For Violence Prevention

BOOK THREE
Functional Family
Therapy

Blueprints for Violence Prevention

FUNCTIONAL FAMILY THERAPY

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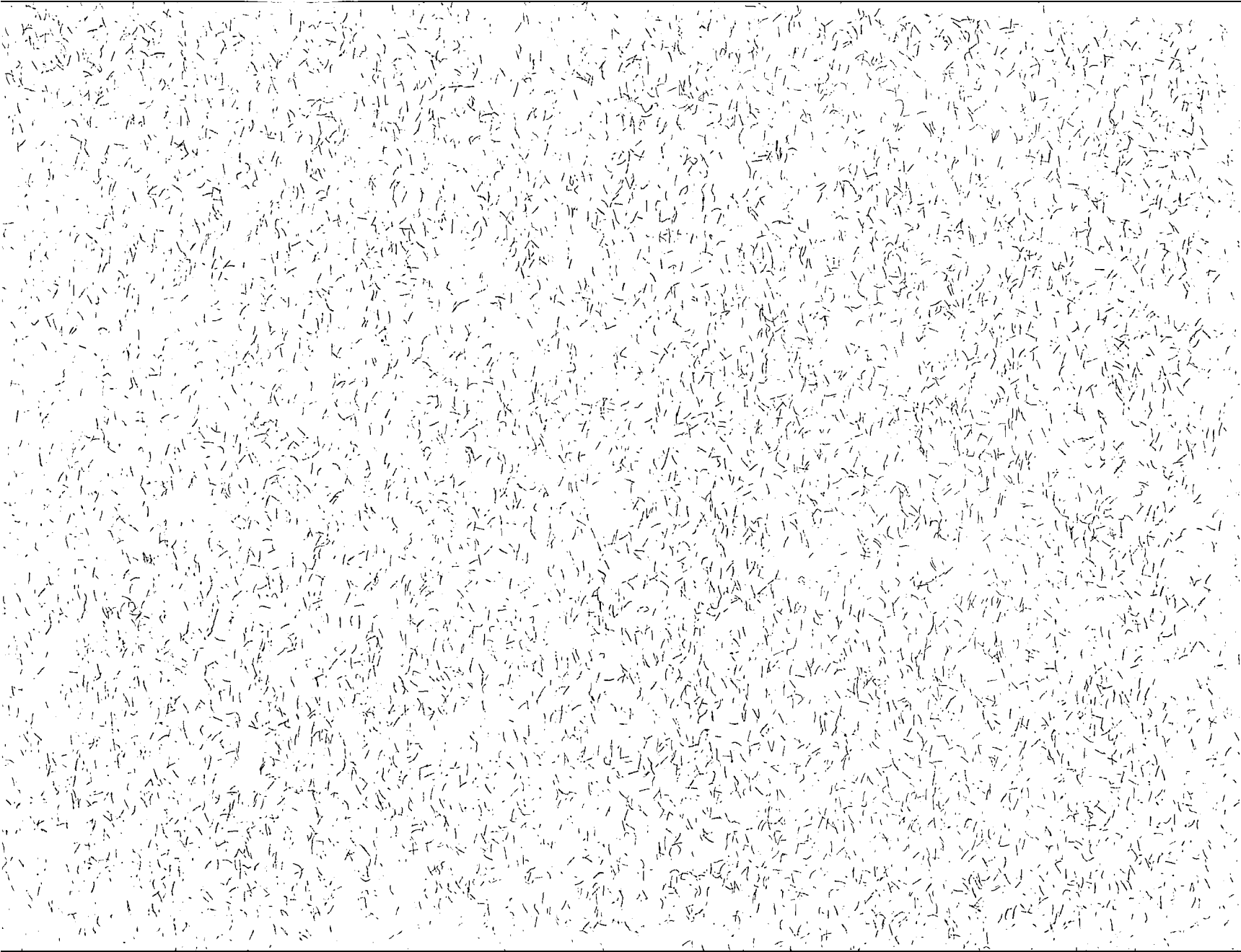

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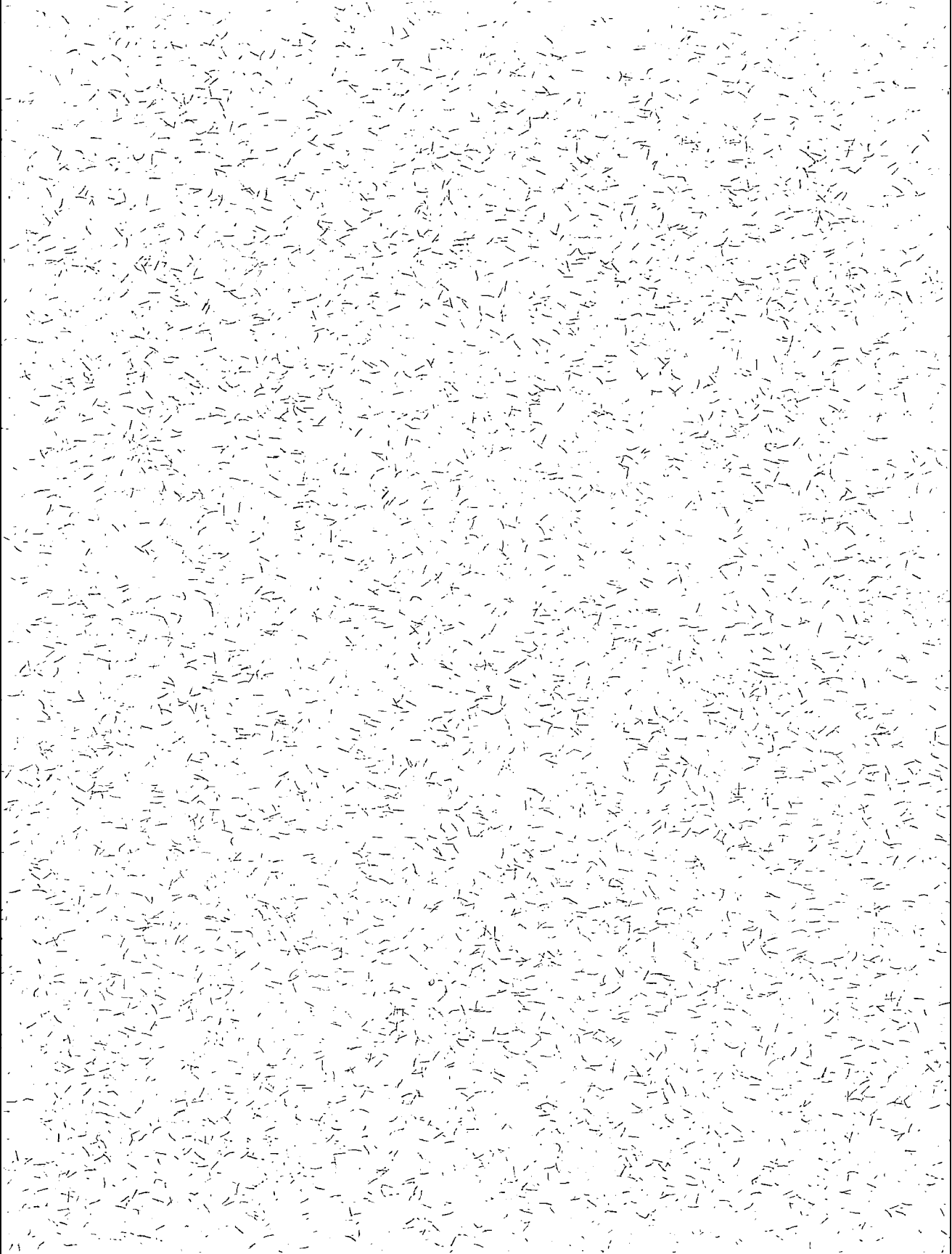

