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Dear ~~Dr. Donohue~~ Brad:

I want to thank for you contributing a chapter to Innovations in Adolescent Substance Abuse Intervention to be published by Elsevier Science Ltd. Your and Nate Azrin's chapter entitled "Family Behavior Therapy" is excellent, and I look forward to including it our book. We anticipate sending the book in manuscript form to the publisher within the next two months, and I will update you as the book approaches publication. Thanks again your contribution.

Sincerely yours,

Eric

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Theoretical Background and Rationale

The standardized program that we will describe in this chapter was initially developed in several controlled treatment outcome studies with illicit drug abusers funded by the National Institute of Drug Abuse (Azrin, Acierno, et al., 1996; Azrin, Donohue, et al., 1996; Azrin, McMahon, et al., 1996). The program incorporates multiple interventions that target the adolescent's drug use, conduct, problem-solving skills, family relationships, and communication skills. It derives from the conceptualization of drug usage as a strong inherent primary reinforcer, the use of which is often enhanced by imitation, physiological and situational prompts, the absence of sources of reinforcement, and/or remoteness or uncertainty of the usual negative consequences (familial/social/legal/vocational/medical). This conceptualization has been outlined previously as the basis for the community reinforcement treatment (CRT) program for alcoholism with adults (Azrin, 1976; Azrin, Sisson, Meyers, & Godley, 1982; Hunt & Azrin, 1973). As applied to youth with severe conduct problems, the present conceptualization views a strong positive parent-youth relationship as central in remediating problem behaviors, including drug use, just as the CRT approach had emphasized a positive marital relation with the adults. This conceptualization of youth conduct problems has been described in the Reciprocity Counseling program for youth (Besalel & Azrin, 1981), which emphasizes contingency management, and positive communication training. The current program is designed to address drug use and associated behavioral problems using a number of specific standardized procedures, each of which will be described in detail.

RUNNING HEAD: Family Behavior Therapy

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therapist by one of the kids who participated in our program, "Thanks for the candy. It's nice to know at least someone gives a shit about my needs." The interviewer attempts to (7) elicit potential problems that may cause the youth to miss the scheduled appointment (e.g., parents and youth have an argument immediately prior to the appointment time), and subsequently (8) engages the youth in an exercise to identify solutions to problems that may have been generated. After this initial telephone contact with the youth, the interviewer asks to speak with the primary guardian and essentially replicates the eight step process with the guardian.

Two days after the initial face-to-face session with the therapist (i.e., the intake session), the youth and parent are again contacted separately by telephone. The interviewer tells both persons positive things that the therapist said about them, including, if applicable, their punctuality in arriving to the session. The youth and parent are prompted to ask questions about their therapy, and their suggestions relevant to program/therapist improvement are solicited. These suggestions are transmitted to the therapist prior to the next session. The guardian and youth are asked to verify their next appointment time, and potential problems and solutions related to attending the scheduled appointment are again reviewed, when necessary.

Assessment.

Upon arrival at the clinic for the intake session, the youth and legal guardian are offered a snack and beverage, and program consent forms are reviewed and subsequently endorsed by both the youth and guardian. An overview of the program is provided by the therapist that includes the following: (a) assessment will include two outpatient sessions of about 90 minutes

Description of the Intervention Program

Initial Contacts with Program Participants

As substance abusers and their significant others are notorious for poor therapy attendance, we have developed an empirically-validated method of improving their session attendance (Donohue, Azrin, et al., 1998). In this procedure, an attendant conducts a phone interview with the youth and parent 3 days prior to the first scheduled appointment. We have found contacts greater than 3 days prior to the scheduled appointment is too far removed from the scheduled session to act as a "reminder," and calls 1 or 2 days before the appointment seem to increase the probability of patients rescheduling the appointment. During this initial contact the interviewer attempts to build rapport with the youth through an eight step process. The adolescent is asked to (1) describe problems that others (usually parents, judges, teachers) have recently caused him/her, and (2) empathy for elicited concerns is subsequently provided. The interviewer (3) reviews benefits that other youth have reported as a result of participating in the program (e.g., reduced time in jail/probation, better treatment from parents), and then an attempt is made to (4) elicit potential benefits from the youth's perspective. The youth is (5) asked to identify what s/he is looking for in a therapist, and then told that the assigned therapist will stress these attributes (the therapist is later instructed to emphasize these attributes during therapy). The youth is told that (6) snacks and sodas will be available for the adolescent's pleasure. The snacks and sodas are offered to assist in establishing the treatment program as a generalized reinforcer for the youth. As eloquently revealed to a

questionnaires, the parent is interviewed using the Parent-Child Assessment Survey to obtain clinical diagnostic information (Hodges, Kline, Stern, Cytryn, & McKnew, 1982), and an estimate of the adolescent's drug use frequency is ascertained from the parent, according to the time-line follow-back method (Sobell, Sobell, Klajner, Pavan, & Basian, 1986). After the parent interview is concluded, the therapist collects the questionnaires from the youth and carefully checks to make sure the youth has completed all items correctly.

The parent then is instructed to go to the waiting room to complete the parent questionnaires. These questionnaires include the Child Behavior Checklist to obtain the parent's perspective of the youth's conduct (Achenbach, 1991b), and the Parent Satisfaction with Youth Scale (Donohue, Decato, Azrin, Teichner, in press). While the parent completes these questionnaires, the youth is assessed for substance abuse and dependence, according to the substance disorders section of the Structured Clinical Interview for DSM-III-R (Spitzer, Williams, Gibbon, & First, 1992), and the youth's report of his/her drug use frequency is assessed via the timeline-follow-back procedure (Sobell, Sobell, Klajner, Pavan, & Basian, 1986). The second assessment session is focused on obtaining a urine drug screen from the youth, and assessing youth relationships with family and friends, youth hobbies and activities, and youth goals for treatment.

Drug Analysis. At least during the initial stages of interventions, we believe it is very important to test the youth's urine for illicit drugs during each session to provide an objective measure of substance use. Broad screen assays (testing a variety of drugs; e.g.,

each, (b) treatment will include 15 sessions that will fade in duration (90 minutes to 60 mins.) and frequency (once per week to once per month) over 6 months time, (c) post-treatment and 6-month follow-up assessment sessions will be implemented to measure progress, (d) treatment builds on patient strengths, (e) program goals are designed to help the youth eliminate problems due to drug use and other undesired behaviors, improve family relationships, and enhance academic/work performance, (f) the youth and parent will determine which interventions are emphasized in treatment, and (g) therapists utilize validated treatment manuals to guide their intervention. The adolescent is then instructed to go to the restroom with an attendant to provide a supervised urine specimen for drug analysis (see Drug Analysis section below for details of this procedure).

