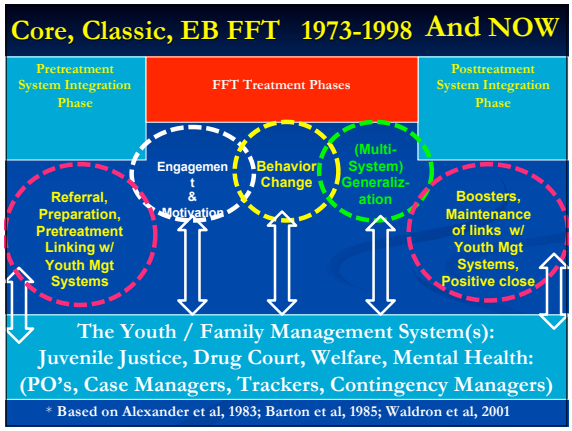
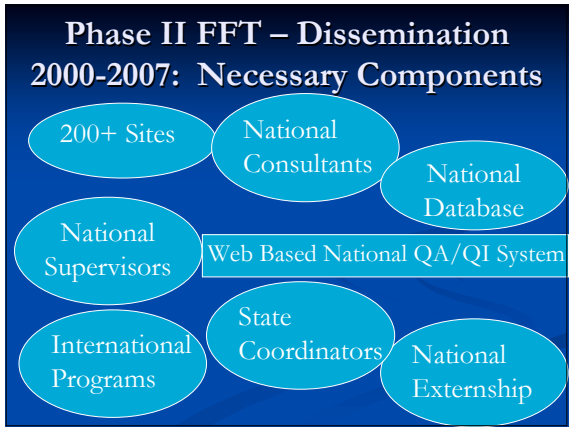

2nd Annual Blueprints Conference
Denver Colorado, March 16-18, 2008
e Conference Session 1 – The Renewal of FFT
James F Alexander, PhD


Core, Classic, EB FFT 1973-1998 And NOW
Pretreatment System Integration Phase
FFT Treatment Phases
Posttreatment System Integration Phase
Engagement & Motivation
Behavior Change
(Multi-System) Generaliz-ation
Referral, Preparation, Pretreatment Linking w/ Youth Mgt Systems
Boosters, Maintenance of links w/ Youth Mgt Systems, Positive close
The Youth / Family Management System(s):
Juvenile Justice, Drug Court, Welfare, Mental Health:
(PO's, Case Managers, Trackers, Contingency Managers)
* Based on Alexander et al, 1983; Barton et al, 1985; Waldron et al, 2001


Phase II FFT – Dissemination
2000-2007: Necessary Components
200+ Sites
National Consultants
National Database
National Supervisors
Web Based National QA/QI System
International Programs
State Coordinators
National Externship

But the CORE of FFT is still Relationships

And we still depend on DATA to guide what we do

FFT Phase III: 2008 +

- Clarifying, elucidating, refining the clinical model
- Clarifying, elucidating, refining the Consultation & Supervision
- Partnering and "re-partnering"
- Integrating, specializing & "modularizing"
- "Manualizing" context specific (e.g., cultures)
- Enhancing our ability to capture data and tracking all of the above

What Have We Learned As We Move Into Phase III of FFT?

What Did We Seem To Lose Sight Of?
(Back to Basics)

Yes, even Tiger Woods sometimes has to go back to his coach and get back to basics

Basics #1
FFT Doesn't Begin With the Family
FFT Pre-intervention Major Tasks*

- PRETREATMENT

- GOALS: Responsive and timely referrals, positive "mindset" of referring sources, immediacy

- ACTIVITIES: Establish relationship with referring sources, be available, maintain a positive attitude, appraise multidimensional (e.g., medical, educational, justice) systems already in place

*Based on Alexander, Pugh & Parsons, 1998; Alexander, Barton, Waldron, & Mas, 1985

Who Should Attend E & M?
Who Are The "Major Players?"

1 – Family member(s) seen as part of the "problem" or "problem sequence" according to referral source(s).

2 – Family members we think (based on referral info and first calls to the family) are likely to "shut the process down" - and who probably can!

