

FFT Strategies for Addressing Internalizing Symptoms in Youth with Co-Occurring Substance Abuse and Depression*

Holly Barrett Waldron^{1,2}, Michael S. Robbins^{1,2},
Paul Rohde²,
Charles W. Turner²,
& Janet L. Brody²

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Rates of Comorbidity

- ◆ Higher rates of mood and disruptive disorders occur among adolescents with substance use disorder (SUD) than those without
- ◆ Young adults with history of depression have twice the risk for future SUD
- ◆ Prevalence of Major Depressive Disorder (MDD) in adolescents with SUD is 18% to 35%
- ◆ A third to a half of youth entering inpatient treatment for MDD meet criteria for SUD

Impact of Comorbidity

- ◆ Comorbid depression/SUD may be strongest risk factor for suicidal behavior
- ◆ Adolescents with comorbid depression and SUD have significant higher rates of suicide than adolescents with depression alone
- ◆ SUD/depression also associated with:
 - History of abuse/trauma
 - Academic impairment
 - HIV risk behaviors



Impact on Treatment

- ◆ **Comorbidity complicates conceptualization and provision of treatments**
- ◆ **Comorbidity generally associated with drop-out, poorer recovery, and relapse**
- ◆ **In dually diagnosed youth, treating either depression or substance abuse alone is insufficient for both disorders**
- ◆ **No evidence exists regarding whether to treat comorbid disorders sequentially or simultaneously**

Impact on Treatment

Among adolescents with SUD, depression is associated with:

- Better treatment attendance
- Higher treatment completion rates
- BUT higher SUD relapse rates (McCarthy et al., 2005; Rowe et al., 2004; Waldron et al., 2006; White et al., 2004)



Research Evaluating Treatments for Adolescents with Comorbid MDD/SUD

- ◆ **Small, uncontrolled pharmacotherapy studies for depressed/SUD adolescents (Cornelius et al., 2001; 2005; Deas et al., 2000; Riggs et al., 1997; Solhkhah et al., 2005):** some reductions in depression and substance use have been found
- ◆ **Riggs et al. (2007), in the first randomized clinical trial, found:**
 - Reduced depression in medication and nonmedication treatments
 - Regardless of treatment, reductions in depression were associated with significantly less drug use
 - Less than 10% sustained abstinence (> 1 month)
- ◆ **Cornelius et al. (2004, 2005), in an open-label study of fluoxetine with 10 comorbid adolescents, found that:**
 - all patients discontinued their medication by the 2nd month of follow-up
 - 80% experienced MDD recurrence during 5-year follow-up

FFT for Comorbid MDD/SUD: Randomized Clinical Trial Findings*

Evaluation of two EBTs:

- **For Substance Abuse/Dependence:**
Functional Family Therapy (FFT)
- **For Depression:**
Adolescent Coping With Depression (ACWD)

* Rohde, Waldron, Turner, Brody, & Jorgensen, 2011
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Study Description

- **Adolescents (13-19) with Co-Occurring Substance Use and Depression Disorders**
- **Youth randomly assigned to one of three treatment delivery sequences:**
 1. **ACWD followed by FFT (ACWD/FFT)**
 2. **FFT followed by ACWD (FFT/ACWD)**
 3. **Intervention involving an integration of FFT and ACWD (Integrated Tx: IT)**
- **In all sequences, treatment included 24 sessions programmed for a 20-week period**

Available Sample

- **172 youth and families at two sites (Portland, OR and Albuquerque, NM)**
- **Youth assessed at baseline, every 5 weeks during treatment, and at 8- and 12-month follow-ups**
- **Complete treatment data available on 74 youth**
 - 33 in CBT/FFT**
 - 17 in FFT /CBT**
 - 24 in Integrated treatment**