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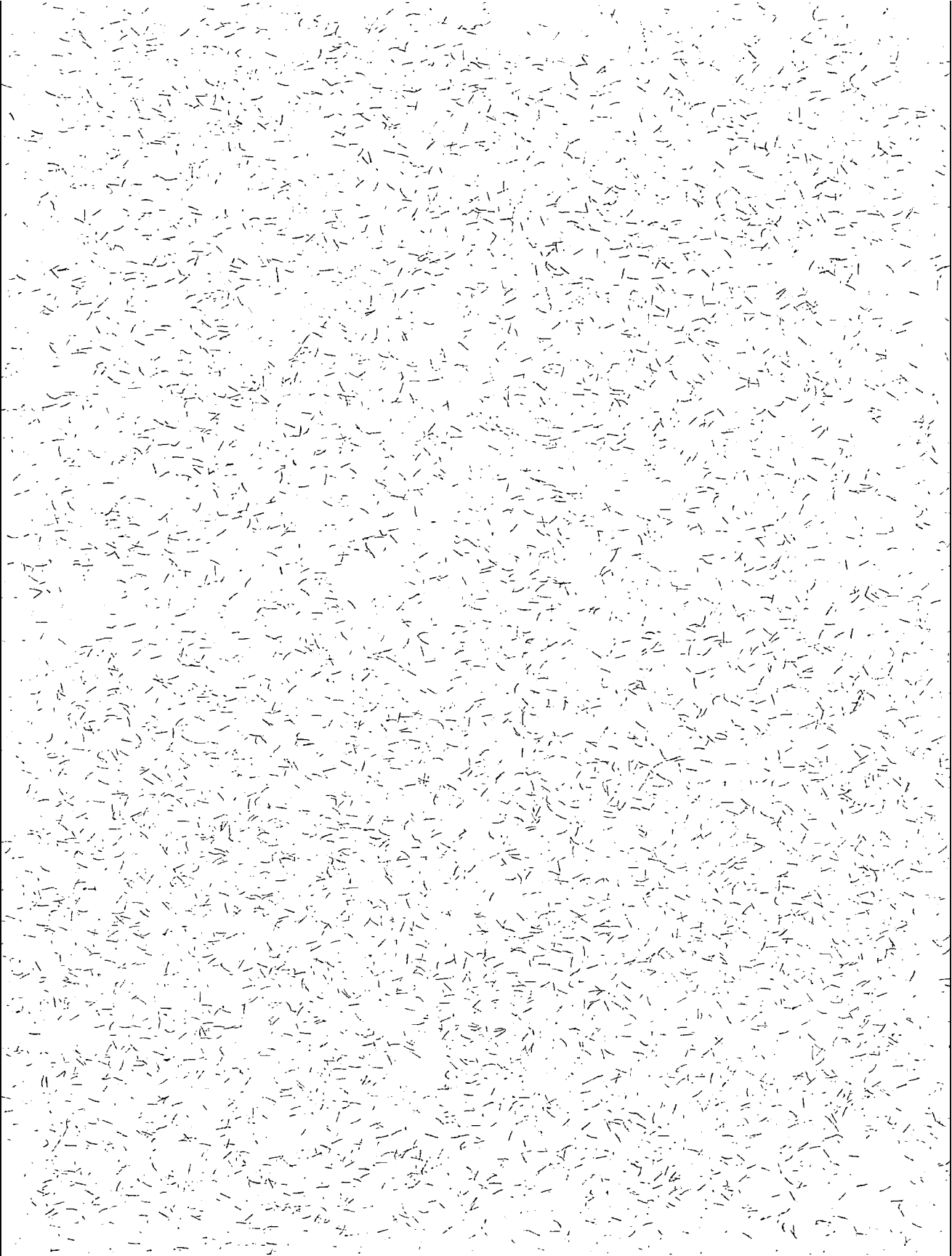


EDITOR'S INTRODUCTION

Introduction

The demand for effective violence and crime prevention programs has never been greater. As our communities struggle to deal with the violence epidemic of the 1990s in which we have seen the juvenile homicide rate double and arrests for serious violent crimes increase 50 percent between 1984 and 1994,[1] the search for some effective ways to prevent this carnage and self-destructiveness has become a top national priority. To date, most of the resources committed to the prevention and control of youth violence, at both the national and local levels, has been invested in untested programs based on questionable assumptions and delivered with little consistency or quality control. Further, the vast majority of these programs are not being evaluated. This means we will never know which (if any) of them have had some significant deterrent effect; we will learn nothing from our investment in these programs to improve our understanding of the causes of violence or to guide our future efforts to deter violence; and there will be no real accountability for the expenditures of scarce community resources. Worse yet, some of the most popular programs have actually been demonstrated in careful scientific studies to be *ineffective,* and yet we continue to invest huge sums of money in them for largely political reasons.

What accounts for this limited investment in the evaluation of our prevention programs? First, there is little political or even program support for evaluation. Federal and state violence prevention initiatives rarely allocate additional evaluation dollars for the programs they fund. Given that the investment in such programs is relatively low, it is argued that every dollar available should go to the delivery of program services, i.e., to helping youth avoid involvement in violent or criminal behavior. Further, the cost of conducting a careful outcome evaluation is prohibitive for most individual programs, exceeding their entire annual budget in many cases. Finally, many program developers believe they know *intuitively* that their programs work, and thus they do not think a rigorous evaluation is required to demonstrate this.

Unfortunately, this view and policy is very shortsighted. When rigorous evaluations have been conducted, they often reveal that such programs are ineffective and can even make matters worse.[2] Indeed, many programs fail to even address the underlying causes of violence, involve simplistic "silver bullet" assumptions (e.g., I once had a counselor tell me there wasn't a single delinquent youth he couldn't "turn around" with an hour of individual counseling), and allocate investments of time and resources that are far too small to counter the years of exposure to negative influences of the family, neighborhood, peer group, and the media. Violent behavior is a complex behavior pattern which involves both individual dispositions and social contexts in which violence is normative and rewarded. Most violence prevention programs focus only on the individual dispositions and fail to address the reinforcements for violence in the social contexts where youth live, with the result that positive changes in the individual's behavior achieved in the treatment setting are quickly lost when the youth returns home to his or her family, neighborhood, and old friends.

