about a child’s life is not the same as condoning negative behaviors. Instead, it signals to the child that parents understand the reasons why he is acting this way. Parents are often initially too exasperated, angry and “checked-out” to assume this attitude. Therapists can help by

- modeling curiosity and openness to discuss the adolescent's life experience and peers;
- having family members participate in playful exercises of perspective-taking and reverse role-playing; and
- referring to evidence-based methods of communication regarding developmental issues in talking to adolescents.

Here is an example of how therapists might convey these messages to parents:

*Therapist:* "I know it may be hard to imagine sometimes, but studies by psychologists have shown that parents can influence their kids more by repeatedly letting them know they are open to hearing what's going on in their lives, even if you know they have done something wrong, than by talking to them in a way that feels like they are being monitored."

### **3) Assisting the family in creating an environment where drug use and abstinence efforts can be discussed openly**

Therapists should make it clear to the adolescent and parents that one purpose of APT treatment is to talk openly about the adolescent's drug use and to support his efforts to stop using. Some parents enrolled in APT have histories of drug use or drug treatment themselves, and this may influence how family members talk about drugs and drug use.

In their efforts to keep lines of communication around drug use open during family treatment, therapists should consider strategies including

- highlighting how impressive it is that the adolescent has taken a huge positive step by agreeing to participate in drug treatment;
- highlighting how impressive it is that the parents have agreed to participate in treatment and consider realistic solutions to the child's problem;
- firmly indicating to the adolescent at the very beginning of treatment that no deals will be made to keep relapses a secret and that all urine tests will be conducted with parents present;
- working separately with parents on clarifying and taking control of the messages they give about their own past drug use and general attitudes about drugs; and
- being certain that the focus of family sessions is not on blaming the kid for drug use, but on how to help achieve abstinence in a constructive and non-judgmental way.

Also, it is important to remember that many families have never had experience with **urine testing** or strongly associate it as something required in the context of a supervisory or adversarial relationship, e.g., with a probation officer. Therefore, therapists should be upfront about how and why urine testing fits into APT treatment

to ensure that this aspect of the treatment model does not stifle communication. They should also coach parents on appropriate ways to respond to relapses or positive urine drug tests.

Urine testing is useful in a number of ways in family-focused drug treatment. It sets a tone for open communication about drug use and allows therapists to shape constructive parental responses to test results—such as, for example, coaching parents to give positive reinforcement for negative tests and to avoid punitive responses to positive tests by remaining focused on adolescent’s efforts to change behavior and the barriers that might have led to the “slip.” (See Appendix 1 for a more detailed discussion of how to incorporate urinalysis in treatment.)

#### **4) Assisting the family in using strength-based language to work toward behavior change**

Teaching families to talk about problems in a way that is solution-focused and non-judgmental is a challenge. To be effective in this goal, therapists must first recognize the problems and validate how family members feel about them, including a sense of urgency or hopelessness in certain situations.

A strength-based approach to talking about problems is one that

- looks for inherent strengths in the adolescent and family that may help him overcome his problems;
- does not use stigmatizing labels;
- minimizes blaming; and
- emphasizes the belief that the solution to the problem lies within the family.

The following is an example of how therapists might respond in a strength-based manner to a negative or unproductive comment.

*Grandma:* “Yeah, well he’s the one who has caused all the problems. He just needs to get his act together.”

*Therapist:* “Mrs. Ortiz, I really think your grandson needs to hear more of your supportive side, the side of you that signed up for family therapy knowing that the solution to helping him is for the whole family to come up with solutions together and not just blame one person.”

#### **5) Using good communication to de-escalate conflict and problem-solve as a family**

Helping families to identify and neutralize triggers and patterns of escalation will improve healthy communication. Therapists should ask themselves the following questions when working with a family on communication skills:

- Does each family member feel comfortable expressing his or her point of view when a conflict arises?
- Are family members able to listen and acknowledge the point of view of others?
- Can family members verbalize a response without becoming overly defensive or using devaluing, blaming or retaliatory language?

Therapists can help families to short-circuit conflict escalation by working with all members to analyze how conflicts tend to unfold, how each member contributes to the pattern and in brainstorming ways in which each can contribute to de-escalating conflicts. Techniques therapists can use to help facilitate de-escalation include

- asking all family members to agree ahead of time to honor a “time out” signal from any member who feels that a conflict is escalating and
- setting up ground rules, when working with volatile families, in which all members agree not to engage in overt hostility, retaliation or name calling.

### ***C. Reinforcing family roles***

APT therapists’ support of the adolescent’s efforts to change his behavior starts with helping strengthen and clarify the roles of parents and adolescents within a family. To achieve this goal, APT therapists can help parents establish a set of rules and expectations for behavior that are developmentally appropriate for their adolescent. Among therapists’ key focus points in this area should be the following:

- 1) helping family members understand their roles;
- 2) fostering feelings of competence, satisfaction and authority in parents; and
- 3) fostering good parenting skills, such as limit-setting and monitoring.

Each of these three issues is discussed in detail below.

#### **1) Helping family members understand their roles**

The goal is to reinforce existing strengths of the parents and at the same time to recognize the aspects of their style that have become overly rigid or ineffective. To obtain this information, therapists can ask a number of questions that should provide the raw material for discussing how to make positive changes in parenting. Among useful questions are the following:

- “What do you most value about your role as parent?”
- “What do you find most frustrating about being a parent?”
- “What do you most value about your relationship with your adolescent?”
- “How were you parented as a child and what aspects of your parents’ style have you incorporated into your approach to parenting?”

- “What elements of your parents’ style of parenting would you like not to repeat?”

Questions such as these can be asked without the child present, in preparation for family therapy sessions. They may also be useful to ask of all family members in a family therapy session to reveal areas of role confusion and situations that make family roles feel less satisfying—and to generate some consensus about family roles and the importance of strengthening them.

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**Case study: Family members’ roles and responsibilities**

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Karina and her mother had been fighting in a family therapy session over why Karina would not come home from school to check in first before going to hang out with her friends. Rather than focus on the behavior, the therapist focused on roles:

- Mom:* “You make me feel like I’m not your parent any more.”
- Therapist:* “You know, I’m glad you brought this up because this is something that you can help to clarify for each other—what it means to feel like a parent and what Karina wants as a daughter.”
- Karina:* “She just wants me to do what she says all the time and she don’t know I have a life too.”
- Therapist:* “Well, listening to what your mom tells you to do may be part of what she meant, but I hear you saying you want your mom to acknowledge that you also have a life. Why don’t we ask her what would make her feel valued as a parent?”
- Mom:* “Well of course I want her to respect what I ask her to do, but what would really make me feel like a mom is for her to want to come home after school to spend a few minutes talking to me.”
- Therapist:* “So your mom is saying she would feel more valued as a parent if you spent a few minutes with her after school. Maybe you could use those few minutes after school to tell her some things about your life.”
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**2) Fostering feelings of competence, satisfaction and authority in parents**

Many parents who enroll with APT believe they have lost authority over their child and are incompetent parents. APT therapists can seek to improve parental competence by focusing on limit-setting and other parenting skills. When working with parents therapists should

- adopt the stance of a collaborator rather than an expert on how to

- parent their child;
- look for past and current instances of parenting strengths and successes to build upon;
- empathize with parents when they discuss the difficulties they have in parenting teenagers;
- acknowledge parents' concerns about working with a therapist who may not have direct experience raising teenagers; and
- acknowledge that parents may feel they have been criticized during their experience with other outside systems—in family court, by probation officers, etc.

### 3) Fostering good parenting skills

The most common parenting issues that emerge in family therapy are limit-setting and monitoring. **Limit-setting** is a real challenge for parents who feel they have lost control of their kids. Therapists should work with parents outside as well as within family sessions to seek improvement in limit-setting. Therapists' steps might include

- deciding on a behavior that both the therapist and parents agree needs to change. Start small—for example, the amount of time an adolescent is allowed to spend on the telephone in the evening;
- role-playing with parents the process of introducing and negotiating a reasonable limit prior to a family session;
- reminding parents that including the adolescent in the negotiation increases his “buy-in”;
- coaching parents to introduce the topic in a family session;
- clearly supporting parents during family sessions. Limit-setting is an area in which therapists must ally themselves with parents but should not take part in the actual setting of the limits; and
- checking in with parents between sessions by telephone or in person as to how the limit-setting is going, and offering support and suggestions if necessary.

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#### Case Study: Limit-setting

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A mother has previously decided during a one-on-one session with the therapist (whose name is Erica) that she would like her adolescent daughter to only spend one hour per night talking on the telephone—and only between 7 p.m. and 10 p.m. The therapist has coached the mother on how to bring this up in a family therapy session, suggesting she minimize negotiation around this limit. The therapist has indicated that she will support the mother's efforts to establish the limit but would not bring the topic up herself during this session.

- Mom:* “Erica and I were talking before the session about how something has to be done about this endless phone calling that goes on at all hours.”
- Therapist (Erica):* “Yes, and the fact that you brought it up with me before today’s family session indicates just how serious you are about the issue. I was impressed with the idea that you came up with and I’m glad you decided to work with your daughter on this in today’s session.”
- Mom:* “What was it we came up with?”
- Therapist:* “I think *you* had established a very reasonable rule you plan to enforce.”

*NOTE: In this example the therapist supported the parent as the limit-setter and sought to reframe the parent’s tendency to try to use the therapist as the “enforcer.”*

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**Monitoring** is the other common parenting issue that arises during family therapy. The APT model assumes that information about what kids are doing outside the home and who they are with at those times cannot be coerced by parents. Instead, this information needs to emerge in the context of a trusting relationship where the adolescent feels comfortable talking about what he is up to. Therapists should support parents in family sessions whenever monitoring comes up as an issue, but also encourage parents to

- demonstrate a clear interest in knowing what their adolescent is up to when not at home by being curious about peers and activities;
- validate the adolescent’s strivings for autonomy and exhibit a willingness to grant the adolescent more autonomy when he can prove he is ready;
- set specific and attainable conditions for increased autonomy; and
- show an interest in meeting the adolescent’s peers.

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### **Case Study: Monitoring**

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- Parent:* “I don’t know who these friends of yours are that you spend all this time with.”
- Therapist:* “It sounds like you are saying you will be much more comfortable with the time your son spends away from home once you have a chance to meet the friends he is hanging out with.”
- Adolescent:* “You just assume all my friends are thugs and it’s like you interrogate me every time I get home.”
- Parent:* “Well, if he wants me not to be in his face all the time about



where he was, he should let me know who these kids are at least.”

**Therapist:** (To the adolescent) “This sounds like progress to me. Your mom is inviting you to introduce some of your friends to her and, if I am hearing her correctly, this will make her less likely to do what feels to you like ‘interrogation.’ Is this something you would be willing to do?”

**NOTE:** *In this example, the therapist offered the family members a framework in which the adolescent can maintain some autonomy yet at the same time provide information to his mother about his peer affiliations in a way that does not trigger the power struggles they have been having.*

### Partnerships with Supervisory Agencies

Many parents struggle to develop productive partnerships with supervisory agencies. Problems establishing effective relationships typically fall into one of two categories:

- *The adversarial relationship.* Parents who immediately lock horns with a probation officer may do so because they feel their parental authority is threatened; they believe the probation officer does not appreciate the magnitude of the problems they and the adolescent are dealing with; or that they simply do not have the social skills necessary to navigate this unique relationship. APT therapists can support parents by coaching and modeling appropriate skills for dealing with the situation. For example, therapists might consider accompanying parents to initial probation meetings and demonstrating ways of combining assertive and respectful communication.
- *Abdicating parental authority.* Parents who immediately place excessive trust in a probation officer as the person holding the ultimate “parental authority” over their child may do so because they have been made to feel disempowered by a system that is often critical of the parenting efforts of parents with juvenile justice-involved kids. They may also feel hopeless about their ability to control their adolescent’s behavior and therefore turn to a probation officer to set limits they have been unable to enforce. APT therapists must work with both the parents and the supervising agent to empower parents to take on more responsibility for setting limits, trusting the process of building a better relationship with their kid and trying new parenting skills.