Although youth and their parents are scheduled to meet with their therapist together for the first 15 or 20 minutes of their assessment sessions to discuss the youth's presenting problems, we have found it helpful to interview the youth and parent separately during most of the assessment phase. This schedule allows the therapist to briefly observe youth/parent interactions, while having sufficient time to assess the youth and parent in confidence. If the guardian is interviewed first, the counselor provides the youth with self-report questionnaires to complete in the waiting room. These questionnaires include the Youth Self Report to assess the youth's conduct across several dimensions from the youth's perspective (Achenbach, 1991a), the Social Problem Solving Inventory (D'Zurrilla, & Nezu, 1990), and the Youth Satisfaction with Parent Scale (DeCato, Donohue, Azrin, & Teichner, in press). While the youth completes these

indicate no use, when in fact drug use has occurred, since illicit drugs other than marijuana ("hard drugs") are excreted rapidly, making it difficult to detect these drugs. In the case of Marijuana, which although rarely may be detected for up to 2 or 3 weeks (particularly when youth are obese, inactive, and have recently consumed a large quantity of marijuana), most drug testing companies will report the level of THC found in the urine. Thus, the recent level may be compared with the previous level (recent use of marijuana would be suggested if the recent test indicates a higher level of marijuana in the youth's system). Youth often argue that positive test results for marijuana are due to breathing marijuana smoke of someone else. In these cases, we instruct therapists to simply tell the youth that the report indicates drug use, and that the youth will need to avoid similar situations in the future, particularly since a goal of treatment is to avoid drug associated stimuli.

Disclosing Assessment Results and Assessing Patient Expectations for Treatment. We believe it is important to disseminate assessment findings, and assess patient expectations, for several reasons. By having a clear understanding of the presenting problems, parents and their youth are more apt to recognize, and take action to prevent, contributing problem behaviors, as well as to perform behaviors that are incompatible with problem behavior. This process also provides therapists opportunities to discount unreasonable expectations which often lead to an overly critical environment.

The therapist initiates the first treatment session with verbal reinforcement, telling the youth and parent something positive about their participation in the assessment sessions (e.g.,

amphetamines, barbiturates, marijuana, cocaine, PCP, heroin) may be analyzed by professional companies for about $10.00 each. When there is a lack of funding available for extensive drug analysis, broad screen assays may be conducted randomly, the frequency of testing may be tapered with confirmed abstinence, or specific drug screens, rather than broad drug screens, may be conducted. If the youth has difficulty urinating, it helps to run water in the bathroom sink while the youth attempts to urinate, to instruct the youth to put his/her hand in warm water prior to attempting urination, and to provide the youth liquids throughout the session. The latter procedure should be used with caution, as high creatine levels may result from excessive consumption of water and potentially invalidate testing results.

When drug use is indicated in the urine testing, therapists usually disclose results in the presence of the parent(s) and youth, unless extenuating circumstances exist. If the youth denies use, therapists report that the tests are highly valid and the most objective indicator of drug use. Therapists then implement, in a matter-of-fact-manner, the consequences that have been established during contingency contracting procedures for positive urine assays (see Contingency Contracting section below). Therapists then express that it is important to "move on" (i.e., proceed to the next intervention), as false positives (testing indicates drug use, when in fact no use has occurred) are extremely rare. Indeed, when therapists express uncertainty as to the validity of urine drug assays (e.g., "It is possible that marijuana may still be in John's system. Let's give him the benefit of a doubt this first time."), youth more times than not will question the validity of future testings. In fact it is far more often the case that testing will

reduce her/his drug use and troublesome behavior. Youth expectancies of drug use and relevant problem behaviors are also examined (e.g., "John, you are currently using cocaine 1 or 2 days a week. What do you think is going to happen to the frequency of your cocaine use after we start treatment? ..... Why do you think it will be that way?"... . You're also skipping half your classes at school. What do you think will happen to your school attendance during the next few months? .... What makes you think that?....").

As with all sessions, youths are asked to report the number of days that they used illicit drugs since the last session, according to the timeline follow-back method. Youth and parent(s) also are encouraged to bring additional significant others who are invested in helping the youth obtain his/her goals (e.g., friends of youth, family members, older siblings) to subsequent therapy sessions. Expanding the number of people involved in treatment occurs only after all therapy procedures have been implemented at least once, which is typically accomplished by the sixth session. Indeed, friends of the youth usually find the therapy sessions enjoyable, and often have fun modeling therapy procedures with the target youth. Younger siblings, usually under 13, are excused from sessions when drug use frequency reports and drug use scenarios are reported by the parents or substance abusing youth. Indeed, the content is often graphic, and promotes a premature understanding of drug use that often results in biases of younger siblings to think of the reinforcing "cool" side of drug use.

Intervention

After assessment results and therapy expectations are discussed, the youth and

being candid, cooperative, pleasant). The therapist then privately meets with the parent(s), and then the youth, to disclose the results of the assessment sessions using a standardized checklist as a prompt. With the parent(s), the therapist interprets all significantly elevated subscale and total scale scores, diagnoses obtained from P-CAS and SCID-IV, and the lowest Parent Satisfaction with Youth Scale item scores. Parental feedback is encouraged, and parents are asked to discuss past efforts to reduce their youth's drug use and troublesome behavior (desirable and effective methods are praised). Parents are then asked to state their expectations regarding the youth's use of drugs and troublesome behavior consequent to therapy. The therapist provides statements of hope to increase positive expectations for change, and parents are given feedback as to the appropriateness of their expectations. Parents are told that therapy attendance and completion of therapy assignments are strong determinants of goal attainment. As with all sessions, the parents' report of their youth's frequency of illicit drug use since last contact is obtained using the timeline follow-back method.

The parent is then excused, and the therapist meets individually with the youth. The youth is asked if there is anything that she or he felt uncomfortable discussing in front of the parent. Concerns, if any, are addressed, and results of the Youth Satisfaction with Parent Scale are disclosed. In this endeavor, the youth is requested to briefly elaborate on the areas of greatest dissatisfaction from this scale, and empathy is provided, whenever appropriate. If the youth requests information regarding other test results, this information is revealed. The youth is asked to suggest potential methods to improve her/his "situation," including suggestions to

some families do not like contingency management procedures. Therefore, rather than potentially having these persons drop out of treatment, we feel it is most important to enlist their enthusiasm early in therapy by providing the interventions they perceive are most effective, particularly since all of the interventions we describe have demonstrated efficacy in our controlled treatment outcome studies. Thus, we emphasize that procedures be implemented in the order of the patients' rankings (see above).