3 – Family members we think are *necessary* to begin change in the referral youth(s)

4 – Important nonfamily members who will participate and are "appropriate" participants vis-à-vis retaining a highly influential role with the youth / family (e.g., Grandma)

Who Doesn't Need to Be There? - Anyone who doesn't fit above

The Spacing of Sessions During E & M

The spacing, or number of days between the first, second, and third FFT sessions, depends primarily on:

1 - the severity of risk factors,

2 - the immediate availability of protective factors, and

3 - your over all judgment of how long the family can go without a major disruption. With high risk families we would expect 3 sessions in the first 10 days of FFT.

Basics # 1a

We need systems that support these fundamental aspects of FFT

Basics #2

Change, in FFT, derives from developing

A Positive

Relational

Focus

"Bonding" (esp during E&M)

ENGAGEMENT PHASE

GOAL: Enhance perception of responsiveness and credibility, demonstrate desire to listen and help

SKILLS REQUIRED: Qualities consistent with positive perceptions of clients, persistence, matching

FOCUS: Immediate responsiveness, strength based relational focus, individual and cultural characteristics

ACTIVITIES: High availability, telephone outreach, language and dress appropriate, proximal services or adequate transportation, contact as many family members as possible. Schedule sessions as frequently as necessary.

■ MOTIVATION PHASE

- GOAL: Create positive motivational context, minimize hopelessness and blame (of self and other), change meaning of family relationships to emphasize possible hopeful experience
- SKILLS REQUIRED: Relationship & interpersonal skills, nonjudgmental, acceptance and sensitivity to diversity, courage and resilience, non-defensiveness
- FOCUS: Relationship process, separate blaming from responsibility, strength based
- ACTIVITIES : Interrupt highly negative interaction patterns and blaming (Divert and Interrupt). Change meaning through a strength based relational focus, pointing process, sequencing, and Reframing & themes. Schedule sessions as frequently as necessary

MATCHING *(a philosophy as much as "a technique")* ***is a fundamental requisite for effectively engaging and changing families***

"Match to" clients:

We do what it takes for them to feel you are working hard to respect and understand them, their language, norms, etc

Especially during E & M it is "all about them"

Basics #2 – In FFT, E&M Really Counts! And Involves "Family Bonding," NOT Problem Focus

Parent-Youth Alliance in FFT Across Segments 1 & 2 of Sessions 1 & 2

Freidag & Alexander, 2008

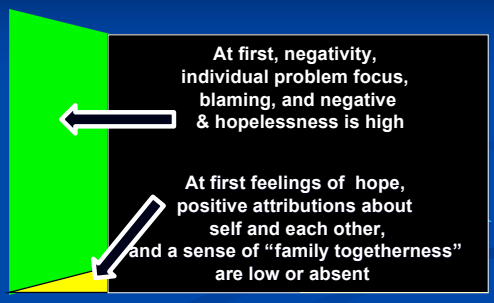
Major Techniques of E & M

- Interrupt & Divert
- Point Process
- Sequencing, Selectively attend to positive elements of patterns and reports
- Strength Based …… Relational Focus
- "Do something" ("Take a risk")
- ----------
- Theme Hints
- Relabels
- Reframes (Acknowledge "-" then suggest "+")
- Themes (Relational and Organizing)