Sample Demographics

- **Age**

- mean =16.5, SD=1.4

- **Gender**

- 74% male; 26% female

- **Race/Ethnicity**

- 31% Hispanic

- 50% non-Hispanic White

- 4% African American

- 15% other/mixed

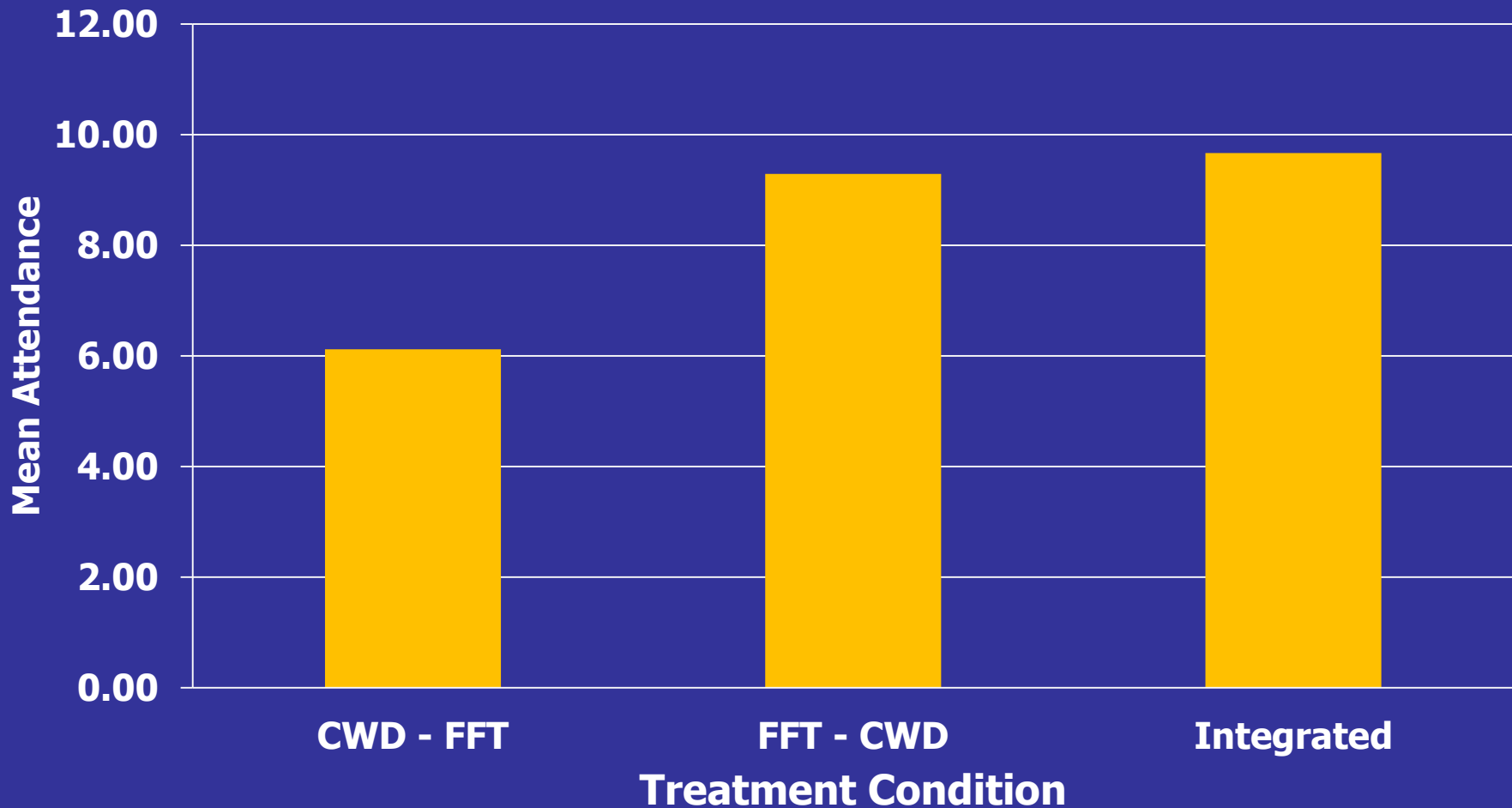
Outcomes

- **Mean attendance**
 - **Engagement (>3 sessions)**
 - **Retention (> 6 sessions)**
- **Therapeutic Alliance (FFT and ACWD)**
- **Family participation in FFT**
- **Teen participation in ACWD**
- **Homework completion in ACWD**