## D. Improving relationships with outside systems

APT therapists can and should play a role in maximizing the family’s access to social, emotional and economic support from the community. It is not the therapists’ responsibility to perform traditional case management functions themselves; instead, their strategy should be to promote family members’ capacity to access services on their own. Playing this role will be even more important with low functioning or multiply stressed families. Systems and support services that families may need help accessing include

- medical and mental health providers;
- housing assistance;
- schools (*see Chapter 7*); and
- probation or other services related to community supervision.

## E. Encouraging strength-based parenting

APT therapists can encourage parents to expand their parenting repertoire to include strategies that capitalize on the strengths of their adolescent. These strategies might include skills such as “positive reinforcement” and “shaping” that parallel APT’s Cognitive Behavioral Therapy (CBT) approach to behavior change. (*See Chapter 6 for more detailed information on what constitutes CBT.*)

The therapists' main objectives in this effort should be to

- get parents to appreciate APT's strength-based approach and to incorporate this way of thinking into parenting their adolescent;
- get parents to use positive-reinforcement as a primary parenting strategy;
- teach parents to use behavior-shaping techniques. This includes helping them understand the role triggers and skills play in behavior change; and
- help parents to feel in the loop about other behavior change efforts the therapist may be working on individually with the adolescent.

### 1) What is strength-based parenting?

Strength-based parenting is a strategy based on the acknowledgement of and focus on developmentally appropriate strengths. For example, it is appropriate for adolescents to want to choose their own friends. Therefore, rather than demand that an adolescent not spend time with a particular peer—which is what parents might do with a younger child—it is more effective and “strength-based” for parents to respond to the friendship choices their adolescent is making in a nonjudgmental manner. Parents can express their concern by indicating an interest in meeting their child's friends, having a discussion about what qualities he wants in a friend and showing a general openness to hearing about how successful the adolescent thinks his choices have been.

Among the major challenges of the strength-based approach is for parents to avoid considering blaming or labeling to be potential solutions to behavior problems. Instead, parents need to be encouraged to look for adaptive strengths in their child. Parents often think that pointing out strengths or offering positive reinforcement to their kids constitutes condoning or forgiving of past misbehavior. It can be hard to break the cycle of negative behavior and blaming; parents will need a lot of coaching to get to this point.

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#### Case Study: Strength-based parenting

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*Parent:* “He is still so lazy in the morning. He drives me crazy when he doesn't get out of bed in time to make it to first period.”

*Therapist:* “I want to remind you that we agreed that he's not necessarily lazy, but really hasn't been in a routine of waking up early in a long time. You told me that twice this week he got up on time without you waking him; how does that make you feel as a parent?”

*Parent:* “Proud of him because he is showing some effort and we actually got to have breakfast together yesterday.”

*Therapist:* “So could you tell him that instead of telling me?”

*Parent:* “Michael, you know I'm proud of you for trying.”

*Therapist:* “I can tell from looking at Michael's reaction that he's proud

too and reacted better than when you called him lazy—even though he knows you called him that out of frustration.”

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## 2) Teaching parents to use positive reinforcement

Positive reinforcement refers to either verbal praise or a reward given in response to good behavior. The challenge is to convince parents to trust using positive reinforcement at a point when they are feeling hopeless, angry and frustrated about their child’s behavior. It helps to introduce it as something that works for other families; parents may be more willing to try something if they know they are not alone. It may also be helpful to assure parents that APT and other evidence-based programs have learned what strategies tend to work, including positive reinforcement.

Here is an example of how therapists might explain to parents why the APT model emphasizes positive reinforcement:

*Therapist:* “I know it’s hard to praise Shana for little things when you feel the big things haven’t changed yet, but our experience with this has taught us to encourage you as parents to use praise at every step—it’s really what works.”

## 3) Teaching parents to use shaping

Shaping is the process of using positive feedback and practical aids to gradually bring about behavior change. The strategy is based on evidence indicating that an adolescent’s behavior can be “shaped” by reinforcing aspects of a behavior and/or the steps the adolescent takes toward the ultimate behavioral goal.

Therapists may also find it necessary or helpful to explain to parents why shaping is important. Explanations might include discussion of the following evidence-based observations:

- Problem behavior takes a long time to develop and cannot be undone overnight or with a single parenting intervention like “zero tolerance.”
- Kids respond better to gradual coaxing with positive attention than to coercion and negative attention.
- Negative attention paid to a problem behavior can actually have an effect opposite to that desired by parents, and may even reinforce problem behavior.
- Kids love praise.

Curfew compliance is a good example of a behavior that can be shaped. It is a behavior that many people—including probation officers, therapists and parents—have a stake in

improving, but which seldom changes unless parents take the lead and use shaping as a strategy.

For the adolescent, complying with a curfew is not just a simple black-and-white matter of “come home on time vs. come home late,” which is how it is viewed by most adults in the adolescent’s life. Curfew compliance also requires the adolescent to master a series of other behaviors including time management, refusal skills when peers tempt the adolescent to stay out late, delaying gratification and planning.

Curfews are often described as absolutes—meaning that the adolescent will get in trouble if he does not comply—but in practice this is almost never true. Parents and probation officers seldom check on the adolescent’s arrival time with the regularity they promise, and they often give the adolescent an unspecified number of “chances” to miss curfew before any action is taken. The negative effects of these inconsistencies are compounded by the fact that, kids are almost never given positive feedback for good effort to get home on time.

To apply the principles of shaping to improving curfew compliance, therapists should work with parents to

- appreciate the multiple skills that the adolescent has to master before he can be successful in meeting curfew;
- reinforce those skills. For example, parents might provide their kid with a watch as part of an effort to help him develop the necessary time-management skill. They could also be encouraged to praise or reward the adolescent for checking-in by phone one or two times well before curfew time each night;
- positively reinforce—with verbal praise or actual reward—gradual improvements in how close to curfew the kid gets home, with greater praise or reward for actually coming in before curfew.

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### **Case study: Shaping curfew compliance**

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The following are examples of the types of feedback that parents should be encouraged to use with their kids when dealing with curfew compliance:

*Parent:* “I’m really psyched that you came in 10:30—that’s 45 minutes earlier than last night. It seems like we’re getting closer to that 8:30 curfew every night. Good job!!”

*Parent:* “Your mom and I were so impressed that you picked up the phone to call us even though the call came after the curfew passed. The call was very thoughtful and shows us that are starting to think about managing your time better.”

*Parent:* “I know an 8:30 curfew is tough on you right now, but since

you made it home on time twice this week we'd like to buy you that basketball jersey you asked for.”

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#### **4) Keep parents in the loop about individual CBT work**

Because most CBT work also takes place with the adolescent individually, it is important to keep parents in the loop at all times and to solicit their input and participation in any strategy to help the adolescent change behavior. Therapists should be aware that the skills they teach or build upon in individual therapy sessions will have an impact on parents. If unprepared, parents may feel undermined if their child suddenly shows signs of behavior change such as increased assertiveness. Some strategies therapists can use to avoid appearing to undermine parents include

- always showing respect for parents' point of view;
- notifying parents as to what behaviors are being targeted; and
- avoiding the temptation to coach kids independently in how to “deal with” their parents—and focusing instead on working with all involved to improve how they deal with each other.

## CHAPTER 6

# USING COGNITIVE BEHAVIOR THERAPY (CBT)

### **A. What is CBT?**

Cognitive behavior therapy (CBT) is an approach designed to change problem behaviors and strengthen positive ones. In CBT, therapists help adolescents identify the things that “trigger” problem behavior as well as the things that “reinforce” that behavior.

#### **The Building Blocks of APT’s CBT Strategy**

1. Positive reinforcement from important people in a kid’s life is the key to changing behavior.
2. Behavior change occurs through gradual shaping.
3. Problem behaviors are best viewed as adaptations to a problematic environment.
4. Capitalizing on existing skills and strengths is the key to behavior change.
5. Parents can help kids change behavior by understanding the adolescent’s triggers.

*Triggers* can be external things in an adolescent’s social or physical environment or internally based ways of thinking that are inappropriate or irrational. *Reinforcers* are the things that keep a behavior occurring by providing a reward. A problem behavior can be reinforced because it has some positive benefit for an adolescent, such as improving social status among peers or providing relief from a particular symptom. For example, adolescents often say that marijuana smoking makes them feel less agitated. This feeling—or even just the expectation of this feeling—can reinforce smoking behavior, even though marijuana use may have negative consequences.

CBT can be effective in helping adolescents change problem behaviors. It can help them learn and strengthen the skills that will enable them to get involved in more pro-social behaviors. The CBT strategies discussed in this chapter are most effective if they are used by parents as well as therapists. CBT principles can help parents understand the benefits of using positive reinforcement with their kids and also to recognize how their behavior as parents can support the adolescent’s own behavioral-change goals and expectations.

### **B. The first step in CBT: Functional analysis**

CBT should begin with a functional analysis, which may be considered both an assessment tool and an intervention. First of all, it consists of recognizing the following two types of target behaviors:

- *pro-social behaviors*, such as positive peer interactions or community activities, and
- *problem behaviors*, such as substance abuse, fighting and using hostile language with parents.

Following the assessment, the main goals of therapists and parents in a functional analysis are to

- demonstrate to the adolescent that they are interested in both positive and negative behaviors;
- understand the target behavior they are looking to help the adolescent with by recognizing what triggers, motivates or reinforces it;
- motivate the adolescent to feel that he has the capacity to change behavior. Helping an adolescent understand what triggers and reinforces both his positive and problem behaviors can help him to begin to make changes; and
- find existing strengths and explore areas where skills-building is needed.

## **1) Conducting a functional analysis**

A functional analysis is conducted using the appropriate functional analysis form; separate forms are used for problem behaviors and pro-social behaviors. (*Appendix 2 contains a complete set of functional analysis forms with guidelines for standard probes.*)

Information does not need to be gathered in any particular order. Therapists should tailor their approach to the adolescent's personality. A fairly non-verbal adolescent might need to use the functional analysis form as a worksheet to be filled in. A more verbal adolescent might do better by telling a story of a particular target behavior and then working with therapists to break down the story into triggers and reinforcing consequences.

There are three broad steps that therapists should take during the functional analysis process:

- select and discuss a pro-social behavior;
- teach the adolescent to break behaviors down into triggers and reinforcers; and
- teach how to improve skills.

In-depth information about each step follows below.

### **1) (a) Step 1: Select and discuss a pro-social behavior**

Therapists should always start with a functional analysis of a pro-social behavior. This step demonstrates that therapists appreciate the adolescent's existing skills and good qualities and indicates that their primary interest is to help him do more pro-social things and to get more enjoyment from them. Therapists should maintain an interested and appreciative attitude as they explore which behavior to analyze. This is an opportunity to build rapport and trust.

Rules of thumb for getting the adolescent to provide a useful description of the target behavior include

- allowing the adolescent to use his or her own style of describing behavior; and



- allowing the adolescent, when discussing a pro-social behavior, to select the positive behavior or activity he wants to emphasize even if the adults in the adolescent’s life have different opinions about an “appropriate” activity. Therapists might say, for example, “So now I want you to tell me about something you really like doing a lot...something you are good at or have fun doing.”

**1) (b) Step 2: Teach the adolescent to break behaviors down into triggers and reinforcers**

Next, therapists should work with the adolescent to identify the triggers and reinforcers that prompt the selected pro-social behavior as well as triggers that serve as barriers to getting involved in a pro-social behavior. It will then be easier to discuss similar prompts—some of which will be the same—for his problem behaviors.

*1) (b) i. Identifying Triggers*

“Triggers” are situations, behaviors, thoughts and feelings that precede or make a target behavior more likely to happen. An adolescent’s ability to avoid negative behavior and increase positive behavior depends to a large extent on his recognition and understanding of various triggers. Helping the adolescent to analyze events and associated feelings and thoughts that precede a behavior is an important step. Things like smoking weed or skipping school do not “just happen;” there are many reasons for such behavior that kids have control over.