Progress in our ability to effectively prevent and control violence requires evaluation. A responsible accounting to the taxpayers, private foundations, or businesses funding these programs requires that we justify these expenditures with tangible results. No respectable business or corporation would invest millions of dollars in an enterprise without checking to see if it is profitable. No reputable

physician would subject a patient to a medical treatment for which there was no evidence of its effectiveness (i.e., no clinical trials to establish its potential positive and negative effects). Our failure to provide this type of evidence has seriously undermined the public confidence in crime prevention efforts generally, and is at least partly responsible for the current public support for building more prisons and incapacitating youth—the public knows they are receiving some protection for this expenditure, even if it is temporary.

The prospects for effective prevention programs and a national prevention initiative have improved greatly during the past decade. We now have a substantial body of research on the causes and correlates of crime and violence. There is general consensus within the research community about the specific individual dispositions, contextual (family, school, neighborhood, and peer group) conditions, and interaction dynamics which lead into and out of involvement in violent behavior. These characteristics, which have been linked to the onset, continuity, and termination of violence, are commonly referred to as "risk" and "protective" factors for violence. Risk factors are those personal attributes and contextual conditions which increase the likelihood of violence. Protective factors are those which reduce the likelihood of violence, either directly or by virtue of buffering the individual from the negative effects of risk factors.[3] Programs which can alter these conditions, reducing or eliminating risk factors and facilitating protective factors, offer the most promise as violence prevention programs.

While our evaluation of these programs is still quite limited, we have succeeded in demonstrating that some of these programs are effective in deterring crime and violence. This breakthrough in prevention programming has yet to be reflected in national or state funding decisions, and is admittedly but a beginning point for developing the comprehensive set of prevention programs necessary for developing a national prevention initiative. But we are no longer in the position of having to say that "nothing works."

Ten proven programs are described in this series of ***Blueprints for Violence Prevention***. These Blueprints (which will be described later in this Editor's Introduction) are designed to be practical documents which will allow interested persons, agencies, and communities to make an informed judgment about a proven program's appropriateness for their local situation, needs, and available resources. If adopted and implemented well, a community can be reasonably assured that these programs will reduce the risks of violence and crime for their children.

Background

The violence epidemic of the 1990s produced a dramatic shift in the public's perception of the seriousness of violence. In 1982, only three percent of adults identified crime and violence as the most important problem facing this country; by August of 1994, more than half thought crime and violence was the nation's most important problem. Throughout the '90s violence has been indicated as a more serious problem than the high cost of living, unemployment, poverty and homelessness, and health care. Again, in 1994, violence (together with a lack of discipline) was identified as the "biggest problem" facing the nation's public schools.[4] Among America's high school seniors, violence is the problem these young people worry about most frequently—more than drug abuse, economic problems, poverty, race relations, or nuclear war.[5]

The critical question is, *"How will we as a society deal with this violence problem?"* Government policies at all levels reflect a punitive, legalistic approach, an approach which does have broad

public support. At both the national and state levels, there have been four major policy and program initiatives introduced as violence prevention or control strategies in the 1990s: (1) the use of judicial waivers, transferring violent juvenile offenders as young as age ten into the adult justice system for trial, sentencing, and adult prison terms; (2) legislating new gun control policies (e.g., the Brady Handgun Violence Prevention Act, 1993); (3) the creation of "boot camps" or shock incarceration programs for young offenders, in order to instill discipline and respect for authority; and (4) community policing initiatives to create police-community partnerships aimed at more efficient community problem solving in dealing with crime, violence, and drug abuse.

Two of these initiatives are purely reactive: they involve ways of responding to violent acts after they occur; two are more preventive in nature, attempting to prevent the initial occurrence of violent behavior. The primary justification for judicial waivers and boot camps is a "just desserts" philosophy, wherein youthful offenders need to be punished more severely for serious violent offenses. But there is no research evidence to suggest either strategy has any increased deterrent effect over processing these juveniles in the juvenile justice system or in traditional correctional settings. In fact, although the evidence is limited, it suggests the use of waivers and adult prisons results in longer processing time and longer pretrial detention, racial bias in the decision about which youth to transfer into the adult system, a lower probability of treatment or remediation while in custody, and an increased risk of repeated offending when released.[6] The research evidence on the effectiveness of community policing and gun control legislation is very limited and inconclusive. We have yet to determine if these strategies are effective in preventing violent behavior.

There are some genuine prevention efforts sponsored by federal and state governments, by private foundations, and by private businesses. At the federal level, the major initiative involves the Safe and Drug-Free Schools and Communities Act (1994). This act provided $630 million in federal grants during 1995 to the states to implement violence (and drug) prevention programs in and around schools. State Departments of Education and local school districts are currently developing guidelines and searching for violence prevention programs demonstrated to be effective. But there is no readily available compendium of effective programs described in sufficient detail to allow for an informed judgment about their relevance and cost for a specific local application. Under pressure to do something, schools have implemented whatever programs were readily available. As a result, most of the violence prevention programs currently being employed in the schools, e.g., conflict resolution, peer mediation, individual counseling, metal detectors, and locker searches and sweeps have either not been evaluated or the evaluations have failed to establish any significant, sustained deterrent effects.[7]

Nationally, we are investing far more resources in building and maintaining prisons than in primary prevention programs.[8] We have put more emphasis on reacting to violent offenders after the fact and investing in prisons to remove these young people from our communities, than on preventing our children from becoming violent offenders in the first place and retaining them in our communities as responsible, productive citizens. Of course, if we have no effective prevention strategies or programs, there is no choice.

This is the central issue facing the nation in 1998: *Can we prevent the onset of serious violent behavior?* If we cannot, then we have no choice but to build, fill, and maintain more prisons. Yet if we know how to prevent the onset of violence, can we mount an efficient and effective prevention

initiative? There is, in fact, considerable public support for violence prevention programming for our children and adolescents.[9] *How can we develop, promote, and sustain a violence prevention initiative in this country?*

Violence Prevention Programs—What Works?

Fortunately, we are past the "nothing has been demonstrated to work" era of program evaluation.[10] During the past five years more than a dozen scholarly reviews of delinquency, drug, and violence prevention programs have been published, all of which claim to identify programs that have been successful in deterring crime and violence.[11]

However, a careful review of these reports suggests some caution and a danger of *overstating* this claim. First, very few of these recommended programs involve reductions in violent behavior as the outcome criteria. For the most part, reductions in delinquent behavior or drug use *in general* or arrests/revocations for *any offense* have been used as the outcome criteria. This is probably not a serious threat to the claim that we have identified effective violence prevention programs, as research has established that delinquent acts, violence, and substance use are interrelated, and involvement in any one is associated with involvement in the others. Further, they have a common set of causes, and serious forms of violence typically occur later in the developmental progression, suggesting that a program that is effective in reducing earlier forms of delinquency or drug use should be effective in deterring serious violent offending.[12] Still, some caution is required, given that very few studies have actually demonstrated a deterrent or marginal deterrent effect for serious violent behavior.