Mean Attendance: FFT

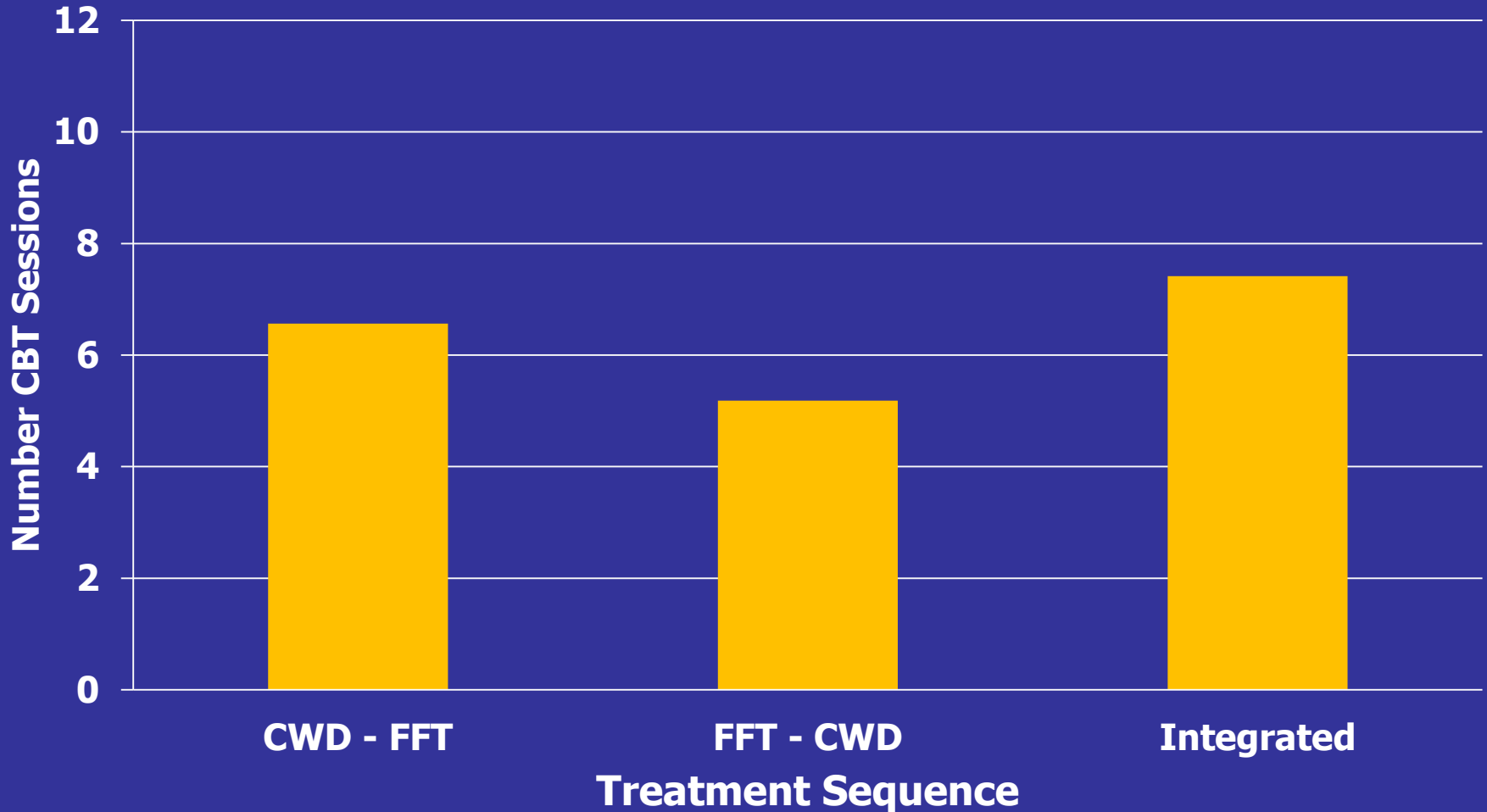
- **FFT**
 - 12 sessions programmed/offered
 - Mean = 8.0 sessions (SD = 5.3)
- **ACWD**
 - 12 sessions programmed/offered
 - Mean = 6.5 sessions (SD = 4.1)

Mean Attendance: FFT



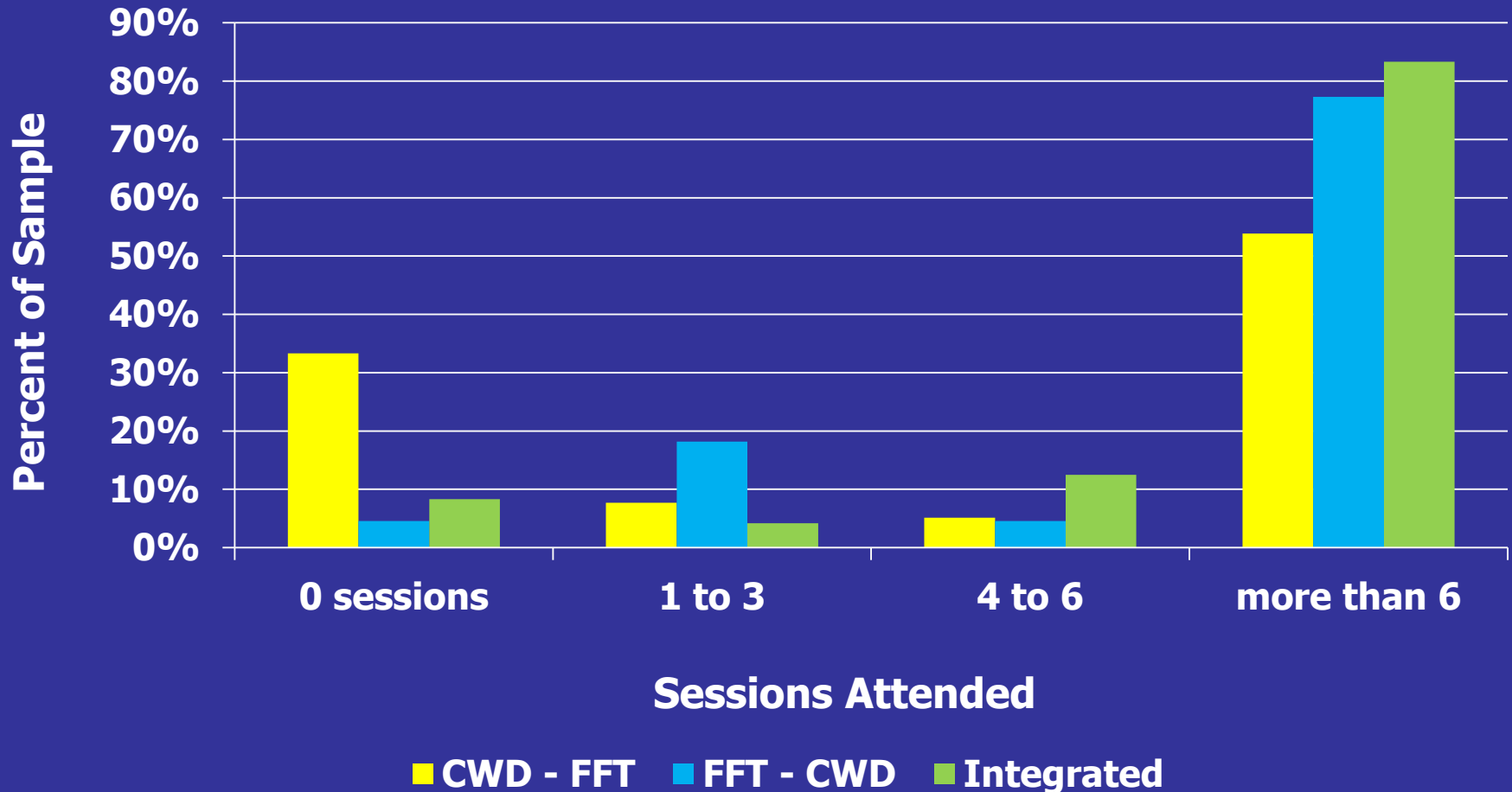
CWD-FFT had significantly fewer sessions than FFT-CWD or IT; no differences between FFT-CWD and IT.