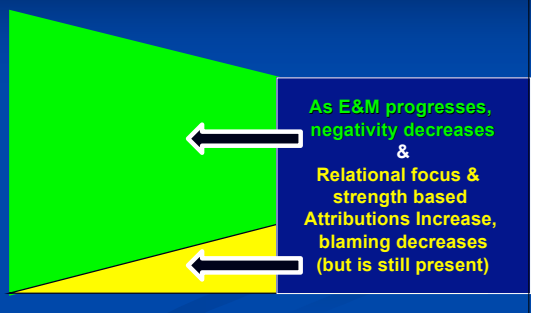
1 - Change Focus

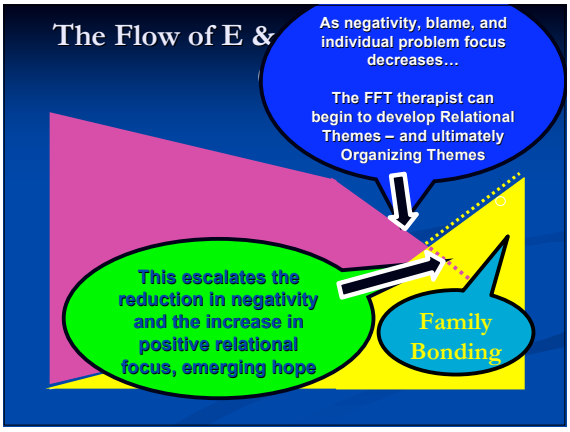
2 - Change Meaning

Review: The Flow of E & M Interventions



The Flow of E & M Interventions (2)





What is the Difference Between a Reframe and a Relabel?

- Relabel – to change the "tone," description, or meaning of a behavior or feeling
  - E.g., in response to an angry outburst: "With that anger I can see how hurt you are." Or just "I can see how hurt you are."
- Reframe – to acknowledge the negative components of a behavior but offer a possible alternative *motivation* for the behavior
  - E.g., in response to an angry outburst: "That was a pretty angry outburst "X", but I'm wondering if in addition to expressing your anger you weren't also protecting "Y" by letting him/her know how sensitive you are about that subject so s/he can work on bringing it up differently? And "Y," my guess is that because the anger was so intense you couldn't hear the reaching out part of what "X" said.

What Are Reframes?

Reframes consist of a simple 3 step process:

- 1) Identify and make clear the negative aspects of a problem behavior / pattern (the one you are going to attempt to reframe);
- 2) offer a possible noble* (or benign) but misguided intent or meaning;
- 3) observe the family for feedback , and based on the family members' reactions (affirming or disaffirming) you refine and elaborate the reframe or you apologize for "misunderstanding" and move on.

* "Noble" intent = to benefit another

Summary of Steps in Reframing

- **Acknowledge the negative**
- **Reframe: Possible positive / noble but misguided intent, motive, meaning**
- **Evaluate the effect of the reframe and Refine or Change**

Themes - More Comprehensive Than Reframes: Transitional Hope Evoking Meaning of Experiences

- We develop themes to **link the pervasive negative *experiences* of the past to a possibly hopeful experience of what they may "mean." To do so** we offer an ***alternative meaning (experience of) painful past relationship patterns.***
- **This alternative meaning *temporarily* provides family members with a sense that they are not defined solely by their past bad behavior(s), but by a shared experience that emerged from misfortune, misguided attempts at positive solutions, and sometimes merely the unfortunate events of living with fewer resources than they need or struggling with others' mistakes**

Jim's Simple System

- Relabeling – attempts to change the "label" ("meaning," "tone," "experience") of a behavior or pattern
- Reframing – attempts to also change the perception of the "motivation" for the behavior
- Themes – attempt to change the experience of relationships (not just behaviors & patterns)

Caveat to Basic #2

- You can focus on a negative behavior during E&M - as long as you have a way to relabel, reframe, or create a theme around it.
- Otherwise
  - Selectively focus on the positive (Robbins)
  - Focus on relationship rather than behavior
  - Turn it into a strength based focus

Basic #3: What You Believe Is What Organizes How Well You Will Do FFT

	Not an FFT Focus			Not an FFT Focus
Who are they?	"Victims"	"Hurt," "Emotionally Damaged" People	"Organic" e.g. Fetal Alcohol	"Unfixable" "Bad / Evil People"
Primary Focus: Engage & Motivate around	Pain	Pain & mis-perception	"Damage" → dis-perception	Their "Logic"
Behavior Change & Gen'zation Goals	"Rescue"	Teach / Provide Corrective Experience & Beh'l Options	Structure / Reduce Behavioral Options	Sanctions / Remove Behavioral Options