Second, the methodological standards vary greatly across these reviews. A few actually score each program evaluation reviewed on its methodological rigor,[13] but for most the standards are variable and seldom made explicit. If the judgment on effectiveness were restricted to individual program evaluations employing true experimental designs and demonstrating statistically significant deterrent (or marginal deterrent) effects, the number of recommended programs would be cut by two-thirds or more. An experimental (or good quasi-experimental) design and statistically significant results should be minimum criteria for recommending program effectiveness. Further, very few of the programs recommended have been replicated at multiple sites or demonstrated that their deterrent effect has been sustained for some period of time *after* leaving the program, two additional criteria that are important. In a word, the standard for the claims of program effectiveness in these reviews is very *low*. Building a national violence prevention initiative on this collective set of recommended programs would be risky.

Blueprints for Violence Prevention

In 1996, the Center for the Study and Prevention of Violence at the University of Colorado at Boulder, working with William Woodward, Director of the Colorado Division of Criminal Justice (CDCJ), who played the primary role in securing funding from the Colorado Division of Criminal Justice, the Centers for Disease Control and Prevention, and the Pennsylvania Commission on Crime and Delinquency, initiated a project to identify ten violence prevention programs that met a very high scientific standard of program effectiveness—*programs that could provide an initial nucleus for a national violence prevention initiative.* Our objective was to identify truly outstanding programs, and to describe these interventions in a series of "Blueprints." Each Blueprint describes the

theoretical rationale for the intervention, the core components of the program as implemented, the evaluation designs and findings, and the practical experiences the program staff encountered while implementing the program at multiple sites. The Blueprints are designed to be very practical descriptions of effective programs which allow states, communities, and individual agencies to: (1) determine the appropriateness of each intervention for their state, community, or agency; (2) provide a realistic cost estimate for each intervention; (3) provide an assessment of the organizational capacity required to ensure its successful start-up and operation over time; and (4) give some indication of the potential barriers and obstacles that might be encountered when attempting to implement each type of intervention. In 1997, additional funding was obtained from the Division of Criminal Justice, allowing for the development of the ten Blueprint programs.

Blueprint Program Selection Criteria

In consultation with a distinguished Advisory Board,[14] we established the following set of evaluation standards for the selection of Blueprint programs: (1) an experimental design, (2) evidence of a statistically significant deterrent (or marginal deterrent) effect, (3) replication at multiple sites with demonstrated effects, and (4) evidence that the deterrent effect was sustained for at least one year post-treatment. This set of selection criteria establishes a very high standard, one that proved difficult to meet. But it reflects the level of confidence necessary if we are going to recommend that communities replicate these programs with reasonable assurances that they will prevent violence. Given the high standards set for program selection, the burden for communities mounting an expensive outcome evaluation to demonstrate their effectiveness is removed; this claim can be made as long as the program is implemented well. Documenting that a program is implemented well is relatively inexpensive, but critical to the claim that a program is effective.

Each of the four evaluation standards is described in more detail as follows:

1. Strong Research Design

Experimental designs with random assignment provide the greatest level of confidence in evaluation findings, and this is the type of design required to fully meet this Blueprint standard. Two other design elements are also considered essential for the judgment that the evaluation employed a strong research design: low rates of participant attrition and adequate measurement. Attrition may be indicative of problems in program implementation; it can compromise the integrity of the randomization process and the claim of experimental-control group equivalence. Measurement issues include the reliability and validity of study measures, including the outcome measure, and the quality, consistency, and timing of their administration to program participants.

2. Evidence of Significant Deterrence Effects

This is an obvious minimal criterion for claiming program effectiveness. As noted, relatively few programs have demonstrated effectiveness in reducing the onset, prevalence, or individual offending rates of *violent behavior*. We have accepted evidence of deterrent effects for delinquency (including childhood aggression and conduct disorder), drug use, and/or violence as evidence of program effectiveness. We also accepted program evaluations using arrests as the outcome measure. Evidence for a deterrent effect on violent behavior is certainly preferable, and programs demonstrating this effect were given preference in selection, all other criteria being equal.

Both primary and secondary prevention effects, i.e., reductions in the *onset* of violence, delinquency, or drug use compared to control groups and pre-post reductions in these *offending rates,* could meet this criterion. Demonstrated changes in the targeted risk and protective factors, in the absence of any evidence of changes in delinquency, drug use, or violence, was not considered adequate to meet this criterion.

3. Multiple Site Replication

Replication is an important element in establishing program effectiveness. It establishes the robustness of the program and its prevention effects; its exportability to new sites. This criterion is particularly relevant for selecting Blueprint programs for a national prevention initiative where it is no longer possible for a single program designer to maintain personal control over the implementation of his or her program. Adequate procedures for monitoring the quality of implementation must be in place, and this can be established only through actual experience with replications.

4. Sustained Effects

Many programs have demonstrated initial success in deterring delinquency, drug use, and violence during the course of treatment or over the period during which the intervention was being delivered and reinforcements controlled. This selection criterion requires that these short-term effects be sustained beyond treatment or participation in the designed intervention. For example, if a preschool program designed to offset the negative effects of poverty on school performance (which in turn effects school bonding, present and future opportunities, and later peer group choice/selection, which in turn predicts delinquency) demonstrates its effectiveness when children start school, but these effects are quickly lost during the first two to three years of school, there is little reason to expect this program will prevent the onset of violence during the junior or senior high school years when the risk of onset is at its peak. Unfortunately, there is clear evidence that the deterrent effects of most prevention programs deteriorate quickly once youth leave the program and return to their original neighborhoods, families, and peer groups or gangs.

Other Criteria

In the selection of model programs, we considered several additional factors. We looked for evidence that change in the targeted risk or protective factor(s) mediated the change in violent behavior. This evidence clearly strengthens the claim that participation in the program was responsible for the change in violent behavior, and it contributes to our theoretical understanding of the causal processes involved. We were surprised to discover that many programs reporting significant deterrent effects (main effects) had not collected the necessary data to do this analysis or, if they had the necessary data, had not reported on this analysis.