Mean Attendance: ACWD

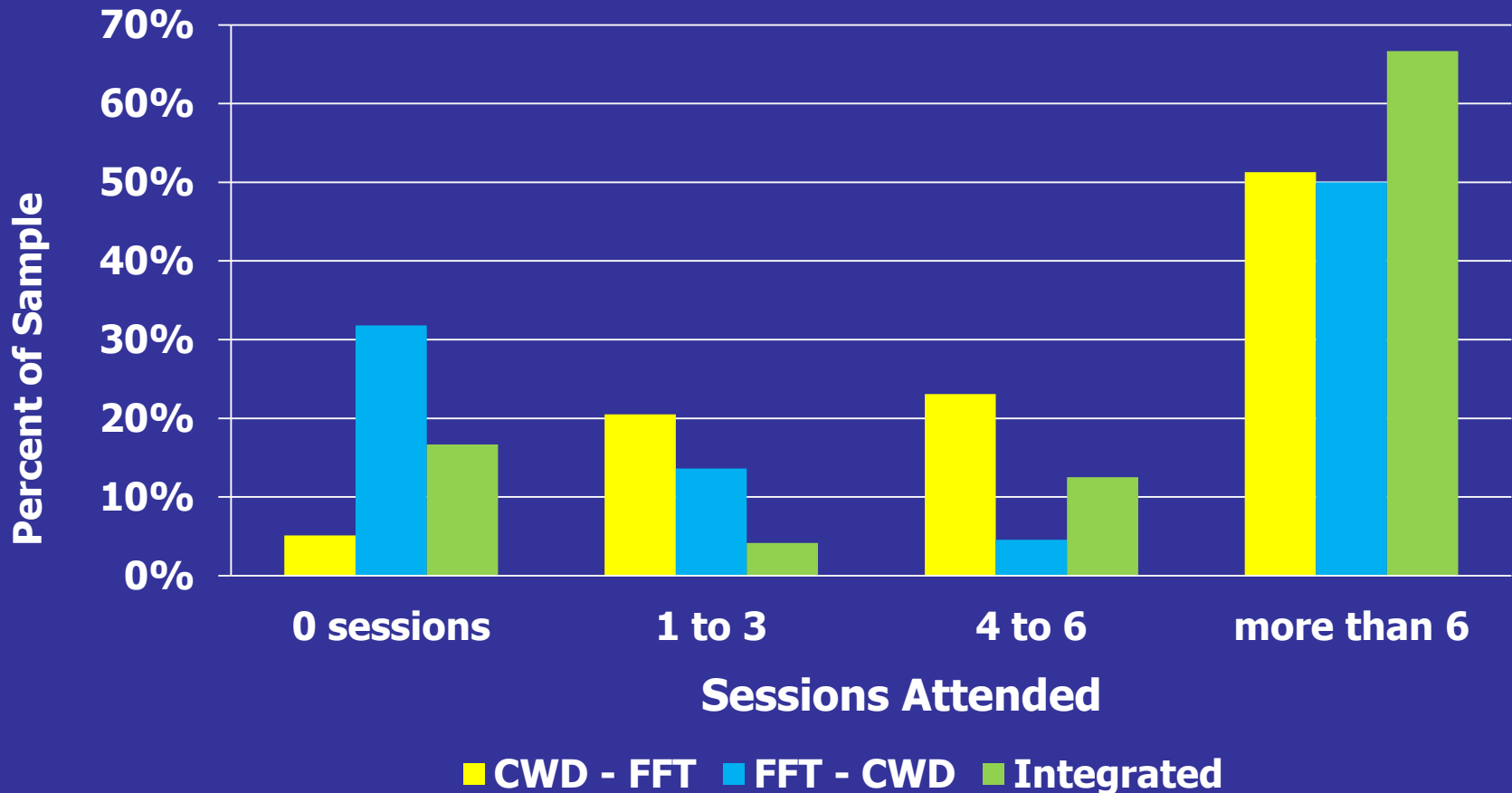


No differences between any of the sequences

FFT Engagement/Retention (% Attending FFT Sessions)