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**Case Study: Functional analysis of a pro-social behavior**

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The following is an excerpt from a functional analysis where the therapist seeks to help an adolescent to remove a barrier, in this case a negative trigger, and to identify and maximize the things that trigger and facilitate a pro-social activity the adolescent is interested in doing more frequently. In this case the therapist and adolescent are discussing his involvement with his high school football team.

- Therapist: “So what are the things that have to happen before you feel motivated to go to football practice?”
- Adolescent: “Well for one thing there better not be something more important going on with my friends, ’cause lately I’m not trying to miss out on what’s happening with my friends.”
- Therapist: “Like what sorts of things have you missed out on?”
- Adolescent: “It’s not specific things, I just see them outside the building having fun and before I know it I’ve skipped practice.”
- Therapist: “Do you think about what you’re missing when you are at practice?”
- Adolescent: “No, because I’m having fun.”
- Therapist: “Do you ever ask your friends what their plans are for after

school so you know ahead of time where and when to meet them after practice?”

Adolescent: “I know what you’re driving at. You think not knowing what my friends are gonna be up to is triggering me to skip practice.”

Therapist: “That’s exactly what I’m driving at because that’s what you just explained to me. I wonder if you could create a new trigger that would motivate you to go to practice by making plans with them ahead of time? Because both things are important to you, playing football and staying in the loop about what your friends are up to.”

Adolescent: “That’s not how we do things, but I could try that.”

*NOTE: In this example the therapist helped the adolescent to take control of a trigger—feeling torn between football and staying connected to his friends—which periodically led him to avoid participating in a valued pro-social activity. The therapist thus helped the adolescent create an opportunity to practice new social skills with his friends—being assertive and making plans.*

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### **Case Study: Functional analysis of marijuana-use triggers**

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The following is an excerpt from a functional analysis in which a therapist seeks to help an adolescent recognize and understand the external and internal triggers for his marijuana use:

*Therapist:* “Remember how we talked about triggers and how knowing what your triggers are might help you to stay away from weed? You mentioned that you’ve been smoking a lot of weed and I wondered if we could talk about some of things that trigger you to smoke.”

*Adolescent:* “Nah, it’s just all my friends and everybody’s smoking all the time.”

*Therapist:* “So, everybody is smoking around you and that’s what kind of triggers you to smoke?”

*Adolescent:* “Yeah, my friends hang out in the courtyard in front of my building in the morning smoking up and how am I gonna not smoke up with these guys?”

*Therapist:* “So they are just there in the morning...are there any other people you smoke with?”

*Adolescent:* “Nah, it’s pretty much just them.”

*Therapist:* “I’m curious about what you mean when you say, ‘how am I gonna not smoke with them?’ Do you mean you feel pressure to smoke with them?”

*Adolescent:* “Well I always do and they gonna think I’m a punk if tell them I

ain't gonna smoke.”

*Therapist:* “So just the fact that they are there when you walk out the door is one trigger, but it sounds like you also feel some pressure not to come off like a punk in front of your friends. Can you tell me about the last time this happened?”

*NOTE: In this example the therapist gathered some valuable information about the sequence of events prompting the adolescent to smoke weed. There was an external as well as a strong internal trigger. The therapist then asked for a specific example of this sequence in order to begin the functional analysis.*

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### 1) (b) ii. Identifying long- and short-term consequences

Adolescents generally need help understanding what reinforces a target behavior after it occurs and what the long- and short-term positive and negative consequences are. Some key points to remember include the following:

- **All target behaviors, whether problem or pro-social, have at least a short-term benefit for the adolescent.** If therapists do not acknowledge and validate this fact, they will quickly alienate the adolescent, cutting off any meaningful discussion of the long-term negative consequences of the behavior.

*Sample situation:* For many adolescents, smoking weed with their friends confers a “cool” status in their social group, helps them to control volatile emotions or simply feels good. These consequences are very valuable to the adolescent—and therapists need to acknowledge and validate that the goals of feeling “cool,” in control and of feeling good in general are worthwhile goals.

- **Focusing on the negative consequences of behavior does not motivate an adolescent to change.** Most adolescents are well-versed in the negative consequences associated with their problem behaviors. In fact, many will fixate on the negative consequences of a target behavior during a functional analysis because they believe that is what therapists want to hear. Therefore, it is important not to dwell on details of the negative consequences, but to counter-balance any discussion of them with a plan of action for attaining the positive, adaptive outcomes associated with that same target behavior.

*Sample situation:* An adolescent is chronically late for curfew. During functional analysis of this behavior, he says he thinks the long-term negative consequences are that he will not build trust with his parents, he could have his curfew changed or that he could get locked up again if his probation officer finds out. He identifies a short-term positive consequence of staying out late to be that it makes him feel more mature and independent—and indicates that he has few outlets to that make him feel that way. Although therapists should acknowledge the presence of the serious negative consequences, it is even more important to focus equal or greater attention on the adolescent’s desire to feel mature and independent by brainstorming new ways of achieving that goal other than through missing his curfew. For example, a kid might

discover through brainstorming that he derives a feeling of independence from telling his parents what time he will be home by leaving them a note, even if he indicates that he will be home before his curfew.

### **1) (c) Step 3: Teach how to improve skills**

Most of the skills taught by APT therapists are situation-specific. However, there are some universal skill sets that nearly all kids will need help developing. Among them are problem-solving skills; goal-setting skills; anger-management and conflict-resolution skills; how to refuse and avoid using drugs; and how to seek out new drug-free social and recreation situations. How and why each of these five skills is important is discussed below.

**Problem-solving skills.** Most adolescents struggle with logical problem-solving. One reason is that they have just entered a developmental phase in which they increasingly and intuitively understand the future impact of their behaviors—yet at the same time may be confused, scared or immature. Therapists can help them acquire the skills needed to solve many existing and potential future problems by coaching them on how to address the problems systematically. Among the important lessons a therapist can impart is why and how to establish a process and then to evaluate the results of each step forward. *[Additional information about problem-solving skills may be found below in Section 1) (c) i.]*

**Goal-setting skills.** Setting attainable goals and coming up with a systematic plan to work toward them is a challenge for many adolescents. They may need encouragement and advice on how to overcome their reluctance or ability to plan and set appropriate goals.

**Anger-management and conflict-resolution skills.** Adolescents often are unable or unwilling to control their emotions when appropriate under generally accepted social standards. This is not unusual; they are undergoing rapid and confusing changes, physically and emotionally, and feel pressured in new and unwelcome ways. Sometimes their emotions can lead them to lash out or respond in a potentially destructive manner. Kids who are involved in frequent fights and conflicts, who use drugs (particularly marijuana) to calm themselves or who become more aggressive under the influence of drugs or alcohol, could all benefit from learning skills to better manage their anger. *[Additional information about anger-management skills may be found below in Section 1) (c) ii.]*

**Refusal and avoidance of drugs.** Although most kids enrolled in APT enter the program because of a high frequency of marijuana use, marijuana is not physically addictive and they rarely experience physical cravings for it. Also, kids in New York City are almost never dependent on other drugs. Therefore, their desire and ability to not use drugs are linked to mental and social issues, not physical ones. Helping kids to refuse drugs and avoid situations where they are likely to use them involves exposing and challenging the beliefs kids have about their use, such as the common assumption that “I’m not cool unless I smoke.” Therapists should help them acquire the confidence and skills needed to avoid drugs, especially when such skills are not yet in their repertoire. An adolescent should ultimately reach the point where he can say no without feeling “un-

cool.” [Additional information about refusal and avoidance skills may be found below in Section 1) (c) iii.]

**Seeking out new drug-free social and recreation situations.** APT therapists should work with the adolescent and parents to explore activities and programs that are interesting and accessible to the adolescent. Most kids with little experience in organized activities (such as sports) will require hands-on coaching and support from therapists to get motivated to join and then to stay involved with such activities.

As the functional analysis proceeds, therapists should consider whether the adolescent already has any of these universal skills—in which case they may need strengthening—or needs more extensive skills-building support from the ground up. The functional analysis process is just one instance where an adolescent’s adaptive skills (those he already exhibits) become apparent; further information about strengths and weaknesses can come from a variety of places: teachers, family sessions, less formal interaction with the kid, etc. Some basic rules of thumb in working on skills-building with adolescents include the following:

- The strength-based approach requires clinicians to focus attention consistently on adaptive skills that kids have and identify any possible “upside” to their less effective efforts to cope. For example, with a kid who tends to avoid tension at home by staying out too late and getting in trouble, a therapist can reframe the behavior by focusing on the part that is adaptive. The therapist might say to the kid, “You are being really active about trying to deal with the stress you feel at home. Let’s come up with some ways to do that that won’t get you in trouble.”
- Skills are tangible and demonstrable. Therapists should model specific examples of positive behavior for the adolescent. For example, it would be useful to follow up a statement like “Why don’t you try telling your mom how happy you are when she does that?” with an example of what language and words an adolescent might actually use to express that thought.
- Role-playing is crucial. It not only provides kids with an opportunity to learn and practice new skills, but also can assist kids in their efforts to assess and remove some of the barriers that prevent them from coping or behaving in certain ways. For instance, an irrational belief like “I can’t refuse to smoke weed without looking like a punk” might emerge during an exercise in which an adolescent is asked to try out how he might refuse marijuana when it is offered.

Therapists may find the following suggestions useful as they seek to teach adolescents new skills and help them change behaviors.

- Ask kids for advice on how to handle difficult situations. This is a nice way to break the ice and to identify strengths to build on.
- Encourage and prepare kids, through role-playing, to try responding to a problem situation in a way they might not have considered before.
- Coach new skills in real time. Tell kids and parents that they can e-mail or

- call you (and leave messages on your answering machine, if necessary) to give immediate feedback on successes and difficulties.
- Reframe the basis for and effects of problem situations and problem behaviors. Common ways to reframe include:
    - finding positive intent in negative behavior;
    - seeing crises as opportunities;
    - magnifying positive exceptions to problematic behavior; and
    - seeing failure as a learning experience.
  - Communicate in ways that do not cause resistance. For example, instead of saying, “I don’t want you to storm out of the family session this week,” try a phrase like this: “I’d like you to work with me to get all the way through the next session.”

### *1) (c) i. Problem-solving skills*

The framework for basic problem-solving skills is something that should permeate APT therapists’ work with kids. It is important to remember that kids do not intuitively know how to systematically problem-solve. Key elements of teaching problem-solving skills include the following:

- recognizing that there is a problem. Kids may not be aware that a problem exists, so defining a problem is the first step toward a solution;
- identifying and specifying the problem. Kids may need help identifying a manageable problem to address. Therapists should focus on defining the problem in a way that makes it sound approachable—kids tend to blow problems out of proportion or, conversely, minimize them;
- considering and brainstorming about various approaches to solving the problem. Therapists should let the adolescent brainstorm first before stepping in with advice—this is an excellent way of immediately empowering the kid;
- selecting the most promising approach. Mapping out consequences and thinking ahead (“What will happen if I...?”) are key skills here. Kids with impulse control issues will typically have difficulty visualizing consequences; and
- assessing the effectiveness of the approach that was actually implemented. Therapists should ask themselves and the adolescent, “What actually happened?” Among issues to consider are whether the approach selected got a fair try and whether or not it worked, and why. Therapists should also practice good “spin control” by reframing mixed results so they are not discouraging, and thus establishing a framework on which to build future efforts.



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### **Case Study: Problem-solving**

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Andre is a 15-year-old boy who began avoiding a particular class in school because he felt that the “teacher had it out for him.” He told the therapist that the situation was completely out of his control because this teacher has a reputation for choosing one kid to pick on each year and he was selected this time. The therapist acknowledged that while it may be true that the teacher had decided to pick on him, it was not necessarily true that Andre was powerless to come up with some possible solutions. Andre agreed to approach the issue using problem-solving strategies instead of just giving up and receiving a failing grade in the class due to poor attendance.