We also looked for cost data for each program as this is a critical element in any decision to replicate one of these Blueprint programs, and we wanted to include this information in each Blueprint. Evaluation reports, particularly those found in the professional journals, rarely report program costs. Even when asked to provide this information, many programs are unable (or unwilling) to provide the data. In many cases program costs are difficult to separate from research and evaluation costs. Further, when these data are available, they typically involve conditions or circumstances unique to a particular site and are difficult to generalize. There are no standardized cost criteria, and it is very

difficult to compare costs across programs. It is even more difficult to obtain reliable cost-benefit estimates. A few programs did report both program costs and cost-benefit estimates. There have been two recent cost-benefit studies involving Blueprint programs which suggest that these programs are cost-effective, but this information is simply not available for most programs.[15]

Finally, we considered each program's willingness to work with the Center in developing a Blueprint for national dissemination and the program's organizational capacity to provide technical assistance and monitoring of program implementation on the scale that would be required if the program was selected as a Blueprint program and became part of a national violence prevention initiative.

Programs must be willing to work with the Center in the development of the Blueprint. This involves a rigorous review of program evaluations with questions about details not covered in the available publications; the preparation of a draft Blueprint document following a standardized outline; attending a conference with program staff, staff from replication sites, and Center staff to review the draft document; and making revisions to the document as requested by Center staff. Each Blueprint is further reviewed at a second conference in which potential users—community development groups, prevention program staffs, agency heads, legislators, and private foundations—"field test" the document. They read each Blueprint document carefully and report on any difficulties in understanding what the program requires, and on what additional information they would like to have if they were making a decision to replicate the program. Based on this second conference, final revisions are made to the Blueprint document and it is sent back to the Program designer for final approval.

In addition, the Center will be offering technical assistance to sites interested in replicating a Blueprint program and will be monitoring the quality of program implementation at these sites (see the "Technical Assistance and Monitoring of Blueprint Replications" section below). This requires that each selected program work with the Center in screening potential replication sites, certifying persons qualified to deliver technical assistance for their program, delivering high quality technical assistance, and cooperating with the Center's monitoring and evaluation of the technical assistance delivered and the quality of implementation achieved at each replication site. Some programs are already organized and equipped to do this, with formal written guidelines for implementation, training manuals, instruments for monitoring implementation quality, and a staff trained to provide technical assistance; others have few or none of these resources or capabilities. Participation in the Blueprint project clearly involves a substantial demand on the programs. All ten programs selected have agreed to participate as a Blueprint program.

Blueprint Programs: An Overview

We began our search for Blueprint programs by examining the set of programs recommended in scholarly reviews. We have since expanded our search to a much broader set of programs and continue to look for programs that meet the selection standards set forth previously. To date, we have reviewed more than 450 delinquency, drug, and violence prevention programs. As noted, ten programs have been selected thus far, based upon a review and recommendation of the Advisory Board. These programs are identified in Table A.

The standard we have set for program selection is very high. Not all of the ten programs selected meet all of the four individual standards, but as a group they come the closest to meeting these standards that we could find. As indicated in Table A, with one exception they have all demonstrated

Table A. Blueprint Programs

PROJECT	TARGET POPULATION	EVID. OF EFFECT*	MULTI-SITE	COST/ BENEFIT	SUSTAINED EFFECT	GENERA-LIZABLE	TYPE OF PROGRAM
Nurse Home Visitation (Dr. David Olds)	Pregnant women at risk of preterm delivery and low birthweight	X	X	X	through age 15	X	Prenatal and postpartum nurse home visitation
Bullying Prevention Program (Dr. Dan Olweus)	Primary and secondary school children (universal intervention)	X	England, Canada; South Carolina		2 years post-treatment	Generality to U.S. unk.; initial S.C. results positive	School-based program to reduce victim/bully problems
Promoting Alternative Thinking Strategies (Dr. M. Greenberg and Dr. C. Kusche)	Primary school children (universal intervention)	X	X		2 years post-treatment	X	School-based program to promote emotional competence
Big Brothers Big Sisters of America (Ms. Dagmar McGill)	Youth 6 to 18 years of age from single-parent homes	X	Multisite single design, 8 sites			X	Mentoring program
Quantum Opportunities (Mr. Ben Lattimore)	At-risk, disadvantaged, high school youth	X	Multisite single design, 5 sites; replic. by D.O.L.	X	through age 20		Educational incentives
Multisystemic Therapy (Dr. Scott Henggeler)	Serious, violent, or substance abusing juvenile offenders and their families	X	X	X	4 years post-treatment	X	Family ecological systems approach
Functional Family Therapy (Dr. Jim Alexander)	Youth at risk for institutionalization	X	X	X	30 months posttreatment	X	Behavioral systems family therapy
Midwestern Prevention Project (Dr. Mary Ann Pentz)	Middle/junior school (6th/7th grade)	X	X		Through high school	X	Drug use prevention (social resistance skills); with parent, media, and community components
Life Skills Training (Dr. Gilbert Botvin)	Middle/junior school (6th/7th grade)	X	X		Through high school	X	Drug use prevention (social skills and general life skills training)
Multidimensional Treatment Foster Care (Dr. Paricia Chamberlain)	Serious and chronic delinquents	X	X	X	1 year post-treatment		Foster care with treatment

significant deterrent effects with experimental designs using random assignment to experimental and control groups (the Bullying Prevention Program involved a quasi-experimental design). All involve multiple sites and thus have information on replications and implementation quality, but not all replication sites have been evaluated as independent sites (e.g., the Big Brothers Big Sisters mentoring program was implemented at eight sites, but the evaluation was a single evaluation involving all eight sites in a single aggregated analysis). Again, with one exception (Big Brothers Big Sisters), all the selected programs have demonstrated sustained effects for at least one year post-treatment.

The first two Blueprints were published and disseminated in the fall of 1997: the Big Brothers Big Sisters Program and the Midwestern Prevention Project. The other eight Blueprints will be published during 1998—four in the spring, two in the summer, and the final two in the fall.

Technical Assistance and Monitoring of Blueprint Replications[16]

The Blueprint project includes plans for a technical assistance and monitoring component to assist interested communities, agencies, and organizations in their efforts to implement one or more of the Blueprint programs. *Communities should not attempt to replicate a Blueprint program without technical assistance from the program designers.* If funded, technical assistance for replication and program monitoring will be available through the Center for the Study and Prevention of Violence at a very modest cost. Technical assistance can also be obtained directly from the Blueprint programs with costs for consulting fees, travel, and manuals negotiated directly with each program.

There are three common problems encountered by communities when attempting to develop and implement violence prevention interventions. First, there is a need to identify the specific risk and protective factors to be addressed by the intervention and the most appropriate points of intervention to address these conditions. In some instances, communities have already completed a risk assessment and know their communities' major risk factors and in which context to best initiate an intervention. In other cases this has not been done and the community may require some assistance in completing this task. We anticipate working with communities and agencies to help them evaluate their needs and resources in order to select an appropriate Blueprint program to implement. This may involve some initial on-site work assisting the community in completing some type of risk assessment as a preparatory step to selecting a specific Blueprint program for implementation.