ACWD Engagement/Retention (% Attending ACWD Sessions)

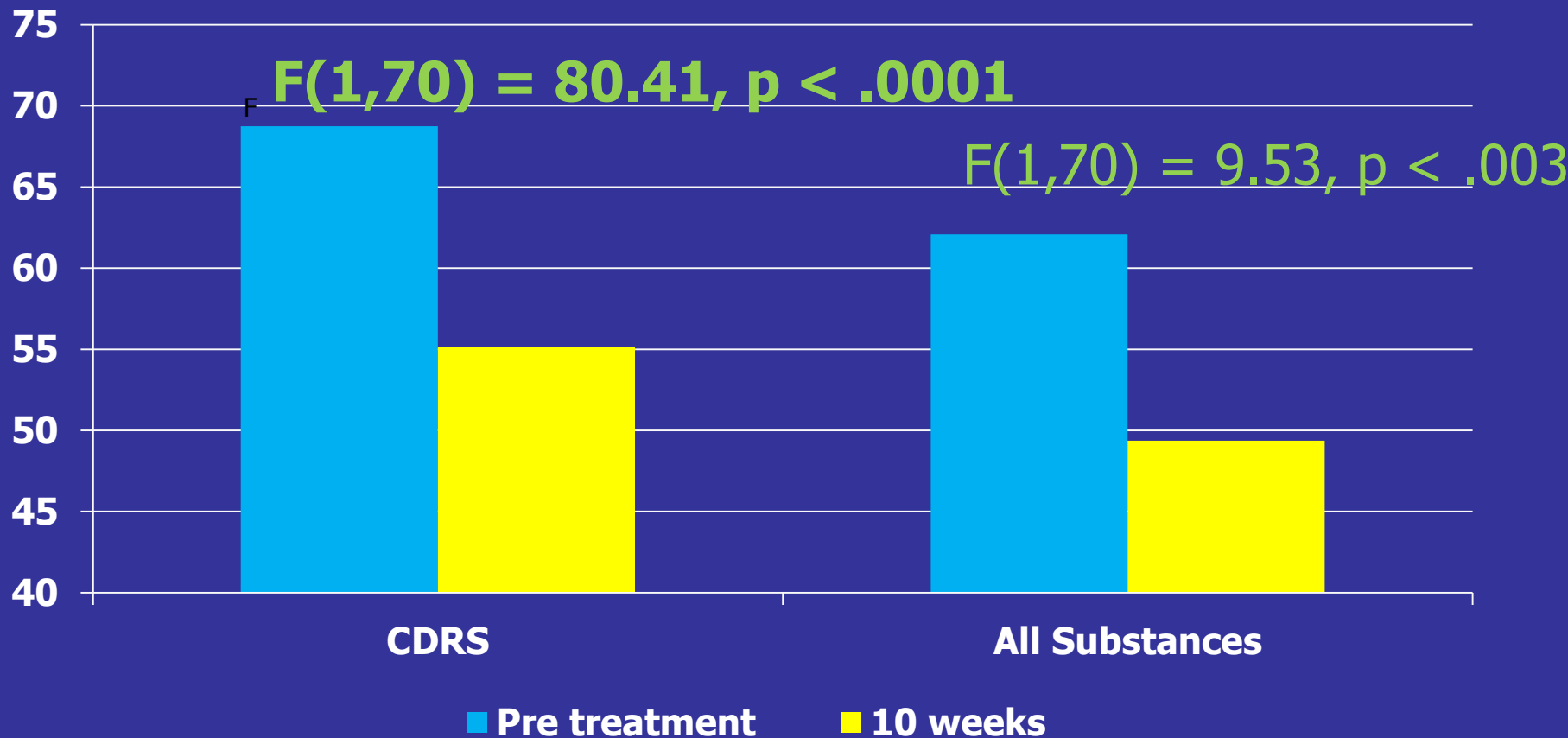


Engagement

- All families attended some FFT if offered early in treatment
- Better engagement & retention in ACWD sessions for IT
- Percent who failed to engage in FFT:
 - 41% CBT/FFT
 - 23% in FFT/CBT
 - 12% in Integrated Treatment
- Percent who failed to engage in ACWD:
 - 26% CBT/FFT
 - 46% in FFT/CBT
 - 21% in Integrated Treatment