The Annoyance Review. The purpose of the Annoyance Review procedure is to elicit initial motivation of the youth to decrease drug use and problem behaviors by making the youth more aware of the negative consequences of these actions. The parent(s) is first asked to view their completed Parent Satisfaction with Youth Scale, and select up to 5 domains that are of greatest concern. Each elicited target behavior and illicit drug is recorded in a list. The youth then is seen individually, and a rationale is provided. For example, a therapist might say, "I have been informed about the concerns that others have had regarding your use of drugs; including the trouble that you have experienced with adults. However, I haven't had a chance to speak with you about these concerns. I'm interested in knowing what unpleasant consequences you've experienced, or that you imagine could happen, with these things, if any, so that I may appreciate your concerns more fully."

For substance use, and each problem domain identified by the parent, the youth is asked to rate, on a scale of 0-100, how unpleasant it would be if the youth's current pattern of drug use and conduct continued. Each rating is recorded next to its corresponding domain in a

parent(s) are seen together by the therapist so that interventions may be mutually selected from a list of therapy options. The youth and parent are each provided a handout that depicts treatment options. Two columns are included in the handout; one column consists of easy-to-understand descriptions of the various treatment procedures (e.g., "Getting rewards from my parent(s) for decreasing drug use and staying out of trouble" represents our behavioral contracting therapy; "Reviewing ways to avoid situations that involve drugs and trouble, and planning to spend more time in situations that don't involve drugs and trouble" represents our stimulus control intervention); and the other column provides space for the both the parent and youth to rate the expected efficacy of each of these procedures from 0 to 100 (i.e., 0=not helpful at all, 100=completely helpful). With the exception of procedures that both the parent and youth rate at zeros, expected efficacy means are tabulated, and the youth and parent are told that the procedures will be implemented in the order of their rankings, with the expectation that the use of the procedures will be successive and cumulative. That is, once a procedure is implemented for the first time, it is implemented during each subsequent session, albeit to a lesser degree. After all procedures are implemented at least once (usually by the 6th session), the youth and parent(s) rate them again, which determines the degree of emphasis on each procedure for the remainder of therapy.

We will now broadly depict how the interventions are implemented. The empirical literature strongly suggests contingency contracting is one of the most effective therapeutic procedures with delinquent youth, suggesting it should be implemented immediately. However,

Therapist - "What do you get upset about?"

Youth - "Lots of things. Like, I must be a bad son."

Therapist - "Why is that upsetting to you?"

Youth - "I don't know. I just don't feel good about myself."

Therapist - "Is it distressing for you to have these thoughts?"

Youth - "Yea."

Therapist - "So another unpleasant consequence of drug use for you is that you have thoughts that you are a bad son and don't feel good about yourself."

After all consequences reported by the youth are fully delineated, therapists prompt for additional unpleasant consequences that may not have been mentioned but are common among this age group (e.g., time in jail, health related problems, negative relationships, hurting/upsetting others, disrespect from others, doing bad in school/work). After the consequences are exhausted, therapists empathize with the youth about how "truly" unpleasant these consequences must be for him/her, particularly the highest rated consequences, and reinforce the idea that it is normal to feel this way. Contrasting positive consequences resulting from drug abstinence and trouble-free behavior also are reviewed.

A modified annoyance review procedure may be implemented in future sessions, whenever resistance and/or lack of motivation occur in therapy. Briefly, the therapist may review the top rated unpleasant consequences for substance use and each problem domain of concern, tell the youth that these consequences are likely to occur, and empathize with the

second column. The youth then is instructed to disclose unpleasant consequences associated with each of the domains. Each of the elicited responses should be recorded in a third column next to its respective domain.

After these initial unpleasant consequences are recorded, the therapist should prompt additional consequences by stating, with neutral affect, "Anything else?" When no more initial consequences are provided for a particular target domain, the therapist proceeds to the next domain, and continues as described above. A typically line of inquiry would resemble the following: "What unpleasant things are associated with your current pattern of drug use? (Youth provides an unpleasant consequence) Anything else? (Youth reports no additional consequences) What are the unpleasant consequences associated with doing things that are against the law? (Youth provides 2 negative consequences) Anything else? (Youth reports no additional consequences) What unpleasant things might happen if you do poorly in school? (Youth reports no unpleasant consequences) Anything else?"

Each of the youth's initial unpleasant consequences rated less than 70 should be repeated to the youth, followed by queries regarding what is especially unpleasant/upsetting about the initial consequence (e.g., "You said that you get in arguments with your mother after you steal things. What is especially unpleasant about arguing with your mother?"). The youth should be encouraged to elaborate, clarify, and/or specify in greater detail the unpleasantries that are disclosed. An example vignette for the youth's response "I get upset after I use crack," is as follows:

a brief listing of them to keep. All communication guidelines are read to the family, each family member is prompted to acknowledge that the guidelines are important to communication, and each family member is asked to commit to "attempt" to comply with the guidelines. The guidelines include (a) no interruptions; (b) not talking for more than a minute without inviting others to comment, (c) disclosing aspects of requests that can be done, instead of using the word "no," (d) no use of sarcasm in any form, (e) no swearing, spiteful, and hurtful statements, (f) avoiding discussion of past problems or weaknesses and instead suggesting solutions to problems, (g) staying focused on specific actions that are desired, not overall criticisms of what negative attitudes are disliked, and (h) speaking in a soft and audible tone of voice.

It is realistically expected that family members will violate guidelines during sessions. However, in obtaining permission from family members to interrupt negative communication and consequently instruct positive communication, the awkwardness of interrupting family members who are emotionally aroused is somewhat alleviated. Role-playing may be initiated enhance communication skills. In the very rare event that in-session parent-adolescent communication becomes extremely conflictual, the family is instructed to separate for 5 to 15 minutes, and the session is resumed once family members are calm. Session duration should subsequently be extended for the number of minutes that was interrupted.

Reciprocity Awareness. This procedure is designed to bring about awareness of the pleasant aspects of the existing relationship. Prior to implementing this procedure, the family is given the following rationale: "Families often forget the positive things they do for one another.

youth regarding the undesirability of these consequences. The youth then may be descriptively praised for past efforts in therapy, including a brief review of several positive consequences for maintaining trouble-free behavior and abstinence from drugs.