Second, assuming the community has identified the risk and protective factors they want to address, a critical problem is in locating prevention interventions which are *appropriate* to address these risk factors and making an informed decision about which one(s) to implement. Communities often become lost in the maze of programs claiming they are effective in changing identified risk factors and deterring violence. More often, they are faced with particular interest groups pushing their own programs or an individual on their advisory board recommending a pet project, with no factual information or evidence available to provide some rational comparison of available options. Communities often need assistance in making an informed selection of programs to implement.

Third, there are increasingly strong pressures from funders, whether the U.S. Congress, state legislatures, federal or state agencies, or private foundations and businesses, for accountability. The current trend is toward requiring *all* programs to be monitored and evaluated. This places a tremendous burden on most programs which do not have the financial resources or expertise to conduct a

meaningful evaluation. A rigorous outcome evaluation typically would cost more than the annual operating budget of most prevention programs; the cumulative evaluations of our Blueprint programs, for example, average more than a million dollars each. The selection of a Blueprint program eliminates the need for an outcome evaluation, at least for an initial four or five years.[17] Because these programs have already been rigorously evaluated, the critical issue for a Blueprint program is the *quality of the implementation*; if the program is implemented well, we can assume it is effective. To ensure a quality implementation, technical assistance and monitoring of the implementation (a process evaluation) are essential.

Limitations

Blueprint programs are presented as complete programs as it is the *program* that has been evaluated and demonstrated to work. Ideally, we would like to be able to present specific intervention components, e.g., academic tutoring, mentoring of at-risk youth, conflict resolution training, work experience, parent effectiveness training, etc., as proven intervention strategies based upon evaluations of many different programs using these components. We do not yet have the research evidence to support a claim that specific components are effective for specific populations under some specific set of conditions. Most of the Blueprint programs (and prevention programs generally) involve multiple components, and their evaluations do not establish the independent effects of each separate component, but only the combination of components as a single "package." It is the "package" which has been demonstrated to work for specific populations under given conditions. The claim that one is using an intervention that has been demonstrated to work applies only if the entire Blueprint program, as designed, implemented, and evaluated, is being replicated; this claim is not warranted if only some specific subcomponent is being implemented or if a similar intervention strategy is being used, but with different staff training, or different populations of at-risk youth, or some different combination of components. It is for this reason that we recommend that communities desiring to replicate one of the Blueprint programs contact this program or the Center for the Study and Prevention of Violence for technical assistance.

Our knowledge about these programs and the specific conditions under which they are effective will certainly change over time. Already there are extensions and modifications to these programs which are being implemented and carefully evaluated. Over the next three to five years it may be necessary to revise our Blueprint of a selected program. Those modifications currently underway typically involve new at-risk populations, changes in the delivery systems, changes in staff selection criteria and training, and in the quantity or intensity of the intervention delivered. Many of these changes are designed to reduce costs and increase the inclusiveness and generality of the program. It is possible that additional evaluations may undermine the claim that a particular Blueprint program is effective, however it is far more likely they will improve our understanding of the range of conditions and circumstances under which these programs are effective. In any event, we will continue to monitor the evaluations of these programs and make necessary revisions to their Blueprints. Most of these evaluations are funded at the federal level and they will provide ongoing evidence of the effectiveness of Blueprint programs, supporting (or not) the continued use of these programs without the need for local outcome evaluations.

The cost-benefit data presented in the Blueprints are those estimated by the respective programs. We have not undertaken an independent validation of these estimates and are not certifying their

accuracy. Because they involve different comparison groups, different cost assumptions, and considerable local variation in costs for specific services, it is difficult to compare this aspect of one Blueprint program with another. Potential users should evaluate these claims carefully. We believe these cost-benefit estimates are useful, but they are not the most important consideration in selecting a violence prevention program or intervention.

It is important to note that the *size* of the deterrent effects of these Blueprint programs is modest. There are no "silver bullets," no programs that prevent the onset of violence for all youth participating in the intervention. Good prevention programs reduce the rates of violence by 30-40 percent.[18] We have included a section in each Blueprint presenting the evaluation results so that potential users can have some idea of how strong the program effect is likely to be and can prepare their communities for a realistic set of expectations. It is important that we not oversell violence prevention programs; it is also the case that programs with a 30 percent reduction in violence can have a fairly dramatic effect if sustained over a long period of time.

Finally, we are not recommending that communities invest all of their available resources in Blueprint programs. We need to develop and evaluate new programs to expand our knowledge of what works and to build an extensive repertoire of programs that work if we are ever to mount a comprehensive prevention initiative in this country. At the same time, given the costs of evaluating programs, it makes sense for communities to build their portfolio of programs around interventions that have been demonstrated to work, and to limit their investment in new programs to those they can evaluate carefully. Our Blueprint series is designed to help communities adopt this strategy.

Summary

As we approach the 21st Century, the nation is at a critical crossroad: Will we continue to react to youth violence after the fact, becoming increasingly punitive and locking more and more of our children in adult prisons? Or will we bring a more healthy balance to our justice system by designing and implementing an effective violence prevention initiative as a part of our overall approach to the violence problem? We do have a choice.

To mount an effective national violence prevention initiative in this country, we need to find and/or create effective violence prevention programs and implement them with integrity so that significant reductions in violent offending can be realized. We have identified a core set of programs that meet very high scientific standards for being effective prevention programs. These programs could constitute a core set of programs in a national violence prevention initiative. What remains is to ensure that communities know about these programs and, should they desire to replicate them, have assistance in implementing them as designed. That is our objective in presenting this series of *Blueprints for Violence Prevention*. They constitute a complete package of both programs and technical assistance made available to states, communities, schools, and local agencies attempting to address the problems of violence, crime, and substance abuse in their communities.

Delbert S. Elliot
Series Editor

ENDNOTES

1. Cook and Laub, 1997; Fox, 1996; and Snyder and Sickmund, 1995 for an analysis of trends in juvenile arrests for violent crimes.

2. Lipsey, 1992, 1997; Sherman et al., 1997; and Tolan and Guerra, 1994.

3. The technical definition of a protective factor is an attribute or condition that buffers one from the expected effect of one or more risk factors, but many use the term more generally to refer to anything that reduces the likelihood of violence, whether that effect is direct or indirect.

4. Maguire and Pastore, 1996.

5. Johnston et al., 1996.

6. Fagan, 1996; Frazier, Bishop and Lanza-Kaduce, 1997; Lipsey, 1997; MacKenzie et al., 1992; Podkopaz and Feld, 1996; and Shaw and McKenzie, 1992.

7. Gottfredson, 1997; Lipsey, 1992; Sherman et al., 1997; Tolan and Guerra, 1994; and Webster, 1993.

8. Gottfredson, 1997.

9. Gallop, 1994.

10. Lipton, Martinson, and Wilks, 1975; Martinson, 1974; Sechrest et al., 1979; and Wright and Dixon, 1977.

11. Davis and Tolan, 1993; Dusenbury and Falco, 1995; Farrington, 1994; Greenwood et al., 1996; Hawkins, Catalano and Miller, 1992; Howell, 1995; Howell et al., 1995; Krisberg and Onek, 1994; Lipsey and Wilson, 1997; Loeber and Farrington, 1997; McGuire, 1995; National Research Council, 1993; Office of Juvenile Justice and Delinquency Prevention, 1995; Powell and Hawkins, 1996; Sherman et al., 1997; and Tolan and Guerra, 1994.