Failure to Engage in Second
Treatment is Not Due to
Improvement after First Treatment

Reduction in Depression and Substance Use (% days) from Pretreatment to 10 Weeks



Conclusions

- Comorbidity complicates treatment of both conditions
- Clear pattern of difficulty engaging youth/families into a 2nd treatment when interventions are sequenced – engagement failure not due to improvement after 1st treatment
- Engaging families is especially difficult if treatment is not the first treatment implemented
- All sequences showed sharp reductions in both depression and substance use at 10-week assessment
- FFT alone and integrated FFT+ACWD led to better engagement and outcomes after 10 weeks, *but...*
 - Early dropout or lower dosage may increase the risk of future relapse for either disorder
 - The impact of FFT and the other treatments on long term outcomes remains to be seen

So far...in co-morbid youth FFT appears as good or better on substance use and depression outcomes compared to combined treatments or depression treatment alone

**FFT Clinical Strategies for
Addressing Depression and
Negative Moods in
Family Sessions**

Characteristics of Depressed Families

Pattern 1: Families with high depressed affect, hopelessness, emphasis on perfection, high standards for behavior, extreme negativity and blaming

- Parents are often overly punitive, harsh
- History of absent or abusive parents themselves is common
 - “I have to do this to make sure he's safe, it's my job”...only later do they make a connection to how they were raised...*
- Particularly resistant to reframes, likely due to guilt over their role in problem
- Persistent encouragement needed to keep families engaged
 - Strength-based comments
 - Positive focus to help them feel connected to tx gains

Common Relational Dynamic for Pattern 1

- ◆ Parent (usually mom) is a “thinking type” while adolescent is very feelings oriented
- ◆ This mismatch in behavioral expectations and responses leads to the parent trying to help the adolescent by structuring:
 - “Just go to class and do your homework”.*
- ◆ The adolescent then feels criticized and responds with increased sadness or acting out
- ◆ In turn, the parent is dismissive of adolescents feelings as being irrelevant

Sample Reframe

“Mom and Steven have two very different styles for approaching the world – and this creates confusion and frustration. Mom – you try everything you know to help Steven be successful – giving him advice and strategies and encouragement. And it’s frustrating and overwhelming when he doesn’t respond. The reason this keeps happening is that Steven experiences the world very differently than you do. For him, it’s not about making a list and meeting deadlines. Steven responds to the world based on how he’s feeling inside, and when he doesn’t feel well, he can’t do the things you ask of him. And then he feels guilty because he knows he’s disappointing you – so it becomes a repeating cycle which leaves everyone upset and feeling hopeless. So, what we need to do is to help the two of you learn how to work with your very different styles so you can communicate and problem solve issues together in a successful way. These are specific skills that we will work on together that will help you feel like you’re back on the same team again.”

Approach to Behavior Change

Communication Training: Emphasize parent ability to prioritize understanding and reflecting adolescent's feelings before attempting to problem solve.

Negative Mood Management: All family members (as detailed in the behavior change section) will need extensive practice on this skill. Once skills are developed, structure parent support of adolescent to challenge irrational thinking.

Characteristics of Depressed Families

Pattern 2: Families with frequent crises and dramatic, emotional, over-reactive behaviors

- Families are much more open and talkative in sessions
 - FFT Therapist: *“It’s like they bring their stuff in to the room and dump it in a pile in the corner and you get to sift through it...like a gift”*
- Abundant opportunities to reframe and develop themes
- Cutting, suicidal ideation more common
- Drama can distract from meeting goals of various FFT phases

Common Relational Dynamic for Pattern 2

In these families, we often see a pattern of conflict between family members that quickly escalates. Once the escalation occurs, family members will engage in dramatic behaviors such as jumping out of a moving car, suicide attempts, dropping the adolescent off at a homeless shelter, etc. The family has trouble recovering from these crises and the crises have a negative impact on progress toward Behavior Change.

Sample Family Reframe: Containing Escalated Behaviors

A “safety net” metaphor: “The family is your safety net. These relationships are the most important ones you have. But over time you’ve developed these extreme habits or patterns of interacting where misunderstandings or miscommunications escalate into dangerous behaviors. Escalated behaviors can often be a sign that people feel overwhelmed by the pain and frustration of not feeling understood. But, this “conflict leading to escalated behavior” pattern makes it difficult for the family to provide the safety net you all need. Imagine someone jumping out of building with a group of fire fighters trying to hold up a net to break the fall. If you’re on the 2nd floor, the net is much more likely to hold than if you’re on the 10th floor. The escalating behaviors are kind of like jumping from the 10th floor. The family doesn’t have a way to provide a safety net in that situation. So, what we need to do is develop new skills and new ways of interacting so no one ever feels like they need to go to the 10th floor to feel heard. And the family is able to manage conflicts in a way that makes everyone feel like the families’ safety net is there for them.”