Communication Guidelines for Therapy. Prior to implementing the core interventions, we have found it helpful to review communication guidelines for therapy. As with all interventions, an initial rationale is provided to the parents and youth together. Rationales contain (a) a very brief statement of the problem to be addressed, (b) the treatment to be implemented, (c) information that the intervention has been successful for other families with similar problems, and (d) an individualized explanation as to why the therapy is expected to be particularly effective with the present family. An example rationale for the Communication Guidelines procedure is as follows: "We have a lot of material to cover in the upcoming treatment sessions. Therefore, it is important to review some guidelines that will increase positive communication during sessions. Guidelines apply to all family members equally, and if a guideline is broken during the session, I will review the guideline with the person who was not able to comply. I will also ask the person to attempt to correct the violation of communication before moving on. Other families have found this procedure to be very helpful because the key to preventing the escalation of session misconduct is early interruption of undesired behaviors. I think this procedure will be particularly effective with your family because you have all expressed a desire to improve communication in your family."

After the rationale for communication guidelines is stated, each family member is given

for the youth (obtained from the "things I do for my child" column), and asks whether the youth likes the way the action is performed. If the youth appreciates the action, the youth is instructed to express that appreciation. If the youth does not appreciate the action, the therapist informs the parent that performing the behavior no longer seems necessary. The youth also may be told to request something that would be similarly desired.

The youth then is instructed to tell the parent something that the youth does for the parent ("things I do for my parent" list), and to ask if the parent likes the way the action is performed. As might be expected, if the parent appreciates the action, the parent is instructed to demonstrate appreciation. If the parent does not appreciate the action, the youth is told by the therapist that it seems no longer necessary to perform the behavior, and the parent is encouraged to request something that would be similarly desired. These appreciation reminders are performed one or two more times in the session, and again during the first few minutes of the subsequent 2 or 3 sessions. Homework also may be assigned to practice the appreciation reminders at home, or to add, and subsequently review, new items to the lists.

Annoyance Prevention. This procedure is an anger management strategy. The following is an example of the rationale for this procedure presented to the family: "Being upset at others makes it difficult to resolve conflicts. This procedure is designed to redirect anger from the person associated with the upset to the situation in which the upset occurred. This procedure has been shown to be very effective, particularly with families like yours who are interested in eliminating aversive interactions." After the youth and parent are given a handout that depicts

suggest a statement recognizing that it might be difficult to grant the request; (e) offer to help facilitate the action; (f) offer to reciprocate the action; (g) tell recipient that the action would be appreciated; (h) suggest an alternative behavior; and (i) ask recipient to accept or suggest an alternative action. Family members are informed all steps do not have to be implemented when trying to make a positive request at home, but that in the office they should practice the complete set of steps.

The youth then is instructed to ask the parent for something that is desired using the positive request procedure. After feedback is provided to the youth, the parent is instructed to respond to the youth's request. The parent is then instructed to perform a positive request of the youth for something that is desired by the parent. The parent and youth are subsequently asked to practice the positive request procedure at home, whenever something is especially desired. Across the next three sessions, each family member should be instructed to practice at least one request, while the therapist provides feedback.

Contingency Contracting. The level system is utilized, whereby standards of the youth's non-drug using and prosocial conduct increase commensurate with parental rewards. Our level system begins with the presentation of the following rationale to the parent and youth: "(Insert youth's name) has a history of using drugs and getting into trouble. The following procedure is designed to increase motivation in adolescents to avoid drug use and perform behaviors that will keep them out of trouble. In this procedure, I will attempt to identify some of the things that (insert youth's name) would like to receive from you, (insert parents' name). I will also attempt

When this happens, it is easy to feel unappreciated. This program will build on your strengths. The therapy we are going to do now is designed to increase awareness of the positive things that you do for one another, and this awareness will motivate your family to continue these positive things in the future." The youth and parent(s) then are instructed to record several things that are done for each other (i.e., Things I do for you that you like; Things you do for me that I like). Therapists prompt responses by glancing at the lists and making generic comments (e.g., "Wow, you sure have a lot of great things on your list." "Some things that I have heard other adolescents say their parents do for them include..."). After a few responses are generated, the parent is instructed to tell something that the youth does for the parent, including a statement of appreciation to the youth. The youth is instructed to say how it felt to be appreciated, and that the youth will make an effort to continue to perform the behavior. The youth then is prompted to disclose something that the parent does for her/him, and to tell the parent that the action is appreciated. The parent is instructed to tell the youth how the appreciation felt, and that the action will continue. If siblings/friends are present, adults may collaborate together and then exchange compliments with the youth as a team. This may be expanded to include siblings if they are present. These statements of appreciation are practiced one or two more times, and are revisited briefly during next couple of sessions. Therapy assignments include making statements of appreciation at home.

The youth and parent also are taught to remind each other of the good things that occur in their relationship. In this procedure, the parent tells the youth something that the parent does

each step of the Annoyance Prevention procedure, the youth is asked to describe a situation in which the youth's parent did something that was annoying. The therapist then models annoyance prevention in response to the situation (e.g., relaxed breathing, objective description of hypothetical situation, stating a situational cause that is out of the individual's control, statement of personal responsibility). The youth is instructed to rehearse the annoyance prevention in response to a similar situation, and feedback subsequently is provided. The parent is also taught to perform the annoyance prevention procedure in a similar manner. The parent and youth are assigned to practice the annoyance prevention procedure at home, whenever appropriate, and both the youth and parent role-play the procedure at least once during the next three sessions, or as needed during sessions.

Positive Request Procedure. This procedure is designed to teach the youth and her/his parents to make requests for desired actions in a positive manner. The following rationale is offered for the procedure: "People who ask for things positively and convincingly usually get more of what they want. Therefore, you are all going to learn to positively request things that are important to you. This will probably reduce the frequency and severity of your arguments, because you will be focusing on mutually satisfying solutions." A form is given to all family members depicting specific steps in making a positive request. The therapist then models the positive request procedure in its entirety for a hypothetical example (elicited from the family), utilizing the following steps: (a) politely request a specific action from the other person specifying when the action is desired; (b) state benefits to recipient; (c) state benefits to self; (d)

feedback when levels appear too easy, or too difficult for the youth to accomplish. In many cases, it is easier for parents to identify extreme levels first, and then complete the middle level.