We are not "rescuers" or "controllers" – We Empower

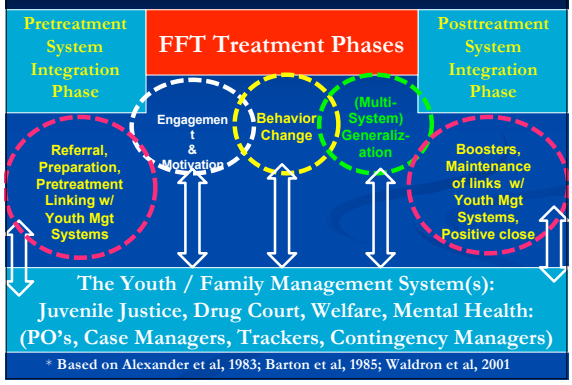
Issues Of Culture: Elliot, 2008 (today)

Fidelity vs Adaptation

* Need for local adaptation is over estimated
* Adaptations must fit with program rational
* Language / cultural adaptations most easily justified
  - Little evidence for race/ethnicity, class, gender differences in school program effects)
- Most frequent threat is to fidelity
  - Agency
  - Therapists

All you white people love to hear about all this culture stuff ... For us, we just live it

Core, Classic, EB FFT



* Based on Alexander et al, 1983; Barton et al, 1985; Waldron et al, 2001

What characterizes many (if not most) of the youth & families we help in FFT? Often There Are Powerful Risk Factors that "Overwhelm" Protective Factors

Comorbidity, Depression, Hopeless; Un (anti)-motivated,	Hx of betrayal, abuse, failure; Physical and Emotional Challenges	Criminal / drug involvement, High Conflict environments
Limited Resources, System Negativity	Resentful, disrespectful, Angry	All leading to a high probability of re-occurrence

Therapist-Family Ethnic Match and Substance Abuse Treatment Outcomes for Hispanic and Anglo Adolescents

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Oregon Research Institute

Funding: NIDA (R01DA09422; R01DA13350; R01DA13354) NIAAA (R01AA12183)

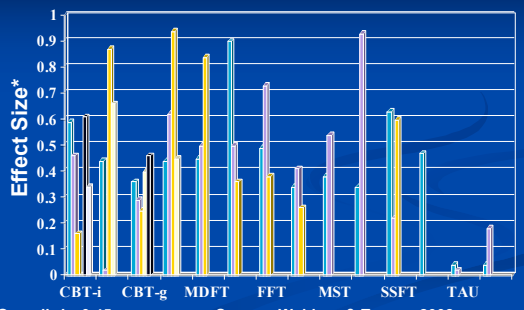
Treatments for Adolescent Substance Use Disorders

- Vast majority of substance abusing youth receive outpatient treatment (SAMHSA, 1998)
- Outpatient treatments appear as effective as more intensive treatments (Winters et al., 1999)
- Randomized controlled trials have provided empirical support for specific treatment models

Randomized Clinical Trials for Adolescent Substance Abuse

- **Family Therapy Trials**
  - BFT Azrin et al., 1994; 2001; Krinsley & Bry, 1997
  - MDFT Dennis et al., 2004; Liddle et al., 2001; 2003; 2004
  - FFT Friedman, 1989; Hops et al., 2007; Waldron et al., 2001; 2005; 2007
  - MST Henggeler et al., 1991; 1999; 2002; 2007
  - SSFT, BSFT, SET (Joanning et al., 1992; Lewis et al., 1994; Robbins et al., in press; Santisteban et al., 2003 Szapocznik et al., 1983; 1986;1988)
- **Cognitive Behavioral Therapy Trials**
  - Individual CBT(Azrin et al., 2001; Dennis et al., 2004; Liddle et al., 2003; Hops et al., 2007; Waldron et al., 2001; 2005; 2007)
  - Group CBT (Dennis et al., 2004; Kaminer et al., 1998; 2002; Liddle et al., 2001; 2004; Waldron et al., 2001; 2005)

Effect Sizes for Adolescent Substance Abuse Treatments



*Overall *d* = 0.45 Source: Waldron & Turner, 2008

Findings from Three Controlled Clinical Trials Evaluating FFT and CBT for Adolescent Substance Abuse and Dependence

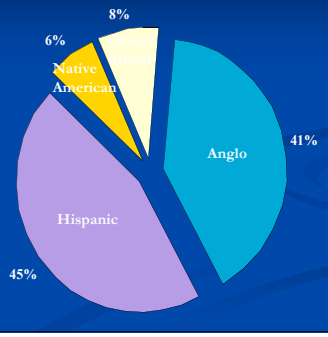
Study Participants

* Living at home, parent willing to participate
* DSM diagnosis Substance Use Disorder
* Appropriate for outpatient treatment
* No evidence of psychosis
* Not receiving other mental health treatment
* English language