Approach to Behavior Change

- **Problem Solving:** Family needs to agree to take escalated behaviors “off the table.” Develop interim strategies for managing conflict while skill building.
- **Communication Training:** Heavy emphasis on reflective listening and assertive communication.
- **Managing negative moods:** Address connection between negative feeling states and impulsive behaviors. Identify alternative (i.e. de-escalated) responses to negative mood states.

Implementing FFT with Depressed Families

- Avoid getting lulled into matching family's flat affect
- Focus on self as role model for family to demonstrate how to be more positive
- Tend carefully to the Motivation Phase
 - families have few skill
 - temptation to shift to Behavior Change too soon
- Persistent efforts required during Behavior Change
 - they don't do homework
 - They don't remember what last session topics were
 - hard to get them engaged in more than superficial efforts
- Cycling back to Motivation Phase is common

Behavior Change

Rationale

“Negative moods and depression are common among drug users during the recovery process. These moods may be related to the depressant effects of drugs, to withdrawal, or to the losses experienced in one’s life (e.g., family, job, school failure, loss of freedom) as a result of drug use. These moods might get better without us working on them, but some people continue to experience problems with depression even after they have been clean for fairly long periods of time. We need to focus more directly on these negative moods because depression is a major reason for relapse and contributes to high-risk situations. It’s understandable that a person might return to drug use as a way to cope with depression, but this can become a vicious cycle that only serves to make you more depressed in the long run. Family relationships also influence depression and it is quite common for more than one person in a family to struggle with depression, so working on this problem together can serve to improve things in several areas in your lives. Coping with depression and negative moods involves changing the way one thinks and behaves. The best way to beat depression is consider each symptom as separate problem to be solved. The symptoms of depression are interrelated; improvement in one area leads to improvement in other areas.”

Overcoming Depression Using AAA

- **Awareness** – recognizing your self-defeating thoughts
- **Answering** – replacing self-defeating thoughts with more realistic ones
- **Action** - changing your behavior to match the new thoughts

Awareness: Noticing Feelings

- **Own your feelings:** Talking to others about how you feel or asking them how they feel in various situations can increase your awareness.
- **Be alert to your body:** For clues about your feelings, notice your posture, your facial expression, and how you are walking and moving.
- **Label your avoidance:** Notice the people, places, or activities that you once enjoyed but are now avoiding. Forget about the reasons why you are avoiding them, just notice when it happens.
- **Notice times when your confidence goes:** Are there times and places when you ask others for help? Were you able to handle this on your own before? This loss of confidence can be related to depression.
- **Look for activities that require great effort:** Do you have to force yourself to make or return a phone call? Do you have trouble completing tasks around the house?
- **Be aware of trouble concentrating or making decisions:** Do you go back and forth over simple decisions or second guess yourself? These can be related to depression.

Awareness: Catching Automatic Negative Thoughts

- ◆ **Our thoughts tell us what to do and how to feel**
- ◆ **Automatic negative thoughts become stronger and drown out sensible thoughts**
- ◆ **Automatic negative thoughts are called “thinking errors” because they are generally wrong**

Types of Thinking Errors

- **Personalizing:** Thinking all situations and events revolve around you. *"Everyone was looking at me and wondering why I was there."*
- **Magnifying:** Blowing negative events out of proportion. *"This is the worst thing that could happen to me."*
- **Minimizing:** Glossing over the saving and positive factors. Overlooking the fact that *"nothing really bad happened."*
- **Either/or thinking:** *"Either I'm a loser or a winner."* Not taking into account the full continuum.
- **Taking events out of context:** After a successful job interview, focusing on one or two tough questions. *"I blew the interview."*
- **Jumping to conclusions:** *"He is talking to that girl. This means he wants to break up with me."*
- **Over generalizing:** *"I always fail - I fail at everything I ever try."*
- **Self-blame:** *"I'm no good."* Blaming total self rather than specific behaviors that can be changed.
- **Magical thinking:** *"Everything is bad because of my bad past deeds."*
- **Comparing:** Comparing self with someone else and ignoring all of the basic differences. *"She has a better figure than mine, he must like her more."*
- **Catastrophizing:** Putting the worst possible construction on events. *"I know something terrible happened."*

Answering

- ◆ Once you begin catching negative thoughts, the next step is to answer them
- ◆ Any given event can have different interpretations - some are closer to reality than others
- ◆ Consider a wide range of possible interpretations beyond the negative ones
- ◆ Separate thoughts from facts - when you believe and act on distorted thoughts, you become more depressed
- ◆ Question the assumptions behind in the thoughts
- ◆ Define “fear” as: *"To lose what I have, something of value, or not to get what I want."*
- ◆ Define “boredom” as *"The Brain is hungry"* because, "The mind is like a monkey," it is always curious, and it seeks to play, to be creative, to do something.