After three levels are identified for each target behavior, the youth's ideal reinforcers are disclosed, and the parent is asked to identify three corresponding levels of increasing value for each reinforcer. For instance, if a youth ideally wanted his parent to buy him a car, the parent may be unwilling to buy the youth a car given a slight improvement in his behavior, but may be willing to let the youth drive the family car on Saturday night if a slight improvement in behavior was demonstrated (i.e., equivalent to 1st level). Similarly, the parent might be willing to assist in the purchase of a used car if the youth demonstrated significant improvements in behavior (i.e., equivalent to 3rd level). As with the behavioral domains, each reinforcer domain includes three levels of increasing reinforcement to facilitate rapid identification of the three levels for the youth. For money (the most common reinforcer desired by youth), parents are instructed to identify the maximum amount that could be provided to the youth per week if the youth was a "perfect" child. This amount is then divided by 7, which becomes the daily amount for the highest level (3rd level). The daily amount for the lowest level (1st level) is obtained by dividing the amount of money that is currently given to the youth on average (prior to establishing the contingency program) by seven. The middle level is obtained by subtracting the lower amount (1st level) from the higher amount, and dividing the resulting amount by two. It sometimes helps to have parents record an inventory of things that are bought for the youth each week to help them understand the difference between contingent and noncontingent reinforcement. All

reinforcers that cannot be provided on a daily basis are included as "bonus" reinforcers. That is, the parent decides how many consecutive days the youth will have to accomplish all behaviors in the respective level before the reinforcer is earned (e.g., 30 consecutive days in which all behaviors are performed will result in a compact disc player for the youth).

The youth is seen again individually to verify daily contingent linkages between level 1 behaviors and level a reinforcers. Bonus reinforcer contingencies are also reviewed. If reservations in accepting the terms are expressed, an attempt is made to negotiate these concerns, though the parent ultimately decides the appropriateness of revised contingencies. The parent is brought into the room, and level system procedures are explained and subsequently role-played. The youth and parent are instructed to schedule a regular time each night to review the youth's performance in all target behavioral domains and provide reinforcers if the target domains were performed adequately. The youth and parent are told that if all behaviors in the respective level are performed all reinforcers in the respective level should be provided, and that if just one target behavior is not performed no reinforcers in that level will be provided. In the event that the youth accomplishes all target behaviors for 7 consecutive days, the youth will advance one level. If illicit drugs are indicated, according to urine testing or reports of parents, the youth must drop one level. The youth can arrange to "make-up" or correct behaviors when they are not performed, but only with parental approval, and youths cannot "make-up" for drug use or being arrested. After the guidelines are explained, the therapist models the role of a parent in reviewing the behaviors with the youth for a hypothetical

troublesome situations confidential. Similarly, the parent is told that in order to be a positive influence on the youth in decreasing drug use, it will be important to keep the youth's reports of interactions with drug use stimuli confidential so that the youth will feel free to disclose this information readily. Of the hundreds of youth who have been served in our program, we have never had a parent petition for these worksheets, although it is the parent's right to do so, first with the therapist, and later in court if the therapist refuses to provide these records because she or he believes it is not in the best interest of the child.

The parent then is seen individually to obtain additional "safe" and "at-risk" stimuli. First, the youth's safe association list is reviewed with the parent to assure that each item is not associated with drug use or trouble. If the youth identifies a stimulus as "safe," and the parent(s) identifies the stimulus as "risk," the stimulus is considered a safe association, but the discrepancy is the reports is recorded. The parent also is asked to disclose people/situations/activities that have, or probably have, involved drug use or trouble for the youth. The parent the describes methods that s/he will attempt to assist the youth in staying abstinent from drugs and out of trouble. Finally, the youth and parent are seen together to schedule a pleasant family activity to perform together prior to next session.

The pleasant aspects of the planned activity are reviewed during the next session. If the youth and parent did not complete the scheduled activity, they discuss what they would have enjoyed most about the activity if they had completed the assignment, and how the scheduled family activity could have been accomplished. Another family activity is planned together, and

have involved drug use or trouble. Other families have found that by talking about drug use and trouble situations with adolescents only, they can be more up-front about these situations, which helps them ultimately accomplish their goals more effectively. I want to remind you both that confidentiality will be necessary. If you both do not have any questions we can get started."

The youth then is seen individually to obtain a list of persons, places, and situations/activities that have never been associated with drug use or conduct disturbance. The youth is prompted to list all enjoyable persons with whom s/he has never used drugs, or engaged in activity that has led to trouble, and all enjoyable situations/activities that have not involved trouble or drug use. A list of persons, places, and situations/activities associated with problem behaviors is obtained in a similar manner. Prompts may be used to generate "risky" stimuli (e.g., Do you find yourself getting into trouble, or using drugs during parties or get-togethers? Who is present? What do you do at the parties? Do you get in trouble or use drugs after drinking?) When time allows, the youth is asked to briefly discuss what is liked/disliked about outstanding stimuli. The youth is prompted to discuss strategies relevant to increasing the likelihood of "staying clean" and out of trouble. The youth also plans the next 24 hours with safe activities, and is asked to attempt abstinence during this time.

The youth is told that it is necessary to obtain a similar list of people, places, and situations that have involved drug use or trouble for the youth from the parent, and that the parent must verify that safe stimuli given by youth have not involved trouble or drug use. However, the youth is told that every attempt will be made to keep his list of drug use and

about to learn is called Self-Control because you will learn to control impulsive thoughts and feelings that usually lead to trouble. Because you're strong-willed, I think you're going to do particularly well with this technique. Do you have any questions?"

The youth then is told that practice sessions will be performed "thinking out-loud" so that the therapist may understand the youth's thinking patterns. The youth is taught that recognizing and stopping thoughts associated with drug use or trouble when the thought first occurs will greatly increase the chances of preventing drug use and troublesome behaviors. The youth is instructed to disclose a situation in which drugs were last used, and to identify the first thought to use drugs in that situation. As the following vignette demonstrates, the therapist must sometimes assist the adolescent in determining his or her "first" thought to use drugs.

Therapist: Tell me about the last time that you used drugs. I'm especially interested in knowing about the thought that you had before you made plans to use drugs in that situation.

Youth: I was in the house and saw a guy smoking from a pipe. I thought a rock would feel good.

Therapist: You did a good job of identifying a thought that eventually led to drug use. However, I want you to think hard. I'm sure you had a thought that brought you to the crack house.

Youth: I started to think of it while I was driving into the neighborhood, and my stomach was churning.

the youth is seen individually to review stimulus items. Specifically, the youth indicates, on a recording sheet, the stimuli encountered since last contact. For each stimulus, the youth is asked what was done to avoid drug use and trouble. When drug use or trouble is reported, the youth is asked to identify alternatives to, or methods to escape from, the situation. The youth also is asked to review the time that was planned (i.e., 24 hours subsequent to previous session), and activities are scheduled for the next 24 hours with non-drug using peers. The parent is seen individually to review parental strategies relevant to helping the youth spend more time with safe stimuli.