Referral Sources

Juvenile Justice System:	43%
Schools:	31%
Newspaper Ads / Flyers:	11%
Self Referred:	10%
Other Treatment Agency:	5%

Ethnicity



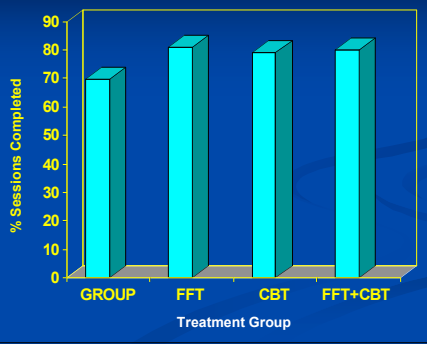
Drug Use Characteristics

Drug	% Using	% Days Used
Marijuana	99	57
Alcohol	95	10
Tobacco	84	64
Hallucinogens	50	2
Cocaine	33	3
Stimulants	22	2
Opiates	10	<1
Sedatives/Tranquilizers	4	<1
Inhalants	2	<1
Other Drugs	9	<1

Common Design Features of Three Randomized Clinical Trials

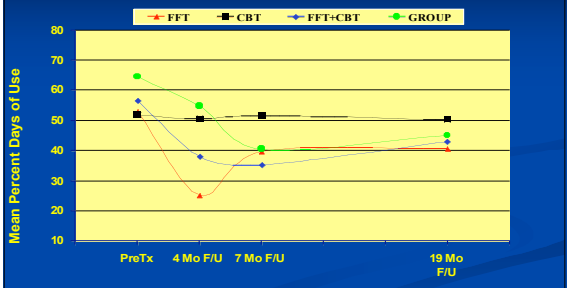
- 12-14 sessions of treatment
- Four assessments conducted at:
  Intake … 3 mon … 7-9 mon … 15-19 mon
- Substance Use Measures
  - Time-Line Follow-Back Adolescent Interview
  - Time-Line Follow-Back Parent Collateral Report
  - Urine Drug Screening

Therapy Sessions Completed



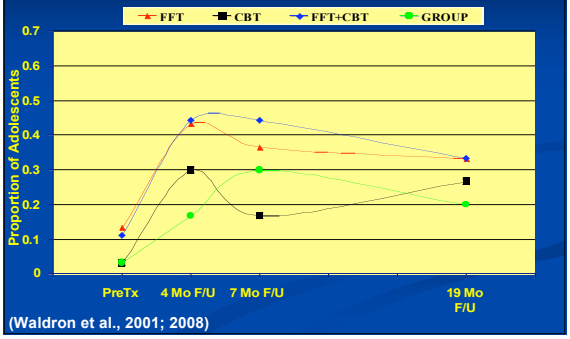
Randomized Trial for Marijuana Abuse (DAYS Project)

Adolescent Marijuana Use at Pre- and Post-Treatment Follow-Up



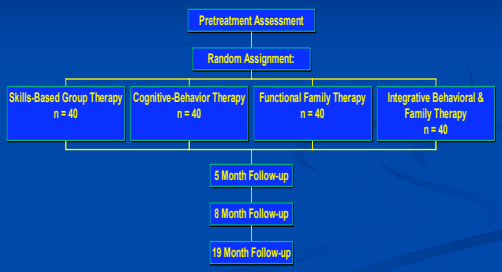
(Waldron et al., 2001; 2008)

Proportion of Adolescents Abstinent or Using at Minimal Levels (<10% of days)

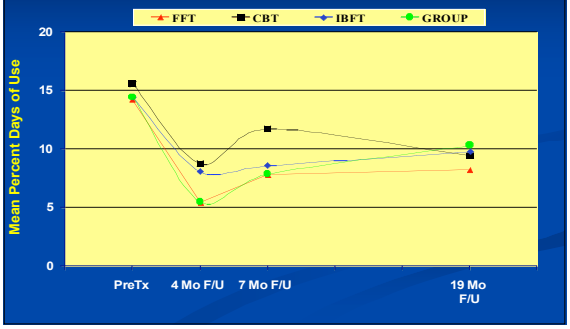


(Waldron et al., 2001; 2008)