10 Questions to Generate Answers to Negative Thoughts

- 1) *What's the evidence? Would this thought hold up in a court of law?*
"A late bus does not mean you can't count on anything"
- 2) *Am I making a mistake in assuming what causes what?*
- 3) *Am I confusing a thought with a fact?*
- 4) *Am I close enough to the situation to really know what's happening?*
"My teacher hates me? I can't know what she's really thinking"
- 5) *Am I thinking in all or none terms?*
- 6) *What do I want? Is thinking "Everything's bad" getting me what I want? Is it doing me any good?"*
- 7) *Am I confusing a low probability (rare occurrence) with a high probability? "When did they last flunk someone for missing 3 days?"*
- 8) *What are the distortions in my thinking?*
- 9) *What are the advantages and disadvantages of thinking this way?*
- 10) *What difference will this make in a week, a year, or 10 years?*

Action

- ◆ **Use Problem-Solving Skills to begin to address unsolved problems contributing to negative thoughts and feeling overwhelmed and helpless**
- ◆ **Change your activity level – increasing positive activities and decreasing negative ones changes brain chemistry, reduces fatigue, improves motivation and mental ability, and has a major impact on mood**

Problem Solving Skills Training

- 1) **Begin with a positive remark (sets tone)**
- 2) **Define the problem**
 - one single issue
 - brief, neutral, concrete, behaviorally specific terms
 - using “I” statements
 - active listening with each new speaker
- 3) **Brainstorm solutions (at least 20 per problem)**
- 4) **Eliminate unworkable solutions**
- 5) **Identify possible alternative – consensus, compromise**
- 6) **Implement solution (how, when, where, who)**
- 7) **Evaluate effectiveness of solution**
 - problem solved? Maintain...
 - modification needed? Go back to Steps 3-7 as needed...

Increasing Pleasant Activities

- ◆ Develop a schedule of activities that is flexible and allows for alternatives or contingencies if the activities you planned cannot be accomplished.
- ◆ Stick with the general plan. If for some reason you cannot do the activity you had planned, don't try to go back and make it up; just go on with the schedule.
- ◆ Schedule activities in one hour and half hour intervals. Do not plan activities that are too specific or too general.
- ◆ Plan for quantity, not quality. When you are depressed, anything worth doing is even worth doing poorly!
- ◆ Be task oriented. Remember that your primary goal is to follow the schedule you have established for yourself. The focus is becoming more active; lessening of depression will follow.
- ◆ After completing a planned day of activities, write down how you have done. Look at what you did right and where you can improve. Again, do not expect to follow the schedule perfectly.
- ◆ Create a menu of activities with the client, brainstorm options; select several based on interests (e.g., specific sports, clubs, organizations), and how to join in.

Decreasing Unpleasant Activities

- **Avoid the situation.** Engaging in the opposite action often solves the problem. Many unpleasant activities can simply be avoided.
- **Change the situation.** Do some “engineering” that modifies the situation to make it more manageable or less aversive.
- **Plan.** Good planning can prevent many unpleasant activities.
- **Say “no.”** Learn to say “no” to things that you do not want to do. This is probably the best way to ward off an unpleasant event.
- **Master the problem.** Move toward an unpleasant activity instead of avoiding it. Embrace the activity and see if you can master it.
- **Limit the activity.** If you just do not like some activity, “build a fence” around it by giving yourself a specific amount of time to work on it and no more.
- **Be careful of your thoughts.** If you’re bothered by thoughts of certain activities, separate the reality from what you imagine.

Managing Negative Moods and Depression Reminder Sheet

Use the Three A's to help overcome your depression:

1) Be AWARE of the symptoms of depression (and fear)

- Moods and the situations that influence them.
- Automatic negative thoughts

2) ANSWER these thoughts

- Ask questions, challenge the assumptions behind thoughts
- Replace the negative thoughts with positive ones

3) ACT differently

- Use problem-solving skills to deal with issues that worry you
- Increase your positive activities
- Decrease your involvement in unpleasant activities
- Reward yourself for the positive steps you are making

Automatic Thoughts: Daily Record

Date/ Time	Situation	Automatic Thoughts	Feeling(s)	Your Response	Results
	<p>What event led to the distressing feelings?</p>	<p>Record the thoughts or images that went through your mind</p> <ul style="list-style-type: none"> • Rate how strong you believed each thought (0-100%) • Which Thinking Errors apply? 	<p>What feelings did you have?</p> <ul style="list-style-type: none"> • How intense were they? (0-100%) 	<ul style="list-style-type: none"> • Respond to each thought using questions below • Rate how much you believe each response (0-100%) 	<ul style="list-style-type: none"> • Rate intensity of feeling(s) • Rate belief in thought(s) • Write a more balanced thought. Rate your belief in this thought (0-100%)

Respond to each of your Automatic Thoughts using the following questions.

- (1) What is the evidence your thought is true? Not true? (Two sides should total 100%)
- (2) Would others agree that your thought is true?
- (3) What are some alternative explanations for your thought?
- (4) What's the worst thing that could possibly happen? The best? Most realistic?
- (5) If a friend in this situation had this thought, how would you respond?
- (6) What are benefits of this thought? The costs? (Two sides should total 100%)