Five or six sessions after the stimulus control procedure is implemented, the family graduates to the second phase. In this phase, the youth and parent review the "safe" items together with the therapist. In the final phase, the parent and youth review both the "safe" and "at-risk" lists together. If the youth indicates any reservations about including the parent in the review of at-risk stimuli, the last phase should not be implemented.

Self-control. The self-control procedure is designed to aid the youth in preventing urges to drink or get into trouble. Youth are provided with the following rationale: "Earlier you told me that you have done spontaneous things that have resulted in trouble for you, such as using drugs. These activities often start out as casual thoughts or mild feelings. Many adolescents say that this is because they react before they've had a chance to think about how the action will affect themselves or others. Tell me about some things that you've done on the "spur-of-the-moment" and that later led to trouble for you or someone else?...The technique you are

tells me to give the old man's mailbox a bash with the bat.").

The second step is to state at least one negative consequence from drug use or troublesome behavior for self, and at least one negative consequence for friends, loved ones, or others affected by the youth. Negative consequences may be obtained from the Annoyance Review procedure, and should be stated with affect reflecting sadness, anger, disgust and/or despair. Muscles should remain tense. Consequences may be rotated (or added) as trials progress. Therapists should prompt detail regarding negative consequences.

Stating the last negative consequence should signal the performance of a muscle review to assure that negative feeling states, and tension in muscles, are not present. Major muscles should be reviewed from head to toe. During this review, if a major muscle is relaxed (e.g., shoulders), the youth should describe this state. If a muscle is tense, the youth should use relaxing cue words until the muscle is no longer tense (e.g., "My arms are getting more and more relaxed. I am imagining a band of relaxation around my arms. They feel relaxed, calm, more and more relaxed"). Deep, rhythmic breaths should occur throughout the trial. Body weight should be evenly distributed and positioned in a relaxed state. Statements referring to the relaxed state of the body are acceptable throughout the relaxation period, which should continue until all muscle groups feel relaxed (ideally about 5 to 10 seconds). If no tension or negative feeling states are present, the youth may be instructed only to breathe deeply.

The next step involves stating several behaviors that may be performed instead of drug use and troublesome behavior. These steps may include: (a) stating several alternative actions

that do not include drug use or troublesome behaviors; (b) briefly checking to make sure the response is unlikely to bring about drug use or trouble for self or others; or (c) reviewing positive consequences for self and others that may occur because of one's actions. During this exercise, it is important to provide prompts to the youth regarding additional alternative behaviors, how self and others would be positively affected by alternative behaviors, what others would do for youth if alternative behaviors were performed, and how problem behaviors may continue to have negative consequences.

After stating several behaviors that are incompatible with problem behavior, the youth is encouraged to choose one option and describe doing the behavior (e.g., "I think the best thing to do is to tell Bob that I have to go to Jackie's house. I'm telling Bob that I have to go to Jackie's house. As I'm telling him I can see that he is disappointed, so I tell him that we can go to the movies together next Saturday. Bob is telling me that I should go to the movies with Jackie. I'm walking away from Bob, and towards Jackie's house. I walk to her house and I'm now telling her that I would like to take her to the movies, and she is smiling and telling me that she'd love to. She tells me that she's proud of me."). When the youth performs this step, the therapist should provide prompts to elicit detail, including questions as to how the youth will successfully resolve difficult situations that are likely to occur. Sometimes the youth may be instructed to practice getting out of difficult interpersonal situations that may lead to drug use, or trouble (e.g., "Show me how you would tell him that you had to go home. I'll be Bob."). Youths should always be instructed to reward their imagined efforts to engage in drug- and trouble-free

Therapist: Now go back further, before you were driving in the neighborhood.

Youth: I was getting paid for mowing a lawn, and I thought I deserved it after working so hard that day.

The therapist then models a self-control trial, and subsequently instructs the youth to rehearse the procedure. The first trial is conducted in response to a drug use situation, and the second trial is conducted in response to a thought to engage in troublesome behavior. Subsequent trials alternate between situations involving drug use and troublesome behavior. The number of trials performed will depend on the youth's extent of drug use and troublesome behavior since last contact. Situations may be generated from desired behaviors that were not performed in the level system. Active drug users and youths that have not performed behaviors targeted in the level system should be instructed to perform more trials than abstainers who are completing level system target behaviors. Poor performance during trials necessitates additional trials per session.

The first step of the self-control procedure is to catch the thought or image to use drugs or engage in troublesome behavior early in the response chain and consequently terminate this thought or image by firmly stating "stop" while muscles are tensed. In the event that the troublesome behavior was an omission of behavior (e.g., not coming home on time, not informing parent of whereabouts prior to curfew), the youth is instructed to state "stop" when the omission could have been prevented. Background information associated with situation should be stated with enough detail to appreciate the situation ("I'm in front of the mailbox. My friend

alternative behaviors.

The next step is to imagine telling a friend and/or family member about having performed the trouble-free alternative behavior. The recipient should respond in a favorable manner, and positive feelings should be delineated. For example, "I'm telling my mom that I could have gone to the movies with Bob, but instead I went to the movies with my girlfriend because she doesn't use drugs. As I'm telling her this I feel good about myself. My mom looks at me and says that I'm doing a great job, and that she's proud of me. She also tells me that she's been thinking about extending my curfew because of my efforts to stay clean."

The trial concludes by describing several pleasant outcomes and positive character attributes (e.g., "I'm really proud of myself for telling Bob that I had to go out with my girlfriend. I'm going to have a great time with her, and improve our relationship. I liked how I told Bob straight-up and didn't beat around the bush. That says a lot about the kind of person I am. I can be direct with people but still not hurt their feelings. If I can keep on doing these kinds of things I'm going to be more motivated to get a part-time job, and get back into school, and my parents said that if I stay clear of drugs, and people who get into trouble, they will give me $400 to help me buy a moped.").

When youths practice the self-control procedure for the first time, it may be necessary to state the situation and prompt the youth to subsequently state "stop" (e.g., "You're in the park. Bob comes up to you and asks if you want to smoke reefer. Go ahead and yell, stop."). Similarly, it may be necessary to prompt the youth to perform each component initially, and later

fade this assistance.

After the youth completes each trial, the therapist asks the youth to provide his/her rating of desire to engage in problem behavior prior to performing the trial, and after the trial is performed (i.e., pre and post trial urge level). The youth is prompted to critique her/his performance, and the therapist subsequently praises the youth for making statements during the trial that reflected protocol adherence, including suggestions or prompts to youth regarding improvement of future sessions.