The therapist and Andre started with a brainstorming session in which they came up with a number of things that Andre could control in the classroom that might have a positive impact on the teacher’s attitude toward him. Andre’s ideas included sitting closer to the front of the room, sitting more attentively in his chair, getting to class early, turning in homework every day for a week and trying to raise his hand with an answer once per class. Andre initially said he wanted to try everything on the list; the therapist convinced him, however, to do only one thing first so they could more easily determine what might work. They decided that Andre would try to raise his hand once per class with an answer or a comment that was relevant to the topic being discussed and that they would then evaluate at the end of the week if that improved the way the teacher responded to him.

The preliminary result of this problem-solving “experiment” was that the teacher seemed to respond to Andre’s efforts with appreciation. It was then clear to Andre that he could influence the resolution of the problem, and he indicated his willingness to try other steps if necessary.

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#### *1) (c) ii. Fostering healthy expressions of anger*

Teaching anger-management skills can be difficult in adults, let alone adolescents with problematic behavior issues. Yet therapists should approach these skills the same way as they do other problem behaviors. The first step is to undertake a functional analysis of the problem and then look for opportunities to build skills around dealing with internal and external triggers. Therapists should keep the following in mind when focusing on anger management among their adolescent clients:

- Identifying triggers and lowering responsiveness to them are critical steps.
- Verbal labeling of internal states can lead to angry outbursts.
- Teaching new skills is necessary to help the adolescent learn to de-escalate and slow down the process of losing control of his anger. Examples of such skills include
  - *self-statements*: helping adolescents to come up with simple statements they can say or think to themselves, such as “I don’t need



- to explode and get in trouble to make my feelings known;”
- *thought-stopping*: helping adolescents learn to immediately shift their attention or distract themselves when an anger-provoking thought occurs; and
- *relaxation and breathing techniques*.
- Teaching new interpersonal skills can help the adolescent to better negotiate trigger situations. Examples of such skills include
  - *recognizing the difference between assertiveness and aggressiveness*: most kids know the difference, but in practice they still confuse the two;
  - *employing systematic problem-solving steps when faced with a situation that triggers anger*; and
  - *attending to, ignoring and reframing social cues*: role-playing can be helpful in desensitizing kids to social cues, such as teasing, that often trigger excessive anger.

1) (c) iii. *Refusal and avoidance skills*

Learning avoidance and refusal skills requires the adolescent to recognize triggers to drug use. Therapists should use a functional analysis to assist in this process. Some steps therapists might consider taking to help adolescents learn avoidance and refusal skills include

- teaching and reinforcing the relationship between the adolescent’s substance abuse and contact with friends who use. A useful exercise to initiate this discussion would be to ask the kid, “How fast could you get some weed and get high if you walked out the door right now?”;
- brainstorming ways of making it more difficult to get high that quickly;
- coaching the adolescent in ways of talking to drug-using peers about his or her intention not to use. This type of coaching is called assertiveness training. Therapists should use role-playing and modeling of possible responses; two excellent initial steps would be to have the adolescent play the role of the person offering the drug (so therapists can get a sense of what he is up against) and teaching the difference between passive and assertive responses. Results from employing these methods might include
  - shoring up the adolescent’s ability to respond rapidly to peers without apologizing or hemming and hawing;
  - successfully encouraging the adolescent to agree to make eye contact with peers during difficult conversations;
  - getting the adolescent to agree that his responses to peers should be firm so as to close the door to further coaxing; and
  - convincing the adolescent to prepare follow-up responses to peers in advance.

Here are some examples of refusal language that APT's adolescent clients have arrived at through role-play:

"No thanks, I need a clear head to talk to my girl."

"Not today, I have to deal with my probation officer."

"No thanks, I'm cool."

## **CHAPTER 7**

### **EDUCATIONAL INTERVENTION**

The adolescent's ability and interest in obtaining a good education is an important goal for family members, especially parents, in the APT program. Education is a priority because it can lead to useful employment opportunities for adolescents and may also help them stay out of trouble.

This section focuses on the mechanics of the very first step towards getting an education: enrolling the student in school. In most cases, adolescents involved in APT therapy have not attended school for several months at the very least because they have been incarcerated or have dropped out for another reason. It may be necessary to enroll the student in his former school or in a new one. Important enrollment and education issues that therapists should be prepared to assist families with include

- a) enrolling the student:** the basic steps that APT therapists should take to support the family through this process;
- b) troubleshooting:** things that can go wrong during the enrollment process and what APT therapists should do in response; and
- c) helping students with special learning needs:** identifying and finding services for students with unmet learning needs.

Each of the three issue areas is discussed in detail below.

#### ***A. Enrolling the student***

In some instances, helping parents enroll a child in school is a relatively simple procedure. APT therapists should gather the appropriate information and documents from the family; coach parents on how to advocate within the school system; and offer additional support by going with them to the school to enroll the student.

##### **1) Obtain the student's educational history**

Therapists' initial step should be to meet with family members to obtain a detailed educational history. If the adolescent is unable to participate because he is incarcerated, therapists should not wait until he is released. Even if the student is not immediately available to meet, therapists should be in touch with parents to gather the student's educational history and begin preparing for the enrollment process as soon as possible.

Among the possible questions therapists might ask during this information-gathering process are the following:

- What are the names of the most recent schools your child has attended?
- Has he traditionally done well in school?
- What aspects of school does he enjoy the most? Find the most difficult?

(For example, what does he feel about getting up in the morning, a particular subject, feeling threatened at school, etc.)

- Has he ever been evaluated for special education? Have you ever thought that he should be evaluated or had it suggested to you by one of his teachers?
- Has he ever been suspended from school?

## **2) Gather necessary documents**

Therapists should get copies of the following key documents for each student:

- most recent transcript
- immunization record
- IEP (individual education plan), for special education students
- proof of residence (such as a utility bill with parents' name)

Gathering these documents as early as possible will prevent delays in enrollment. Therapists should be prepared to call the facility to request the most recent transcripts or other pertinent documentation.

## **3) Coach parents on how to advocate for their child**

Throughout the enrollment process, therapists should focus on helping develop parents' advocacy skills, keeping in mind that they are the primary, long-term advocate for their child. For example, therapists should

- prepare parents for the questions they will be asked by school officials about the student's educational and delinquency history;
- allow parents to speak first when meeting with school officials;
- redirect questions to allow parents to respond (when school officials ask therapists questions that should be answered by parents); and
- find a school official, guidance counselor or placement officer who has advocated for the student in the past to make it easier for the parent to be an advocate.

Parents are often persuasive advocates when given the opportunity and the support. Sharing concrete examples of other parents who succeeded in advocating for their kids can help jumpstart parents to do the same. One mother of an APT kid wrote letters to the mayor and agitated school officials until they listened to her complaints. As a result, the adolescent was placed at an exclusive private school at the city's expense.

## **4) Go with the family to enroll the student**

Therapists may accompany parents to register the child in school if their participation would be helpful to the family and is clinically appropriate. Therapists' primary role in

such situation is to support parents and help make it clear they are their child's principal advocate.

Therapists should not accompany family members to register the student if parents are comfortable doing so without additional support. Therapists should also decline to participate in the registration process if it seems as though parents' confidence and authority within the family hierarchy would be strengthened by their advocacy efforts without the presence of therapists.

### ***B. Troubleshooting: What to do when there's a snag in the enrollment process***

The enrollment process may require additional intervention from APT therapists. For example, the following factors may complicate the enrollment process for students who have been involved in the juvenile justice system:

- High schools in poor communities are often overcrowded, understaffed and forced to function with limited resources.
- Schools are sometimes resistant to welcoming back a student who has had a history of truancy, delinquency or acting-out in school.
- Kids who were not motivated to be in school before being detained are often unsure that they can be academically successful now that they are home again.
- Some students have special learning needs that have not been identified or are not being met adequately.

When confronted with any of these factors, APT therapists have a number of options to help family members with enrollment. For instance, they can

- locate a helpful school administrator;
- gather supporting documents;
- contact an advocacy organization;
- plan for delays in the placement process; and/or
- find a school with small student-to-teacher ratio.

Each of these five options is discussed in detail below.

#### **1) Locate a helpful school administrator**

A contact person within the school can be a catalyst for the enrollment process. A guidance counselor, teacher or placement officer can be useful to the family, especially if the contact person has worked with the student in the past and can provide positive, anecdotal information to convince school officials that he would be a good fit for their school. Helping family members to make a personal connection with a school staff member can also be valuable later when the student is adjusting to his new school.

To find a helpful contact person with the school, therapists should

- ask parents directly whether they have recently had a teacher or guidance counselor who was supportive to them and/or their child; and
- help parents contact this person, if parents agree that it would be helpful.

## **2) Gather supporting documents**

A school or placement officer will make assumptions about a youth's potential based on his transcript and attendance records. Therefore, supporting documentation that vouches for the student's positive behavior and/or academic potential also may be helpful to obtain. Therapists or parents should be prepared to provide letters from previous teachers or school administrators that highlight the student's strengths and learning needs—useful information that the other records may not capture.

For example, one APT client, Angelica, was in detention for several months and made significant behavioral improvements. In contrast to administrators' opinions at her old high school, a teacher from the detention facility developed a positive opinion of Angelica's academic performance and potential. At the parent and therapist's request, the teacher wrote a letter of reference for her. As a result, when Angelica was released she was assigned to a better school than the one that was unwilling to accept her before.

## **3) Contact an advocacy organization**

In certain circumstances, therapists should refer family members to an organization that helps parents advocate for their student's rights. An educational rights advocacy organization can be helpful when

- the learning needs of a student in special education are not met by the educational system; or
- the school is resistant to enrolling a student because he is court-involved and may be labeled a "trouble maker."

For some parents this may be the first time that someone with a measure of authority advocates for their child's legal rights vis-à-vis the school system. It can be informative, helpful and empowering to the parents.

## **4) Plan for delays in the placement process**

When the placement process takes longer than expected, the adolescent's motivation to get into school may begin to ebb. Students who have been in placement for many months are particularly susceptible to being frustrated by delays. Many of them return to the community with a specific timeline and educational goal in mind, and disappointment begins to set in when this goal is not attained quickly. Therapists should address the possibility of a delay in the placement process when speaking with other family members before the adolescent is released from the facility.

In particular, therapists should inform family members that the placement process may take longer than they think. Therapists can help prepare them for the inevitable frustration of waiting by exploring the following questions:

- How has the student traditionally handled anxiety, particularly the anxiety of waiting without knowing what's going to happen next?
- How do parents respond when their child gets anxious, impatient or hopeless? Has this proven to be a helpful response?

### **5) Find a school with small student-to-teacher ratio**

In larger communities there may be a choice of schools. When presented with several schools to choose from, therapists should advise parents to prioritize a school with smaller classes since this will give the student more one-on-one help. The school's distance from the home is another important variable for the family to consider.

When there is a choice of schools, finding an appropriate learning environment may take months. The student may need to attend a less preferred school for a semester before he transfers into a better school.

## ***C. How to help students with special learning needs***

Many of the adolescents in APT either have already been identified by the school system as having special learning needs or are in need of being identified as such. There are specific ways that APT therapists can intervene in both circumstances to help family members navigate the complexities of special education services.

This section is broken into two parts. One focuses on what therapists should do when a student seems to have special learning needs but is not classified as having them; the other part considers situations when a student is misclassified because of an inaccurate assessment. Each scenario is discussed in detail below.

### **1) Evaluating a student who is not classified**

It is not uncommon for an adolescent in APT who is need of special education services to have never been evaluated in the past. APT therapists can play important roles in both assessing whether a student should be evaluated and then in arranging for the initial evaluation to take place if deemed appropriate.

There are generally two reasons why a student has not been evaluated for special education: either the school system has overlooked (often unintentionally) the student's learning needs or ability, or parents oppose having the student evaluated. Each of these reasons is discussed in detail below.



**1) (a) When school personnel have never sought an evaluation**

Often a student has simply never been flagged by teachers as having special learning needs. Therefore, even if teachers have not sought to evaluate the student in the past, therapists should look for certain signs, including:

- A student who seems otherwise motivated to start school begins to act out in school because he is not successful in class, or he loses interest in school and stops attending altogether.
- A student is making an effort in school but gets frustrated because he cannot master the material as quickly as other students.