Randomized Trial for Alcohol Abuse (CEDAR Project)



Adolescent Alcohol Use by Treatment Condition: Pre-Treatment to Follow-Up



Ethnicity and Treatment Outcome

Research on Mental Health Services for Hispanic Clients

- At higher risk for mental illness (due to discrimination, poverty) compared to individuals in dominant culture
- Underutilize mental health services
- Higher premature drop out rates
- Higher likelihood of inappropriate or ineffective services
- Benefit less from services than clients of majority culture
- Referred to substance abuse treatment at higher rates than youth in majority culture
- Experience higher rates of "unsatisfactory releases from treatment"

Shillington & Clapp, 2003 Sue, 1977; Sue et al., 1991; Vera et al., 1998)

Two-Site Randomized Trial for Drug-Abusing Hispanic and Anglo Youth (VISTA Project)

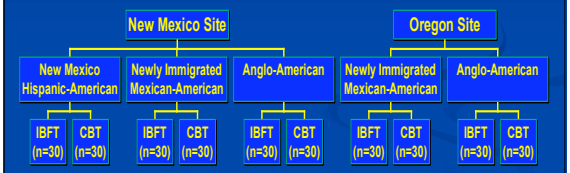
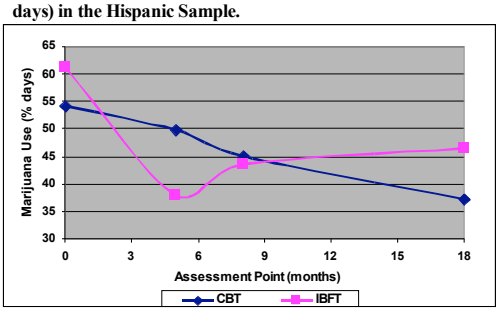
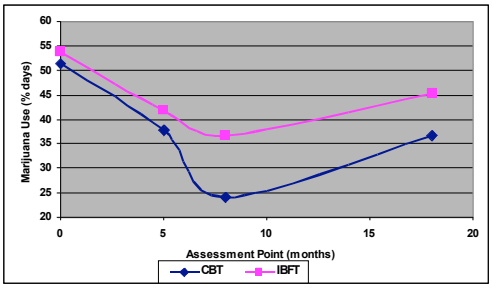


Figure C.1. Effects of CBT and IBFT on Marijuana Use (% days) in the Hispanic Sample.



Note: The individual points represent self -reported days of marijuana use (percent of days) during the past 90 days on the TLFB interview.

Figure C.2. Effects of CBT and IBFT on Marijuana Use (% days) in the Non Hispanic Sample.



Note: The individual points represent self -reported days of marijuana use (percent of days) during the past 90 days on the TLFB interview.

Therapist-Client Ethnic Matching and Family Therapy Outcome

Source: Flicker, Waldron, & Turner, 2008; Journal of Family Psychology

Why Therapist-Client Ethnic Matching?

- Ability to communicate in client's primary language and understand cultural background
- Enhanced therapeutic alliance due to common experience
- Less frequent miscommunication and misdiagnosis
- Therapeutic goals similarly conceptualized
- Similarity positively influences liking, persuasion, and credibility, processes important to treatment success
- Ethnically-matched therapists may more accurately identify the impact of cultural issues on problems
- Ethnic minority clients prefer working with a culturally-similar therapist

Limitations of Prior Research

- Few empirical studies
- Lack of random assignment (selection bias)
- Poor outcome measures
- Combine across culturally diverse groups (e.g., Mexican and Dominican clients categorized as "Hispanic")
- Acculturation not measured