Situations to utilize for drug use trials should be prioritized in the following manner: (1) Most recent hard drug use during past month, according to self-reports of youth and parent, and/or urine drug screens; (2) Most recent marijuana use during past month, according to self-reports of youth and parent, and/or urine drug screens; and (3) Time spent in at-risk situations that are particularly likely to influence drug use. Situations to utilize for troublesome behavior trials may be obtained as follows: In the session review of the level system, ask the parent to disclose a target behavior in the level system that was not performed since the last therapy contact, and that was most desired by the parent. In the event that multiple behaviors were not performed, the behaviors should be ranked according to desirability (no more than three trials regarding troublesome behavior and three trials of drug use, per session). If all level system target behaviors were performed since the last therapy contact, instruct the youth to perform only one trial in response to time spent in the most recent "at-risk" situation listed in the stimulus control procedure.

Empirical Studies

Several controlled treatment outcome studies, funded by the National Institute of Drug Abuse, have demonstrated efficacy of the program. The first study (n = 82; Azrin, McMahon, Donohue, et al., 1994) included a subsample of adolescents. Subjects identified to be using illicit drugs during the time of admission to an outpatient clinic for drug abuse were randomly assigned to the behavioral program described above or to supportive counseling. Study results indicated that subjects receiving the behavioral intervention demonstrated less alcohol and drug use throughout the year following the initiation of treatment than subjects who received supportive counseling. Subjects in the behavioral condition also were significantly less depressed, demonstrated greater satisfaction in their relationships with significant others (e.g., parents), spent less time in institutions, and attended more days at school. Follow-up results indicated that the treatment effects were maintained for up to 9 months after the conclusion of intervention (Azrin, Acierno, Kogan, et al. 1996). Another outcome study, focusing exclusively on adolescents (n = 26; Azrin, Donohue, Besalel, Kogan, & Acierno, 1994), indicated that 73% of subjects who received the behavioral intervention evidenced abstinence from illicit drugs at the conclusion of treatment, as compared to 9% of subjects who received supportive counseling. Subjects who received the behavioral intervention also demonstrated significantly less depression, behavioral problems, days using alcohol, and attended school more often throughout the six months of the study compared to subjects who received supportive counseling. Parents of subjects who received the behavioral intervention also were more

satisfied with their youth than were parents of subjects who received the supportive intervention.

Prescriptive/Matching Issues

The program was developed to accommodate diversity issues, such as poly-substance abuse and dependence, various behavior problems, and preferences in therapy due to cultural and other factors. Indeed, the program is relatively comprehensive, and, although standardized, is flexible in response to individual patient's needs and desires. For instance, the self control procedure includes components that may be used to decrease physiologically-based urges to use addictive drugs or impulses to engage in unacceptable behaviors (e.g., vandalism, truancy). However, this procedure also includes components that address social influences, which have greater potential to bring about long-term changes associated with a drug-free lifestyle. Thus, a youth who uses marijuana only during "get-togethers" and parties may choose to emphasize the social components of the self-control procedure, whereas a youth who is abusing crack cocaine may wish to emphasize the initial steps of the self-control procedure, which include urge-control strategies. Similarly, communication procedures might be emphasized for youths who do not wish to spend much time at home due to poor relationships with their family, whereas families who evidence no major problems in their communication with family may wish only to briefly examine these procedures. However, each therapy should be implemented at least a few times, as family members may deny, or be unaware of, problems that need to be addressed in therapy. For example, a parent may claim that contingency

management strategies are of little importance prior to its implementation, but later change her/his mind after the therapist helps the parent to become aware of her/his history of failing to comply with established contingencies in the behavioral contract.

Anecdotally, we have found the presence of even the most delinquent of peers improves program compliance of our patients because these peers are almost always under their very best behavior to impress the parents of the identified youth so that the parents will be more inclined to allow the identified youth to spend time with the peer. It is also probable that peers are motivated to impress the therapist with compliance, so the therapist will comment to the parents that the peer is a good influence. Therefore, we recommend that family members and friends of the youth be involved in therapy, but not until all therapies are implemented at least once with the parent(s) and youth. When significant others of the patient are included, we have found the following strategies to be useful: (a) limiting the number of non-adult significant others to one, (b) having patients explain all program rationales and procedures, (c) having patients demonstrate how to perform all program techniques, (d) encouraging significant others to actively participate in the therapies (e.g., role-plays, supportive comments), and (d) providing token snacks (candy, cakes) and beverages (sodas, coffee) to visiting significant others to make their visit more enjoyable.

Summary and Future Directions

Our studies provide support for the effectiveness of our program for treating problem behaviors among substance abusing and conduct-disordered youth. The program includes

multiple interventions, with an emphasis on various interventions mutually determined by the youth and her/his parent(s). For several years, we have refined the treatment program in controlled outcome studies. However, the program needs to be evaluated against other therapies with demonstrated success for treating this population. We have recently completed an empirical comparison of the aforementioned program to a standardized problem-solving intervention in a sample of adolescents who have been diagnosed with Conduct Disorder and Substance Dependence (National Institute of Mental Health, 5R01MH53455). Although the outcome study manuscript is not yet prepared, preliminary examination of study data indicate significant improvements consequent to both intervention programs across measures of drug use frequency and behavior. In the future, we plan to compare the program with, and without, contingency management strategies. Indeed, anecdotal information derived from patient and therapist reports suggests that youth who evidence serious behavior problems and high rates of drug use are less responsive to contingency contracting procedures than their younger and less severe peers. Lastly, we are interested in discovering if treatment outcome is enhanced by having patients determine the degree of emphasis placed on each intervention, including the order in which these interventions are implemented during therapy.