*Evaluation example #1.* A 16-year-old named John had reached only a kindergarten-aged reading level, but he had never been evaluated for a learning disability. He wanted to learn, but was stymied by his reading ability. The APT therapist met with John's mom, guidance counselors and teachers to ask them to assess his performance. Simply alerting them to John's obvious learning delay was sufficient to begin the process of getting him the services he needed.

**1) (b) When parents oppose evaluation**

The second reason that an evaluation may not have taken place stems from parents' opposition. A student may never have been evaluated because, despite teachers' concerns over the years for the student's progress, his parents are opposed to special education. Parents' opposition can have many sources, but most often it centers on their perception that special education is a stigma and trap that is hard to escape.

In the face of parental opposition therapists should

- proceed slowly, respectfully exploring with parents why they are reluctant to have their child evaluated;
- provide parents with accurate information about special education services and how they can benefit the student; and
- inform parents of their legal rights to challenge the evaluation results or placement recommendation.

*Evaluation example #2:* The grandmother of an adolescent named Antoine did not want him evaluated because years before her daughter was placed in a special education classroom with students with behavioral disorders. Her daughter subsequently lost interest in school and dropped out; Antoine's grandmother did not want the same thing to happen to him. The therapist informed the grandmother of her right to challenge the evaluation process if she disagreed with the outcome or to refuse the school recommendation if she and Antoine did not like it. This allowed her to pursue the evaluation with more confidence.

On some rare occasions, parents take offense at the suggestion that their child has special learning needs because it implies to them that they have done something wrong

as a parent. These parents may have feelings of humiliation based on the belief that having their child evaluated reflects poorly on their parenting competency. This situation is less common but may be especially difficult for therapists to address

*Evaluation example #3:* Julian was never evaluated for special education because his mom was offended at the prospect. She thought having him evaluated for special learning needs meant that she was not a good parent. The APT therapist explored with her the cultural and personal reasons behind this belief and discussed the potential benefits of special education services. Eventually, when the mom was ready, the therapist accompanied Julian and his mother to the evaluation. Julian's mother said it was the first time that she felt informed about his learning needs and confident about how best to advocate for his education. She was proud that she had fought to get him the services he needed and deserved.

The following are important rules of thumb for therapists working with parents who initially are opposed to special education evaluation:

- Explore with parents their thoughts, beliefs and misconceptions about what it means to be in special education.
- Avoid debating the benefits of special education services with parents who are opposed to it. Instead, encourage them to speak with their child's teacher or school administrator. This may be the first step toward their ability and desire to make a more informed decision.

## **2) Reevaluating a student who is misclassified**

Students who are classified as having special learning needs are often mislabeled or are not getting the services they are eligible to receive under government mandates. There are essentially two types of classifications for students in the special education system: students with an emotionally disturbed (ED) classification have historically had behavioral problems in school, and a learning disabled (LD) classification is for students who have certain learning needs that are not met in a general education classroom. An LD classification is preferable to an ED classification because the former expands the number of placement options and offers greater advantages to students. For a variety of reasons, ED classrooms are often poor learning environments.

Adolescents in the APT program who are returning to the community from an extended placement need to be reevaluated. APT therapists should help parents request a reevaluation so the school has a more accurate understanding of the student's learning needs. This is also an opportunity for therapists to provide letters from the residential placement facility which corroborate behavioral change and/or learning needs that were previously overlooked.

*Reevaluation example:* Edward was classified as ED before he was detained. The APT therapist asked a facility administrator to write a letter acknowledging Edward's behavioral improvement and recommending that he be reclassified as LD. Armed with this letter, Edward and his mother successfully advocated with school authorities for a proper classification and a more desirable school placement.

## **CHAPTER 8**

### **APT TREATMENT TIMELINE**

A family's participation in APT treatment usually begins shortly after the youth is arrested. No matter how long detention lasts, the APT model always includes an intensive four-month treatment period after the adolescent has returned home.

#### ***A. Phases of APT treatment***

Treatment strategies that are useful while the adolescent is in placement are different from what works once he returns home. As a result, APT divides its treatment into three treatment phases corresponding to the pre- and post-release period and to the discharge planning phase. Each of these three treatment phases is discussed in detail below.

##### **1) Phase One: Out-of-home placement**

Phase One encompasses the entire period that the youth is away from home, whether he is in detention or placed in a facility for a set length of time. During this time therapists should

- assess and engage family members;
- set treatment goals with them;
- motivate them for the intensive treatment phase; and
- set up community linkages like school placement and additional treatment services if needed.

##### ***1) (a) Frequency and type of contact in Phase One***

An adolescent's length of stay in placement can vary from a few days to over a year. Kids who are quickly released by a judge or placed on probation will be back in the home almost immediately. Many other cases take a few months to be decided and then the adolescent either comes home or is placed in a state facility for a year or more. In situations when adolescents are returning home relatively quickly, therapists should begin the engagement and goal-setting processes during the brief period of placement.

During Phase One, therapists should seek to

- manage the treatment so that a "motivational peak" does not happen before the child comes home;
- stay in touch with family members so continuity is maintained; and
- facilitate contact between the adolescent and other family members so that family bonds are maintained during phase one.

##### ***1) (a) i. 'Short' stay in Phase One***

When Phase One is brief, it should be treated as the "on-ramp" to the intensive

community phase. The pattern of contact with the child and other family members should be as frequent as necessary to facilitate the goals of assessment, engagement, setting goals for the treatment and planning for the youth's release. At a minimum, in the first two weeks of the treatment therapists should

- see the adolescent, in the detention facility, at least twice;
- conduct a home visit with other family members;
- facilitate at least one family session in the facility or an additional home visit;
- assess school placement and work toward an appropriate school placement if the adolescent is not currently enrolled (*see Chapter 7 of this manual*); and
- attend at least one court date and meet with the adolescent's lawyer.

While the youth is in detention, therapists should continue to see other family members weekly.

**1) (a) ii. 'Longer' stay in Phase One**

Phase One objectives are the same even if it becomes clear that the youth will be placed out of the home for a longer period of time (these are "sentenced" kids). However, in such situations therapists must establish a more appropriate pace. To do so, they should seek to

- conduct monthly sessions with the adolescent in the facility if possible. Phone sessions can be substituted if face-to-face sessions are not possible. During these sessions, therapists should do a functional analysis of substance abuse, problem behavior and pro-social behaviors;
- meet with key facility staff, including counselors and teachers, to collaborate on strategies to help with adolescent's behavioral adjustment to treatment;
- include other family members in these monthly sessions as often as possible (but at least once) in preparation for release from placement;
- hold separate sessions with parents in their home as needed. This should take place at least once in preparation for the child's return;
- check in by phone periodically with parents and the child; and
- maintain regular phone contact with counselors and other staff in facilities where adolescents are placed.

**1) (b) Planning for return to the community**

During the period immediately prior to the adolescent's release, therapists should increase the intensity of contact and interaction. Some of the key priorities for therapists in this period include

- finalizing preparations for school placement;
- setting up community referrals such as psychiatric medication management; and

- conducting a pre-release family therapy session in which therapists motivate family members for the adolescent's fresh start at home and in the community—and also seek to instill a sense of reality about what it may be like at home after his return. This is referred to as the “therapeutic bubble burst.”

**The ‘Therapeutic Bubble Burst’**

The “therapeutic bubble burst” is APT’s technique for assertively managing unrealistic expectations for change upon release from detention, yet without dampening motivation for change.

Therapists should respond immediately to the adolescent’s unrealistic beliefs about returning to the community. The following example indicates how this might be done.

*Adolescent:* “I won’t have trouble resisting my friends because I am just going to stay inside all the time except when I’m in school.”

*Therapist:* “Wow, you sound really motivated to avoid getting in trouble, but we know that you will have to go out sometimes. We need a plan to help you to resist getting into trouble when you are out with friends.”

Therapists should respond immediately to parents’ assumptions that the behavior change has already taken place during placement—and that therefore their participation will not be required. The following example indicates how this might be done.

*Mom:* “Well, he learned his lesson so I guess we’re not gonna have those same problems again.”

*Therapist:* “I’m sure he learned a lot, but we still need to support and encourage him to use what he has learned when he gets home. He’s still a kid, and kids need their families to help them make the right decisions.”

During discussions with parents and other caregivers, therapists should emphasize that substance use “slips” and returns to old ways of behaving may occur as a normal part of the therapy process. The following example indicates how this might be done.

*Therapist:* “Mom, it’s a normal part of being a teenager to slip up once in a while. We need to focus on getting him to change his behavior one step at a time.”

**2) Phase Two: Intensive community treatment**

The “community phases” comprise the period of intensive treatment after the adolescent returns home from placement. APT divides the community phases into four “quarters.” Each quarter lasts four weeks and has a unique set of objectives and expectations for the frequency of therapists’ contact with the family. The final quarter is the discharge planning phase, also known as Phase Three.

**2) (a) Quarter One (weeks 1-4)**

The first quarter of the community phases is when therapists should establish a working relationship with family members or re-start relationships with those who have experienced a long Phase One. The overall objectives in getting treatment off the ground include

- continuing the engagement process;
- continuing to assess family members’ needs; and
- setting attainable short- and long-term goals.

*Frequency of contact:* Therapists should focus on achieving the following during Quarter One:

- Holding one or more family therapy sessions per week
  - a goal-setting exercise should be conducted in the first session
  - a family genogram should be drawn in the first or second session
- Holding one or more individual sessions per week with parents and/or the adolescent

- a functional analysis of pro-social behavior, substance abuse and problem behavior should be conducted
- Holding an initial meeting with supervising aftercare worker or probation officer and family members
  - a plan should be established for further communication and/or meetings with this worker if necessary
- Conducting periodic telephone check-ins (roughly 2 times a week) between sessions. These calls should include both parents and the adolescents, if possible.
- Beginning random urinalysis
  - The first urinalysis should take place in the first week of Quarter One

**2) (b) Quarter Two (weeks 5-8)**

During the second quarter of the community phases, APT treatment should be in full swing—with regular individual and family therapy sessions taking place in the home. Family members should be working toward clearly articulated treatment goals inside and outside of therapy sessions, and a regular pattern of feedback should be established between therapists and the family.

Among the overall objectives therapists should seek to meet during Quarter Two are the following:

- ensuring that family therapy sessions take priority over individual sessions;
- encouraging family members to work actively toward their goals;
- maintaining their engagement and intensity of contact
  - In particular, this requires therapists to strike a balance in their alliances with parents and adolescents;
- encouraging and supporting parents in their efforts to establish the capacity to interact independently with outside agencies like school, probation, etc.
  - This step requires therapists to begin scaling back their role as liaison with outside agencies and getting parents to take on this responsibility; and
- revising treatment plan and goals where and when necessary.
  - This effort requires feedback from family members to fine-tune interventions.

*Frequency of Contact:* Therapists should focus on achieving the following during Quarter Two:

- Holding at least one family session per week (more if needed)
  - family goals should continue to be revisited and updated if necessary
  - positive changes that family members have made should be reinforced

- Holding individual sessions with parents and the adolescent on alternate weeks, if necessary
  - parents may need coaching on how to reinforce new behaviors
  - kids may need extra support trying out new behaviors
- Conducting telephone check-ins once or twice a week
- Contacting, on a monthly basis, school/probation/aftercare staff to enlist them in the treatment strategy
- Continuing random urinalysis two times per month.

## **2) (c) Quarter Three (weeks 9-12)**

During the third quarter, therapists should begin to plan for discharge and work with family members to determine which treatment goals have been met and which still remain a priority for the final stretch of treatment.

Among the overall objectives therapists should seek to meet during Quarter Three are the following:

- emphasizing tracking and giving feedback on progress and positive changes;
- beginning to positively reference/frame the fact that treatment is more than half complete;
- continuing to revise/troubleshoot goals and strategies; and
- encouraging family members to work independently on their goals outside of sessions.