12. Elliott, 1993, 1994; Jessor and Jessor, 1977; Kandel et al., 1986; Osgood et al., 1988; and White et al., 1985.

13. Gottfredson, 1997; Lipsey, 1992; Osgood et al., 1988; and Sherman et al., 1997.

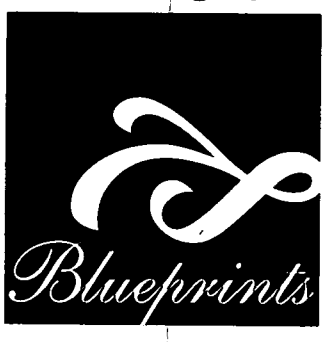
14. Advisory Board members included: Denise Gottfredson, University of Maryland; Mark Lipsey, Vanderbilt University; Hope Hill, Howard University; Peter Greenwood, the Rand Corporation; and Patrick Tolan, University of Illinois.

15. Greenwood, Model, Rydell, and Chiesa, 1996; Washington State Institute for Public Policy, 1998.

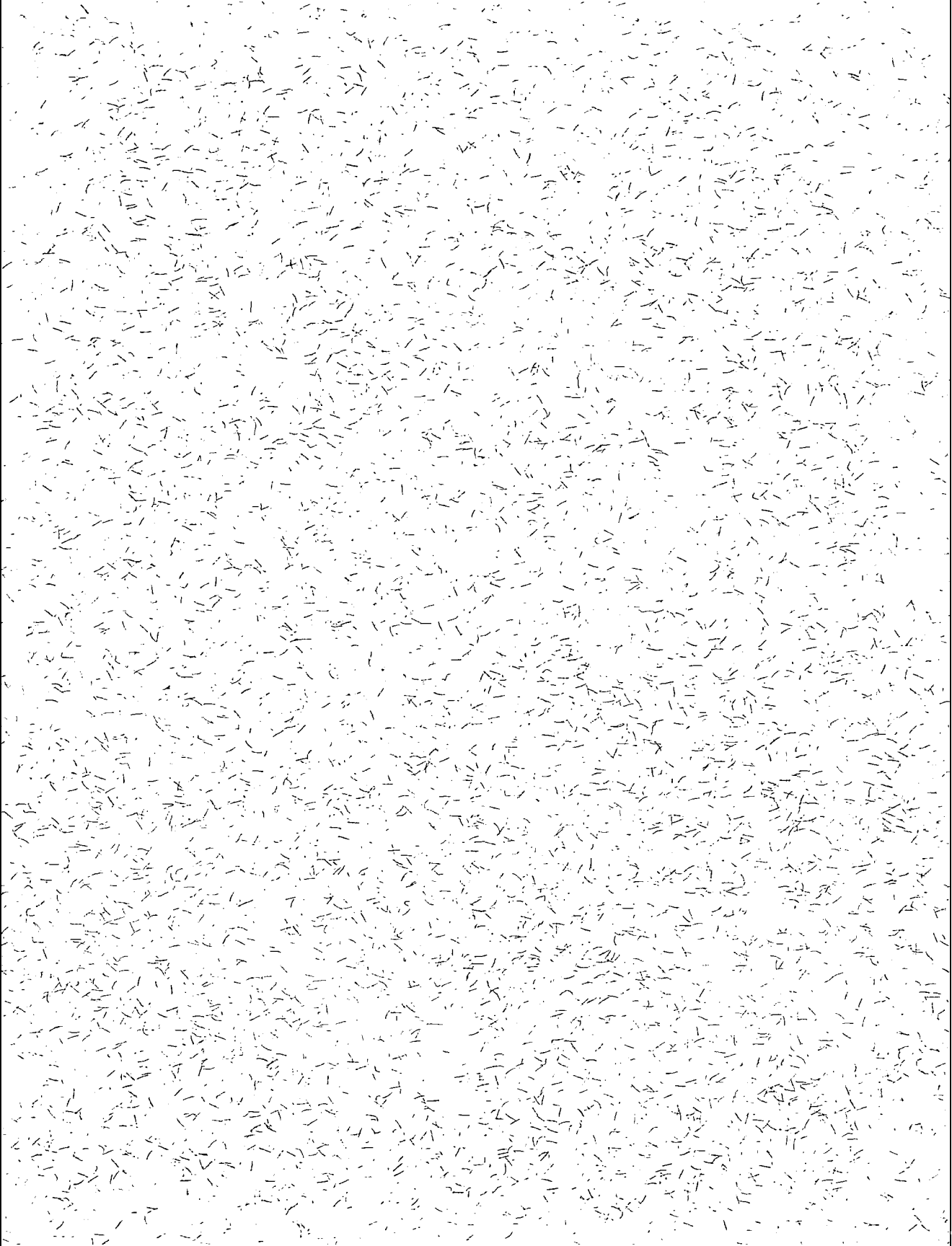
16. The Center has submitted a proposal to the Office of Juvenile Justice and Delinquency Prevention that would provide technical assistance and evaluation of program implementation for 50 replications of Blueprint programs.

17. At some point it will be necessary to reassess each Blueprint program to ensure that it continues to demonstrate deterrent effects and to test its generalizability to other populations and community conditions. In many cases, this will be done at the national level with federal support for large scale evaluations. For example, the U.S. Department of Labor and the Ford Foundation are currently funding seven Quantum Opportunity Programs with outcome evaluations; and the Office of Juvenile Justice and Delinquency Prevention is funding several Big Brothers Big Sisters Programs with evaluations. Local agencies replicating these Blueprint programs may never have to conduct rigorous outcome evaluations, but some continuing outcome evaluations at some level (national or local) is essential.

18. See Lipsey, 1992, 1997, for a review of issues and problems in estimating effect sizes and the range of effect sizes observed for delinquency prevention programs.



Model Program Descriptions



MODEL PROGRAM DESCRIPTIONS

Prenatal and Infancy Home Visitation by Nurses

Nurse home visitation is a program that sends nurses to the homes of pregnant women who are predisposed to infant health and developmental problems (i.e., at risk of preterm delivery and low-birth weight children). The goal of the program is to improve parent and child outcomes. Home visiting promotes the physical, cognitive, and social-emotional development of the children, and provides general support as well as instructive parenting skills to the parents. Treatment begins during pregnancy, with an average of eight visits for about 1 hour and 15 minutes, and continues to 24 months postpartum with visits diminishing in frequency to approximately every six weeks. Screenings and transportation to local clinics and offices are also offered as a part of treatment. Nurse home visiting has had some positive outcomes on obstetrical health, psychosocial functioning, and other health-related behaviors (especially reductions in smoking). Child abuse and neglect was lower and the developmental quotients of children at 12 and 24 months were higher in the treatment group than in the control group for poor, unmarried teens. Follow-up at 15-years postpartum showed significant enduring effects on child abuse and neglect, completed family size, welfare dependence, behavior problems due to substance abuse, and criminal behavior on the part of low income, unmarried mothers. Positive program effects through the child's second birthday have been replicated in a major urban area.