Features of the Current Study

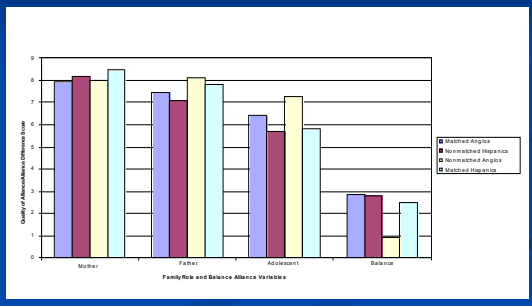
- Data based on three clinical trials
- Families randomly assigned to treatment conditions, therapists (based on case load)
- Clearly identified Anglo and Hispanic families
- Relatively homogeneous New Mexican Hispanic population
- Outcome variables specific to presenting problem
- Acculturation measures

Does therapist-family ethnic matching influence treatment alliance, therapy attendance, and outcome?

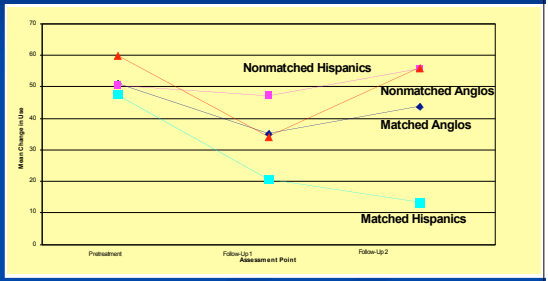
Sample

- 89 substance-abusing youth in FFT
- 84% male
- 13-19 years
- 45 Anglo, 44 New Mexican Hispanic
- 40% 2-parent, 30% 1-parent, 25% blended
- 72% legal involvement
- 36% remanded to treatment
- Mean sessions completed: 89%

Therapeutic Alliance, Ethnicity, and Ethnic Match



Adolescent Marijuana Use by Ethnicity and Ethnic Match



Ethnicity Findings

- No significant differences between Anglos and Hispanics on FFT treatment engagement or outcome
- Hispanic adolescents significantly lower treatment alliances in 1st session

Ethnic Match Findings

- No significant differences between ethnically matched Anglos and Hispanics on engagement or outcome
- Ethnic match not related to attendance or treatment satisfaction
- Non-matched Anglos had most balanced alliance
- Ethnically matched Hispanics had greater decreases in drug use

Therapist Ethnicity Effects

- Hispanic therapists had more balanced alliances with families than Anglo therapists
- Hispanic therapists achieved better substance use outcomes than Anglo therapists

Discussion

- Ethnic match findings, despite highly acculturated Hispanic sample
- Relationship between ethnic match and treatment outcome unrelated to acculturation level
- Therapeutic alliance unrelated to relationship between ethnic match and change in drug use

Implications

- Evidence that FFT is *as* or *more* effective with New Mexican Hispanic families
- Ethnic match more important for Hispanic families than for Anglo families
- Findings highlight the need for
  - ethnic diversity among therapists
  - better cross-cultural competence training

FFT Relies on a Foundation of Respectfulness of Culture and Diversity

The outcome goals of FFT are

- not "healthy" or "normal" families according to someone's theory or ideal, but……..
- obtainable changes that will help this family function in more
  - Adaptive, acceptable, productive ways
  - with these resources …
  - and these value systems
  - in this context

THIS REQUIRES

RELENTLESS EFFORT

TO UNDERSTAND AND RESPECT

THESE YOUTH AND FAMILIES ON THEIR OWN TERMS

Super Summary of the FFT Model and "FFT Attitude:"

- **A Philosophy / Belief System about** people which includes a core attitude of **Respectfulness**; of individual difference, culture, ethnicity, family form
- **A family focused** intervention involving alliance and involvement with all family members **(Balanced alliance)** with therapists who **do not "take sides"** and who **avoid being judgmental.**
- A change model that is focused on risk and (especially) protective factors – **"Strength Based"**
- With interventions that are **specific & individualized** for the unique challenges, diverse qualities, and strengths (cultural, personal, experiential, family forms) of all families and family members.
- And an overriding **Relational** (versus individual problem) focus

MATCHING *(a philosophy as much as "a technique") is a fundamental requisite for effectively engaging and changing families*

"Match to" clients:

We do what it takes for them to feel you are working hard to respect and understand them, their language, norms, etc

Especially during E & M it is "all about them"


FFT