*Frequency of Contact:* Therapists should focus on achieving the following during Quarter Three:

- One or two face-to-face contacts with family members per week. These can consist of a family session, an individual session (with parents or kids) or both kinds of sessions. Regardless, the treatment plan's goal is to taper off sessions to once a week toward the end of this quarter.
- Frequent phone check-ins should continue as a means to support the independent work family members are doing toward their goal outside of therapy sessions
- Continuing random urinalysis one time per month.

## **3) Phase Three: Completion of treatment**

The final month of treatment extends from weeks 12-16. During this period, therapists should focus on reinforcing and celebrating family members' progress and continuing to work on remaining treatment goals. Therapists should also set up referrals to and linkages with community services that may be needed after APT treatment is finished.



At the final session, the youth and other family members are “graduated” and awarded certificates.

Among the overall objectives therapists should seek to meet during Phase Three (also known as Quarter Four) are the following:

- reflecting back on treatment progress and reinforcing positive changes;
- initiating any necessary referrals and taking steps to ensure follow through; and
- helping family members to experience the completion of treatment in a positive way.

*Frequency of Contact:* Therapists should focus on achieving the following during Phase Three:

- Holding two or three family or individual sessions, as needed
- Accompanying family members to agencies where ongoing treatment or support is being sought
- Organizing a final discharge session that summarizes treatment and serves as the “graduation” for the adolescent.
- Awarding the family a certificate of completion

## **CHAPTER 9**

### **PROGRAM STAFFING**

As in most fields, the quality of APT's treatment work depends on the quality and commitment of its staff. Therapists are in the frontline of APT treatment, interacting directly with clients much more frequently than other staff. They must be dependable and engaged, always recognizing that their visibility and assistance are appreciated—and often valued highly—by most clients and their family members.

This chapter provides some basic guidelines for, and ideas about, effective staffing efforts for APT programs. They may be useful to clinical directors and others seeking to find the most appropriate therapists for the clients and communities they serve.

#### ***A. Educational requirements and work load***

It is recommended that APT therapists have a master's-level degree in either social work, counseling or clinical psychology. In most programs, each therapist is likely to be carrying a caseload of roughly 15 adolescent clients and their families at any given time.

#### ***B. Evaluating therapist candidates***

##### **1) General recruitment and evaluation information**

Finding qualified APT therapist candidates can be a challenge. To a large extent, this difficulty stems from the fact that most university-based training programs continue to place a strong emphasis on teaching the principals of diagnosing and treating psychopathology from the perspective of the medical model, which does not highlight (or even acknowledge) the family and other systems in the community as a resource in bringing about behavior change in young people with behavior problems. As a result, the core elements of APT's treatment model—strength-based practice, cognitive-behavioral treatment principles, family systems therapy and a multi-systemic orientation—are not strongly represented on the training curricula of most social work, counseling or other clinically oriented master's degree programs. Candidates recruited to fill therapist positions in APT therefore often have little exposure to the theories and hands-on clinical training in these modalities and treatment orientations.

In evaluating candidates for APT therapist positions, it is important to look for a strong willingness to learn new approaches to treatment that are in many cases antithetical to their prior training. Candidates should be evaluated for their instincts in integrating strength-based and multi-systemic thinking by having them respond to clinical hypotheticals with approaches linked to APT guidelines and philosophy. In interviewing candidates, the APT program's clinical director should role play clinical situations that challenge them to think systemically and to avoid pathologizing or labeling the clients' difficulties.

A key principle of the APT treatment model is that treating families in their own

community contexts not only promotes better treatment engagement and consistency, but leads to a more powerful therapy experience for both family members, who can more quickly attain an optimal level of trust, as well as for therapists, who gain a unique window into the clients' cultural and familial experiences. While often rewarding overall, this approach requires an enormous commitment of time and energy on the part of therapists; furthermore, it rarely provides the same professional prestige as traditional, clinic-based work. It may be difficult for the therapist candidate to evaluate his own readiness and motivation for this type of work during a job interview.

A clinical director or others involved in hiring APT therapists do, however, have some tools to help them evaluate candidates' readiness for APT's field-based work. First, candidates with some past experience with home visits or field work know what this work is like. When these candidates say that the work interests them and that they can do it, their statements have a basis in experience. Second, the clinical director must clearly characterize the nature of the field work without soft-pedaling its intensity or potential for frustration. An effective way of doing this is to thoroughly describe a therapist's typical workday or discuss actual examples from a therapist's work at APT. Third, it is important to allow the therapist candidate time to evaluate his readiness for a field-based job by telling him clearly that he need not indicate in the first interview whether he is prepared to work in this fashion. Finally, it is important to arrange for a candidate who has passed the first interview to meet privately with current APT therapists—who should be encouraged to respond candidly to the candidate's questions about the work.

## **2) Diversity issues**

The communities from which APT draws its client base are not only the most economically disadvantaged in the New York metropolitan area, but are also populated largely by African-American and Latino families. An essential part of the recruitment process should include focusing on building a treatment team that is both reflective of the cultural backgrounds of the clients and sensitive to the special issues they face in accessing treatment services. APT places recruitment materials and job postings in locations where African-American and Latino therapist candidates are likely to seek job information—for example, job fairs with a minority recruitment focus, and Latino and African-American social work organizations. APT also evaluates potential therapist candidates based on their willingness and ability to take a culturally sensitive perspective on the work APT does.

## **CHAPTER 10**

### **FIELD-BASED LIVE FAMILY THERAPY SUPERVISION**

APT's family therapy intervention takes place almost exclusively in the field. Because therapists travel to client's homes, APT does not include clinic-based live supervision that programs doing family therapy traditionally rely upon. Instead, APT uses a supervision method that is based on open "therapeutic reflection" between supervisors and therapists.

During the training period, new APT therapists accompany experienced therapists on family therapy visits as observers. As they begin to take on cases of their own, they are joined by a clinical supervisor who teaches by modeling and engaging the trainee in a therapeutic reflection dialogue about family members' strengths and problems as these issues emerge in the session.

#### ***A. Interactions between therapists and supervisors***

##### **1) Building autonomy**

APT's field supervision allows a gradual increase in the amount of autonomy given to new therapists during the training period. As they become more skilled, trainees are encouraged to take the lead in running sessions. Although they attend sessions less often as training progresses, APT supervisors continue to provide ongoing support by making regular field visits to observe therapists in action and to identify areas where additional supervision is needed.

##### **2) Building on therapists' existing strengths**

In the early stages of field-based training, supervisors emphasize and build on new therapists' strengths to help them achieve competence as a family therapist. Decisions regarding early planned interventions or assessment visits with families should be based on new therapists' existing skills. For example, in an initial family session, a therapist's knack for explaining aspects of the juvenile justice system might be deployed as a way of engaging with family members anxious or confused about what their child is dealing with.

##### **3) Preparatory planning sessions**

Therapists and supervisors should coordinate efforts in advance by having a focused meeting prior to the session. These sessions should be used to review treatment to date, set hypotheses about what the core problems and strengths are and discuss how the treatment should proceed overall and in upcoming specific sessions. Although family therapy sessions should not be scripted, a prep session should outline a general strategy for how therapists might approach them. For example, specific interventions can be planned in advance with a family where parents are undermining each other's parenting efforts. In this situation, supervisors and therapists may decide in advance to watch for and highlight instances of coordinated parenting.

Preparatory planning sessions can also be useful to help therapists generate a list of questions they have about the family. If treatment goals are not clearly defined for whatever reason, supervisors and therapists may plan in advance to hold a goal-setting exercise with family members.

#### **4) Debriefing**

Debriefing after a session is an important training tool. It often takes place as supervisors and therapists travel together by train, bus or car back to the office. Debriefing in a public setting like a train should only take place when supervisor and therapist are certain that their conversation will not be overheard. And, in general, no names or identifying information should be mentioned when debriefing. This shared traveling experience can help build trust between supervisors and therapists and effectively reinforces that they are “in it together” as a team. The debriefing process can help therapists to develop awareness about how their emotional experiences might affect the work. Supervisors should encourage this sort of reflection through modeling—such as using reflections of their own experiences during family sessions.

For example, a supervisor might make the following comment to a therapist during the debriefing process:

Supervisor: “Did you notice that in that session I waited a little too long to intervene with the mother when she was yelling at her son? Even though I knew she was going way too far in berating her son for getting arrested, I think I was too caught up in empathizing with her frustration because of my own frustration with his rude behavior toward me. I’ll need to pay attention to that in the future.”

This sort of self-reflection demonstrates how therapists’ own feelings could get in the way of making an effective intervention in the moment.

#### **5) Supporting the unique needs of field-based therapists**

It is important for supervisors to be aware that field-based clinical work is significantly more stressful than clinic-based work. Supervisors should be prepared to discuss and validate therapists’ experiences and offer praise and reinforcement for their commitment to doing this very difficult work. Supervisors can prepare new therapists by focusing on and directly addressing the following issues:

- Working with adolescents in juvenile detention centers can be challenging and upsetting to therapists who have never worked in these settings. As a part of training, supervisors should accompany new therapists on tours of detention facilities and meetings with facility staff. Also, therapists should be encouraged in group supervision to openly discuss their experiences working in these environments.
- Impoverished neighborhoods, where most of APT families live, may expose

therapists to poverty levels they are not accustomed to. This can be a source of stress for therapists.

- Therapists need to receive specific safety training in advance as part of preparation for the fact that inner-city neighborhoods may pose safety concerns.

## ***B. Interacting with families***

### **1) Introducing live supervision to clients**

Family members are nearly always open to having an additional member of the treatment team attend a family session. Live supervision sessions indicate that APT works as a team and that APT staff take clients seriously enough to invest additional staff time and energy to helping them.

Therapists should seek to introduce the idea that they will be accompanied by another member of the APT team early in the treatment process. Otherwise family members may see this development as a response to a problem. Furthermore, although it can be encouraging for some family members to be aware that a supervisor is overseeing their case, it is not necessary to introduce the field trainer as a supervisor. This can be decided in advance on a case-by-case basis.

### **2) Therapeutic reflection technique**

The therapeutic reflection technique consists of supervisors and therapists asking questions out loud in the presence of family members. It is intended to help family members make changes in how they function or to alert training therapists of the need to focus on a particular strength or issue in a family session. The process serves two functions simultaneously:

- It informs family members of what therapists are thinking, which may be useful for them as they seek ways to deal better with their problems.
- It allows supervisors and therapists to collaborate by posing questions and voicing hypotheses aloud during a session.

For example, a supervisor may turn to a therapist during a live supervision session and say:

“I wonder if this family is aware of the level of trust they have established with each other over the years and how that will allow them to handle some of the difficult issues they will have to talk about while they are in therapy with us—like John’s gang involvement.”

In this example, the supervisor’s reflection, framed as an open-ended question, serves both of the key functions mentioned above simultaneously:

- It highlights for family members that the treatment team feels they have a particular strength in terms of mutual trust. It also provides encouragement that they will be able to handle talking about the difficult topic of the adolescent's gang involvement.
- It is a way of drawing the training therapist's attention to this family strength and is a signal to the therapist that the supervisor feels the family may be ready to address this topic.

## **2) (a) Guidelines for therapeutic reflection questioning**

In general, the effectiveness of therapeutic reflection questions can be determined by how well they encourage family members to imagine using existing strengths or acquiring new skills in order to grow and change. When asked of training therapists, a reflection or question should allow them to imagine a new way of thinking about a family and/or provide them with a clear suggestion for what to do next in the session—for example, highlighting a strength or focusing on a specific topic.

The following are some basic rules of thumb for therapeutic reflections:

- *Reflections should be open-ended* and speculative, thus allowing family members and training therapists ample opportunity to interpret and respond to them.
- *Reflections should focus on strengths* and should have positive connotations rather than focusing on attributions, labeling or blaming.
- *Reflections should use plain language* and avoid clinical terminology.
- *Reflections should be multi-faceted* where possible; as such, they should include both sides of a dilemma or more than one perspective.