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Appendix A

Potential Privileges and Benefits

money:	1) $____ per day , 2) $____ per day, 3) $____ per day.
transportation:	1) ___ mile ride per day, 2) ___ mile ride per day, 3) ___ mile ride per day. or 1) use of car for __ hours per day (approved place, alone), 2) use of car for __ hours per day (approved place w/ _____), 3) use of car for __ hours per day with _____,
lunch	1) caregiver packs lunch, 2) caregiver provides paid school lunch, 3) paid school lunch, and ____.
dessert/meal	1) choice of _____, 2) choice of _____, 3) trip to ____restaurant
laundry	1) caregiver helps with wash, 2) caregiver helps with wash & dry, 3) caregiver helps with wash, dry, and ironing _____.
phone use:	1) use own phone for local calls from ___ to ___. 2) use own phone from __ to ___. 3) unlimited local use of own phones, ____mins. of long distance.
sport/fitness/club membership	1) $___ membership to _____, 2) $___ membership to ____, 3) $___ membership to ___.
Invite friend(s) for sleep over:	1) invite ____, 2) invite ____ and ____ incentives, 3) invite ___ and ___ incentives
Non-drug/alc. party/get-together	1) party with ____ persons, 2) party with _____ persons and ____ incentives, 3) party with ___ persons and ___ incentives
Trips w/ family and/or friends	1) family trip to ____, with ____, 2) family trip to _____, with ____, 3) trip to ____, with ____ .
Buy a pet	1) buy ___ pet, 2) pay for ____ pet supplies per week, 3) pay for ____pet supplies per week.

privacy time	1) ___mins. privacy time in home by self, 2) ___mins. privacy time in home with ___ person, 3) ____mins. home with ____ person(s).
letter to probation officer:	1) slightly improved letter, 2) moderately improved, 3) greatly improved letter.

Appendix B

Target Behavioral Domains

Criminal behavior:	1) no police contacts, 2) no police contacts and school suspensions/detentions, 3) no police contacts, school suspensions/detentions, and neg. school reports.
Drug use:	1) no evidence of hard drug use, 2) no evidence of hard drug use and pot, 3) no evidence of drugs and alcohol.
Conduct in therapy:	1) attended scheduled session, 2) on time for scheduled session, 3) cooperated during session.
School attendance:	1) effort to enroll in school, 2) verification of ____% school attendance, 3) verification of ____% school attendance.
Curfew:	1) curfew till _____, 2) curfew till _____, 3) curfew till _____
Caregiver informed about whereabouts:	1) tell caregiver where going, 2) tell caregiver where going and 1 call during, 3) ask caregiver permission and give 1 call during.
Calm resolution of disagreements:	1) day without intentionally damaging property, 2) day without raising voice at caregiver, 3) day without raising voice at caregiver & compromise in disagreements
Compliance with chores	1) compliance with _____ chores. 2) compliance with _____chores, 3) compliance with _____chores.
Academic progress:	1) read ___ pages of any literature, 2) show caregiver any test, quiz, or school assignment or discuss day at school for ___ min. 3) do ____ mins. of

school homework, or show caregiver any test, quiz, or school assignment at least ___ letter grades above current GPA in ____ subject(s).

Pleasant conversation: 1) say hi or how are you?, etc. to caregiver, 2) talk to caregiver for __ mins. in calm tone of voice about anything, 3) talk to caregiver for __ mins. about anything in calm voice.

Friends: 1) talk about positive aspects of 1 or more friends for up to __ mins. if caregiver wants to, 2) talk about things that were done with friends for __ mins. if caregiver wants to, 3) discuss a problem regarding friends with the caregiver, if caregiver wants to.

Reviewing day: 1) tell caregiver that day was good/bad, 2) tell caregiver one or two highlights of day, 3) ___ mins. reviewing day w/ caregiver.

Appendix C
Example of Level System Recording Form

LEVEL 1

Target goals (check if goal achieved for day)	mon	tues.	wed	thurs	fri	sat	sun
no police contacts							
no evidence of hard drug use							
attendance at scheduled therapy session							
verification of school attendance from principal's office							
mom informed of whereabouts throughout day and night							
tell caregiver where going at night							
day without hitting family, and swearing and raising voice at father							
come home by 11:30 p.m.							
mow lawn by Fri., do dishes Thurs., clean room by Sat.							
talk with either parent about "college life-style"							
say "hi" or "how are you" to father							
talk about hobbies and good qualities of Joey's friends for 1 min.							
check if all behavioral goals above were achieved.							

Check if the following rewards were made available, if all goals achieved?: $1.00 per day, . 5 mile ride, paid school lunch, ice cream after dinner, dad does wash (laundry) by Sun., use phone for local calls, use t.v., invite Bob over for dinner, trip to Keys for fishing trip with dad and Bob during weekend., 1 hour privacy time/day, improved letter to P.O.							

to identify some of the things that (insert parents' name) would like to see you doing better, (insert youth's name). The demands on (insert youth's name) will increase as his behavior improves, but so to will the quality of the privileges and rewards that he is given. The level system has been shown to be very effective in giving adolescents the motivation to stay drug-free and to avoid things that might lead to trouble. I feel this procedure is going to be especially effective in your relationship because you both want a fair exchange. Does this seem like something that you both would like to try out?"

The youth then is seen individually, and asked to identify reinforcers, using a standard list of rewards as a prompt (see Appendix A). If the youth shows interest in a particular domain in this list (e.g., transportation), s/he is asked what is currently being provided by the parent(s) in that area. The youth then is asked to discuss how the domain could be "perfect," and the youth's responses are recorded.

After all items in the list are reviewed, the therapist meets with the parent(s) individually. The parent is shown a generic list of common behavior domains that are associated with trouble-free behavior and drug abstinence (see Appendix B).The parent first is asked to select each domain that needs improvement, and the therapist helps the parent identify three levels of increasing behavioral difficulty (i.e., "slight improvement of current behavior," "moderate improvement," "ideal behavior") that may be monitored on a daily basis. To facilitate rapid identification of appropriate levels, each target behavioral domain includes three hypothetical levels that may be modified to accommodate three levels for the youth. Therapists also provide

situation, including the delivery of reinforcers. The parent engages in guided practice of a similar review with the youth, while the therapist provides feedback, and the procedure concluded with the youth and parent endorsing the contract.

In future sessions, the youth and parent are asked to review pleasant aspects pertaining to the completion of outstanding target behaviors that occurred. The therapist should attempt to determine if the parent monitored targeted behaviors, and if reinforcers were provided as previously agreed. Therapists also should determine that no reinforcers were delivered noncontingently. It should be mentioned that the level system provides a great opportunity to descriptively praise desired behaviors, and that some youth will remain on level 1 for several weeks before a "break through" is made.

Stimulus Control. The stimulus control procedure involves three phases. In the first phase the parent and youth are provided the following a rationale: "In a moment I'm going to ask (insert youth's name) to list people, places and activities that he likes to spend time with the most. Each week (insert youth's name) and I will review these situations so that I can help him avoid drug use and trouble. Everything we talk about during this time will be between (insert youth's name) and me. Later, when (insert youth's name) thinks that it's O.K., I'll invite you to talk with us about things that you can do to make it easier for (insert youth's name) to stay clean and out of trouble. However, we won't talk about situations that may have involved drug use or troublesome behavior during this time together. Later, when (insert youth's name) thinks it's O.K, we will invite you, (insert parents' names), to talk with us about situations that may