## **3) Audio or video taping**

In cases where live field supervision is not logistically possible, audio or video tapes of family sessions are a useful training tool. Tapes can be used by therapists, to illustrate a problem they are having with family members, or by supervisors to offer constructive feedback to therapists.

If supervisors and therapists wish to tape sessions, they should introduce the idea early in the training curriculum or the treatment relationship. Raising the possibility further down the road may cause therapists and/or family members to focus inappropriately on this new procedure.

Therapists often feel more anxiety than do clients about taping. Family members tend to be open to the process and quickly forget there is recording equipment in the room. They are generally only uncomfortable if therapists are uncomfortable. It may be helpful to tape sessions involving supervisors as well in order to break the ice and demonstrate how useful taping can be in refining technique.



## APPENDIX 1

### GUIDELINES FOR THE USE OF GENOGRAMS

Genograms, or family-tree diagrams, are a useful tool for therapists seeking to map out complex family systems, gather useful history and engage with and orient family members to APT's focus on the family. The following are among genograms' positive effects:

- **Genograms help build rapport.** Drawing a genogram with family members is a great ice breaker. Most members enjoy the process of drawing their family tree, and the process gives therapists the opportunity to model an attitude of curiosity and appreciation of family strengths.
- **Genograms frame problems in a family context.** Genograms are a great way for APT therapists to demonstrate, in a very concrete way, APT's belief in the importance of the family and family relationships in developing solutions to the problems that brought members to treatment.
- **Genograms are a valuable family assessment tool.** A genogram is an efficient vehicle for systematic history taking, and it is a format that family members find very non-threatening. Genograms provide an initial glimpse into important aspects of family functioning such as parental authority, cohesiveness and sources of support family roles. They also highlight conflict-ridden relationships and other family risk factors such as losses and traumas, substance use and mental health problems, negative family myths and boundary problems.
- **Genograms provide a good visual representation of the family.** Family systems are very complicated and difficult to understand from a narrative conversation alone. A visual diagram of "who's who?" and what kind of relationships they have with each other is a great way to help clients to gain perspective on the family system as a whole.
- **The process of doing a genogram has therapeutic value in itself.** Constructing a genogram naturally places an emphasis on family connectedness and other strengths in the family. Drawing a genogram can prompt feelings of belonging to a larger system/family; furthermore, the process may help to alleviate a tendency to place blame because genograms provide a clear indication of how complex the sources of a problem can be, thus reminding family members of past successes and the resources they have. This can be therapeutic for the often distressed and fragmented families who enroll in APT.

## Drawing a Genogram

This page and the following one show common genogram symbols and genogram relationship notations. The symbols and notations below represent fairly universal conventions for drawing genograms, but many programs choose to use their own notations and symbols as they see fit.

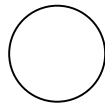
Please note that household composition can be indicated by drawing a circle around those individuals in the genogram who reside together.

### Common genogram symbols

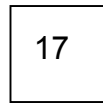
Male



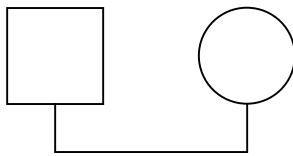
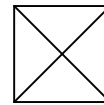
Female



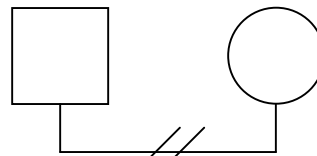
Age: inside symbol



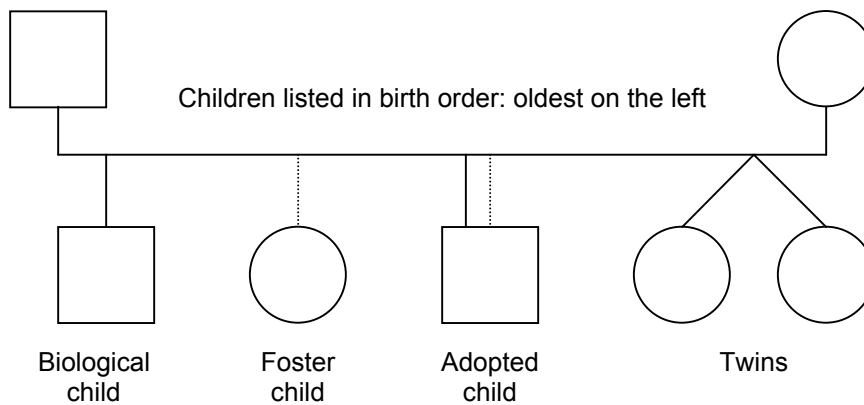
Death



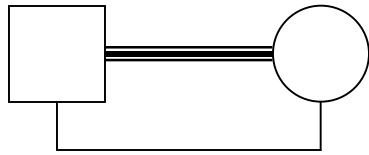
Marriage or long-term relationship



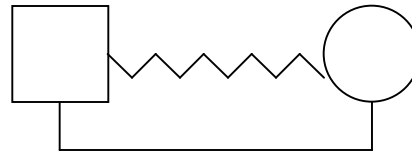
Divorce or separation



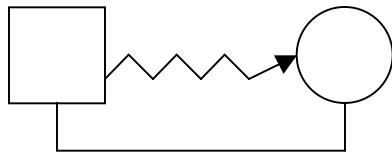
## Genogram relationship notations



Strongly attached;  
close relationship



Hostile, conflict-ridden  
relationship.



Abusive relationship  
(in the direction of  
the arrow)

## **APPENDIX 2**

### **FUNCTIONAL ANALYSIS FORMS**

The following six pages include three types of functional analysis forms, two each for problem behavior, pro-social behavior and substance abuse. For each type of behavior, there is a blank form as well as one containing sample questions. These functional analysis forms were adapted by APT from the Adolescent Community Reinforcement Approach (ACRA) developed for the Cannabis Youth Treatment Study. In-depth information about functional analysis may be found in this manual in Chapter 6.

## APT FUNCTIONAL ANALYSIS OF PROBLEM BEHAVIOR

**DATE:**

**THERAPIST:**

**CLIENT INITIALS:**

### TRIGGERS

EXTERNAL	INTERNAL	BEHAVIOR	SHORT-TERM POSITIVE CONSEQUENCES	LONG-TERM NEGATIVE CONSEQUENCES

## APT FUNCTIONAL ANALYSIS OF PROBLEM BEHAVIOR (with sample questions)

**DATE:**  
**THERAPIST:**  
**CLIENT INITIALS:**

### TRIGGERS

EXTERNAL	INTERNAL	BEHAVIOR	SHORT-TERM POSITIVE CONSEQUENCES	LONG-TERM NEGATIVE CONSEQUENCES
<p>What is usually going on right before (the specific problem behavior being discussed) occurs?</p> <p>Who are you usually with when this occurs?</p> <p>Where does this usually take place?</p> <p>When does this usually take place?</p>	<p>What are you usually thinking about right before the behavior occurs?</p> <p>What are you usually feeling physically right before the behavior occurs?</p> <p>What are you usually feeling emotionally right before the behavior occurs?</p>	<p>Describe the problem behavior in your own words.</p> <p>Describe a typical or specific instance of the behavior.</p>	<p>What do you like about this behavior?</p> <p>Are there positive thoughts, feelings or physical sensations that you have when this behavior is happening?</p> <p>What are other benefits/good things about this behavior?</p>	<p>Can you think of any negative things or problems that result from this behavior? These might relate to:</p> <ul style="list-style-type: none"> <li>• family</li> <li>• friends</li> <li>• physical</li> <li>• emotional</li> <li>• legal</li> <li>• school</li> <li>• job</li> <li>• financial</li> <li>• other</li> </ul>

## APT FUNCTIONAL ANALYSIS OF PRO-SOCIAL BEHAVIOR

**DATE:**

**THERAPIST:**

**CLIENT INITIALS:**

### TRIGGERS

EXTERNAL	INTERNAL	BEHAVIOR	SHORT-TERM NEGATIVE CONSEQUENCES	LONG-TERM POSITIVE CONSEQUENCES



## APT FUNCTIONAL ANALYSIS OF PRO-SOCIAL BEHAVIOR (with sample questions)

**DATE:**  
**THERAPIST:**  
**CLIENT INITIALS:**

### TRIGGERS

EXTERNAL	INTERNAL	BEHAVIOR	SHORT-TERM NEGATIVE CONSEQUENCES	LONG-TERM POSITIVE CONSEQUENCES
<p>Who are you usually with when you_____?</p> <p>Where do you usually_____?</p> <p>When do you usually?</p> <p>What needs to happen first so you can_____?</p>	<p>What are you usually thinking about right before you_____?</p> <p>What are you usually feeling physically right before you_____?</p> <p>What are you usually feeling emotionally right before you_____?</p>	<p>What is the behavior/activity?</p> <p>Describe a typical or specific instance of the behavior/activity.</p> <p>How often do you usually_____?</p> <p>How long does _____ usually last?</p>	<p>What do you dislike about doing___ with who, where, when?</p> <p>What are some negative or unpleasant thoughts you have while you are_____?</p> <p>What are some unpleasant physical feelings you have while you are_____?</p> <p>What are some unpleasant emotional feelings you have while you are_____?</p>	<p>What are the positive results of_____? In each of these areas:</p> <ul style="list-style-type: none"> <li>• family members</li> <li>• friends</li> <li>• physical</li> <li>• emotional</li> <li>• legal</li> <li>• school</li> <li>• job</li> <li>• financial</li> <li>• other</li> </ul>

## APT FUNCTIONAL ANALYSIS OF SUBSTANCE ABUSE

**DATE:**

**THERAPIST:**

**CLIENT INITIALS:**

<b>TRIGGERS</b>
-----------------

<b>EXTERNAL</b>	<b>INTERNAL</b>	<b>BEHAVIOR</b>	<b>SHORT-TERM POSITIVE CONSEQUENCES</b>	<b>LONG-TERM NEGATIVE CONSEQUENCES</b>

## APT FUNCTIONAL ANALYSIS OF SUBSTANCE ABUSE (with sample questions)

**DATE:**  
**THERAPIST:**  
**CLIENT INITIALS:**

<b>TRIGGERS</b>
-----------------

EXTERNAL	INTERNAL	BEHAVIOR	SHORT-TERM POSITIVE CONSEQUENCES	LONG-TERM NEGATIVE CONSEQUENCES
<p>What is usually going on right before you end up using/smoking?</p> <p>Who are you usually with when you use/smoke?</p> <p>Where do you usually use/smoke?</p> <p>When do you usually use/smoke?</p>	<p>Describe what you are thinking about right before you use?</p> <p>What are you usually feeling physically right before you use?</p> <p>What are you usually feeling emotionally right before you use?</p>	<p>Describe a typical or a specific situation where you use/smoke?</p> <p>Tell me about what you usually use.</p> <p>How much do you usually use?</p> <p>Over how long a period of time do you use?</p>	<p>What do you like about using/smoking?</p> <p>Are there positive thoughts, feelings or physical sensations that you have when you smoke?</p> <p>Are there other benefits/good things about using/smoking?</p>	<p>Can you think of any negative things or problems that result from smoking?</p> <p>Probe for problems in these areas:</p> <ul style="list-style-type: none"> <li>• family</li> <li>• friends</li> <li>• physical</li> <li>• emotional</li> <li>• legal</li> <li>• school</li> <li>• job</li> <li>• financial</li> <li>• other</li> </ul>

## **APPENDIX 3**

### **URINALYSIS**

#### ***A. Overview***

Urine drug testing and the handling of results during APT therapy sessions can be an important part of a substance abuse intervention. While urine testing is not the central focus of APT's substance abuse treatment, its results can be very useful in the treatment process—particularly if they are used to establish a platform for open communication among family members about drug use and serve as a starting point for therapeutic feedback to the adolescent.

Like many adolescent treatment programs, APT operates within a larger juvenile justice context and is a licensed substance abuse treatment provider in New York State. Therefore, APT must remain within accepted guidelines for urine testing—and, where necessary, reporting of results—to maintain its license. Adherence to these guidelines also helps to foster good collaborative relationships with outside systems, such as probation officers and family court judges, who have a vested interest in knowing the results of drug tests.

This appendix on urinalysis is divided into three main parts: timing, administration method and reporting of results. Each part is discussed in detail below, followed by information about specific equipment needed for urinalysis.

#### ***B. Timing of urine testing***

Urine drug testing begins when an adolescent is released from detention and should be done randomly throughout the entire community phase of APT treatment. Since APT clients are rarely able to obtain and use drugs in most detention facilities, tests conducted soon after the adolescent's release are usually negative, thus providing an opportunity to “break the ice” by introducing the testing process. The initial test can also function to establish an early pattern of success and a reinforcing experience with the testing process.

The actual frequency of testing can vary on a case-by-case basis depending on a number of key factors, including

- when to test;
- when a client is testing negative; and
- when a client is testing positive.

Each of these factors is discussed in detail below.

### **1) When to test**

APT therapists need not duplicate the testing process when urine testing is being conducted by a client's probation officer or other post-detention supervising agency. In such cases, the APT policy is to facilitate communication with appropriate staff members at the supervising agency to ensure that APT therapists receive test results and can use them therapeutically with their client. The urine test and its results are recorded in APT's clinical record-keeping database, with clear documentation that the test was conducted by an outside agency and additional information as to the therapeutic response to the test result. An exception to this policy might be appropriate in cases where the adolescent requires some additional monitoring in order to achieve a negative test result. In such cases, APT therapists may also conduct planned urine tests in between those that are conducted by the supervising agency.

### **2) When a client is testing negative**

If a client is testing negative, particularly after a period of struggle to establish sobriety, a relatively higher frequency of testing is appropriate to maintain a pattern of positive reinforcement. In such cases, urine drug tests can be conducted as often as weekly. Not only are negative drug test results inherently rewarding for most kids, but they also generally trigger positive responses from parents and other people in kids' lives.

Once a negative result is obtained, therapists may decide to increase the frequency of tests temporarily so as to solidify the reinforcement value of testing negative. The next step in treatment, however, is to move beyond the focus on the test result itself and to seek to solidify the reinforcement value of being drug free.

### **3) When a client is testing positive**

If a client tests positive for drugs, therapists should immediately establish a stepwise behavior plan with the adolescent to help him to avoid using substances and to achieve the goal of a negative urine test result as soon as possible. An appropriate goal should be set for the timing and frequency of the next and subsequent tests. For example, if an adolescent tests positive for marijuana after a period of abstinence, it can be expected that without continued use he may test negative in a period of roughly two weeks. Therapists would then motivate the client to set the goal of achieving a negative test in roughly two weeks' time. Once a negative test is achieved, therapists should follow the guidelines above for responding to negative test results.

## ***C. Administration method***

Upon enrollment into APT, the adolescent client and his parents must be informed that random urine drug tests are part of the APT treatment protocol. Because a number of days may elapse from enrollment to the time of the initial session, therapists should remind family members during the first session that drug testing will take place randomly throughout treatment. At this point therapists should take great care in reinforcing that results of the drug tests will be used constructively as part of APT's efforts to help the adolescent establish and maintain sobriety.

When therapists intend to conduct a urine test, the adolescent should be informed at the outset of the session. Whenever possible, the test should be conducted at the beginning of the session to allow adequate time to discuss the results and to formulate an appropriate behavioral plan based on them. If the adolescent is not able to provide a sample, the test can be conducted later in the session.

Sometimes the adolescent is unwilling to provide a sample. In such situations, therapists should attempt to explore the reasons for the refusal and clarify the usefulness of using urine testing in the treatment. Continued refusal is most often associated with the adolescent's efforts to conceal recent drug use. If refusals persist, therapists may introduce a policy, after discussions with the adolescent and family members, that refusals will be interpreted and/or reported as positive test results.

If the introduction of testing equipment in a session triggers an admission by the adolescent that he used drugs since his last test, therapists do not need to conduct the test. They should, however, record the adolescent's admission in the narrative field of the urinalysis event in the APT database. As with a positive test result, an admission of drug use should lead to a non-judgmental exploration of the adolescent's drug use behavior using the framework of the Functional Analysis (*see Chapter 6*). The exploration should focus on a constructive discussion of the triggers and reinforcers associated with that particular drug use incident and should then lead to continued problem-solving and coaching around the drug-avoidance skills that are already components of individual treatment.

If a client disputes the result of the test, therapists should proceed in one of two ways. They can administer a second test with a new sample during the session and obtain immediate results, or they can opt to send a second sample to the certified laboratory affiliated with the test manufacturer for confirmatory testing. Although the results of on-site urine tests are considered to be preliminary in nature, the accuracy rate for the test APT uses is over 99%; therefore, a second test with a new sample from the adolescent should be sufficient to rule out a false positive. In general, if a client disputes the results of a test it is best to remain positive and non-confrontational—and to resort to sending a sample to a laboratory only if repeated refuting of results becomes a treatment issue.

#### ***D. Reporting/communication of results***

In cases where another supervising aftercare agency is involved and monitoring the adolescent's progress in drug treatment—such as the Department of Probation or the Office of Children and Family Services Division of Aftercare—this agency may request the results of urinalysis from APT therapists. Because it is APT's aim to cultivate collaborative relationships with the agencies involved in the care and supervision of clients who are in APT treatment, it is important to respond affirmatively to any formal requests for a treatment update. However, the confidentiality laws that protect minors in drug treatment are very strict and therapists cannot disclose urine test results without the written consent of the client and his parents.

When such requests specifically seek the results of urinalysis, APT therapists should first

confirm that the appropriate consent forms have been signed authorizing APT to release such information to the agency making the request. Therapists should then collaborate with their supervisor to create a strength-based treatment summary that strategically incorporates any relevant urinalysis results in the context of the client's progress. For example, APT often considers treatment to be largely successful when a positive urinalysis in mid-treatment is followed by a series of negative results. Aftercare agencies that supervise kids post-detention, however, have different responses: to many of these agencies' staff, any positive result on a urine drug test is cause for concern or perhaps even considered a violation by a client's probation officer. In such cases it is more effective and clinically accurate for therapists to highlight the client's progress toward achieving subsequent negative test results than to simply report results. The following is a sample section of a report illustrating this strategy for communicating about urinalysis results:

*Overall, Richard's progress toward abstaining from using marijuana has been very impressive since his release from custody three months ago. As is typical for an adolescent striving to remain drug free, Richard had an early slip and tested positive for marijuana shortly after his release from custody. In the ensuing therapy sessions, Richard was able to openly discuss what triggered the incident and discuss how to resist using in the future. Subsequently, Richard has had three consecutive negative urine drug tests.*

A negative urine test presents therapists with an opportunity to examine and reinforce the adolescent's success at avoiding substances or with engaging in alternative pro-social coping behaviors. Following a negative test result, therapists should use the framework of the Functional Analysis (see *Chapter 6*) to highlight the reinforcers and behavioral skills that have helped the adolescent to maintain sobriety. A positive urine test is also an opportunity to examine the skills an adolescent needs to learn or practice to stay away from substances. These skills might include refusal skills, avoidance of relapse triggers and making positive peer connections in the community.

## ***E. Equipment***

All APT-administered urine drugs tests are conducted using the same type of equipment. Therapists use the following equipment when administering a test:

- **On-site urine drug test kit.** APT currently uses the Drugcheck 5-panel test, a qualitative drug test kit designed to detect the following drugs and their metabolites: marijuana, opiates, amphetamines, cocaine and PCP. Drugcheck is a U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) compliant test kit.
- **Rubber gloves**
- **Watch or clock**



## APPENDIX 4

# CONFIDENTIALITY REGULATIONS GOVERNING DRUG TREATMENT PROGRAMS

### ***A. Overview***

This appendix provides a very general overview of the federal regulations protecting the confidentiality of clients in drug treatment in the United States. Congress passed the regulations as part of an effort to encourage people to seek treatment. They provide strict confidentiality protection for information about a client held by any federally assisted individual or entity providing diagnosis, therapy or referrals for alcohol or substance abuse. With these protections in place, an individual accessing treatment is less likely to fear prosecution or the stigma associated with treatment, both of which are possible consequences when drug abuse problems are disclosed.

There are two sets of federal regulations governing confidentiality for drug treatment programs: the Confidentiality of Alcohol and Drug Abuse Patient Records Regulation Act, also known as **42 CFR Part 2**, and the Health Insurance and Portability and Accountability Act, known as the HIPAA Privacy Rule. Drug treatment programs may also be required to comply with state and local confidentiality laws. However, this appendix only covers the federal Confidentiality of Alcohol and Drug Abuse Patient Records Regulation Act. (The two sets of federal regulations overlap to a great extent, but the HIPAA Privacy Rule also regulates communications with third-party insurers.)

Most drug treatment programs are required to comply with 42 CFR Part 2, and drug treatment programs that engage in the electronic transfer of confidential client information for purposes of communicating with insurers are also required to comply with the HIPAA Privacy Rule.

Programs can consult with their local or state licensing agency for information on which set of regulations they are required to comply with. Helpful information can also be found on these websites: [www.hipaa.samhsa](http://www.hipaa.samhsa) and <http://hhs.gov/ocr/hipaa>.

**Note: Programs should always review the actual regulations in order to learn how to comply and should not solely rely on summaries, such as this one, which may not provide all necessary or relevant information.**

### ***B. Specifics of regulations***

#### **1) What are the confidentiality regulations?**

Simply put, the confidentiality regulations forbid substance abuse treatment providers, including all who work with APT, from disclosing information—except under certain circumstances—to anyone who might reveal that a client applied for or is participating in

substance abuse treatment. Those circumstances or exceptions include the following:

- A disclosure can be made with a client’s written permission, using a written consent form that complies with the regulations (*see below for specific information about consent forms*).
- A disclosure can be made to medical personnel in the case of a medical emergency that poses an immediate threat to the client.
- A disclosure can be made in order to comply with laws governing the reporting of child abuse.
- A disclosure can be made to protect staff from the threat of physical harm by a client, if the threat is made on the program’s premises.
- A disclosure can be made in order to comply with a court-ordered subpoena.
- Information can be disclosed that is not client-identifying—in other words, information that does not identify an individual as an alcohol or drug abuser or an APT patient/client. An example of this is aggregate data that does not disclose identifying information about a client.

## **2) Who is protected by the confidentiality regulations?**

Individuals in one or more of the following three categories are protected by the confidentiality regulations:

- Anyone currently receiving treatment from a substance abuse treatment program.
- Anyone previously receiving treatment from a substance abuse treatment program.
- Anyone interviewed or screened for participation in a substance abuse treatment program, whether or not he was accepted into the program. For example, in cases where a program has an evaluation component and some eligible treatment candidates are not offered treatment because they are assigned to a control group, they would also be covered by the regulations.

## **3) Who must abide by these regulations?**

Anyone who has access to client records must abide by these regulations, including

- program personnel;
- researchers; and
- anyone to whom information about a patient has been disclosed—such as staff at another program to which a client is referred. In such cases, the program sending the information is required to ensure that the party receiving the information receives a notice of re-disclosure (*see below for additional information about re-disclosure*).

#### 4) Disclosure consent forms

As mentioned above, one main exception to the confidentiality regulations is that a substance abuse provider is allowed to disclose information about a client if the client gives his written consent. A consent form that complies with federal regulations must include the following:

- client's name
- name of program
- name of person/entity that will be permitted to receive the information
- purpose of the disclosure
- what information is being disclosed (this should be tailored narrowly to the need necessitating the disclosure)
- an expiration date (either a specific date or when a specific event occurs, such as once the proper information is received)
- the client's signature

The client must also be informed, both orally and in writing, of his ability to revoke consent at any time.

**Note: Disclosing information after a properly executed consent form is obtained must be accompanied by the following notice:**

*This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

#### 5) Storage of confidential information

1. All programs (include APT) that must comply with the federal the regulations must have written procedures that regulate and control access to confidential information.
2. The regulations require that records must be maintained in a secure room, locked file cabinet or other similar container when not in use.