Bullying Prevention Program

The anti-bullying program has as its major goal the reduction of victim/bully problems among primary and secondary school children. It aims to increase awareness of the problem and knowledge about it, to achieve active involvement on the part of teachers and parents, to develop clear rules against bullying behavior, and to provide support and protection for the victims of bullying. Intervention occurs at the school level, class level, and individual level. In Bergen, Norway, the frequency of bully/victim problems decreased by 50 percent or more in the two years following the campaign. These results applied to both boys and girls and to students across all grades studied. In addition, school climate improved, and antisocial behavior in general such as theft, vandalism, and truancy showed a drop during these years.

Promoting Alternative Thinking Strategies

Promoting Alternative Thinking Strategies (PATHS) is a school-based intervention designed to promote emotional competence, including the expression, understanding, and regulation of emotions. The PATHS program is a universal intervention, implemented by teachers (after a three-day training workshop) with entire classrooms of children from kindergarten through fifth grades. The curriculum includes a feelings unit (with a self-control and initial problem-solving skills program within that unit) and an interpersonal cognitive problem solving unit. The generalization of those learned skills to children's everyday lives is a component of each major unit. An additional unit on self-control and readiness is provided for special needs classrooms. Studies have compared classrooms receiving the intervention to matched controls using populations of normally-adjusted students, behaviorally at-risk students, and deaf students. Program effects included teacher-, child sociometric-, and child self-report ratings of behavior change on such constructs as hyperactivity, peer aggression, and conduct problems.

Big Brothers Big Sisters of America

Big Brothers Big Sisters of America (BBBSA) is the oldest and best known mentoring program in the United States. Local programs are autonomously funded affiliates of BBBSA, with the national office in Philadelphia. The more than 500 affiliates maintain over 100,000 one-to-one relationships between a volunteer adult and a youth. Matches are carefully made using established procedures and criteria. The program serves children 6 to 18 years of age, with the largest portion being those 10 to 14 years of age. A significant number of the children are from disadvantaged single-parent households. A mentor meets with his/her youth partner at least three times a month for three to five hours. The visits encourage the development of a caring relationship between the matched pair. An 18 month study of eight BBBS affiliates found that the youth in the mentoring program, compared to a control group who were on a waiting list for a match, were less likely to start using drugs and alcohol, less likely to hit someone, had improved school attendance, attitudes and performance, and had improved peer and family relationships.

Quantum Opportunities

The Quantum Opportunities Program (QOP) provides education, development, and service activities, coupled with a sustained relationship with a peer group and a caring adult, over the four years of high school for small groups of disadvantaged teens. The goal of the program is to help high risk youth from poor families and neighborhoods to graduate from high school and attend college. The program includes (1) 250 hours per year of self-paced and competency-based basic skills, taught outside of regular school hours; (2) 250 hours per year of development opportunities, including cultural enrichment and personal development; and (3) 250 hours per year of service opportunities to their communities to help develop the prerequisite work skills. Financial incentives are offered to increase participation, completion, and long range planning. Results from the pilot test of this program indicated that QOP participants, compared to the control group, were less likely to be arrested during the juvenile years, were more likely to have graduated from high school, to be enrolled in higher education or training, planning to complete four years of college, and less likely to become a teen parent.

Multisystemic Therapy

Multisystemic Therapy (MST) views individuals as being nested within a complex of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Behavior problems can be maintained by problematic transactions within or between any one or a combination of these systems. MST targets the specific factors in each youth's and family's ecology (family, peer, school, neighborhood, support network) that are contributing to antisocial behavior. MST interventions are pragmatic, goal oriented, and emphasize the development of family strengths. The overriding purpose of MST is to help parents to deal effectively with their youth's behavior problems, including disengagement from deviant peers and poor school performance. To accomplish the goal of family empowerment, MST also addresses identified barriers to effective parenting (e.g., parental drug abuse, parental mental health problems) and helps family members to build an indigenous social support network (e.g., with friends, extended family, neighborhoods, church members). To increase family collaboration and treatment generalization, MST is typically provided in the home, school, and other community locations by master's level counselors with low caseloads and 24 hours/day, seven days/week availability. The average duration of treatment is

about four months, which includes approximately 50 hours of face-to-face therapist-family contact. MST has been demonstrated as an effective treatment for decreasing the antisocial behavior of violent and chronic juvenile offenders at a cost savings—that is, reducing long-term rates of rearrest and out-of-home placement. Moreover, families receiving MST have shown extensive improvements in family functioning.

Functional Family Therapy

Functional Family Therapy (FFT) is a short term, easily trainable, well documented program which has been applied successfully to a wide range of problem youth and their families in various contexts (e.g., rural, urban, multicultural, international) and treatment systems (e.g., clinics, home-based programs, juvenile courts, independent providers, federally funded clinical trials). Success has been demonstrated and replicated for over 25 years with a wide range of interventionists, including paraprofessionals and trainees representing the various professional degrees (e.g., B.S.W., M.S.W., Ph.D., M.D., R.N., M.F.T.). The program involves specific phases and techniques designed to engage and motivate youth and families, and especially deal with the intense negative affect (hopelessness, anger) that prevents change. Additional phases and techniques then change youth and family communication, interaction, and problem solving, then help families better deal with and utilize outside system resources. Controlled comparison studies with follow-up periods of one, three, and even five years have demonstrated significant and long-term reductions in youth re-offending and sibling entry into high-risk behaviors. Comparative cost figures demonstrate very large reductions in daily program costs compared to other treatment programs.

Midwestern Prevention Project

The Midwestern Prevention Project is a comprehensive population-based drug abuse (cigarettes, alcohol, and marijuana) prevention program that has operated in two major Midwestern SMSAs, Kansas City and Indianapolis, where it has been known locally as Project STAR (Students Taught Awareness and Resistance) and I-STAR, respectively. The goal of the program is to decrease the rates of onset and prevalence of drug use in young adolescents (ages 10-15), and to decrease drug use among parents and other residents of the two communities. The program consists of five intervention strategies designed to combat the community influences on drug use: mass media, school, parent, community organization, and health policy change. The components focus on promoting drug use resistance and counteraction skills by adolescents (direct skills training), prevention practices and support of adolescent prevention practices by parents and other adults (indirect skills training), and dissemination and support of non-drug use social norms and expectations in the community (environmental support). This program has been effective at reducing alcohol, cigarette, and marijuana use among young adolescents, with some effects maintained up to age 23.

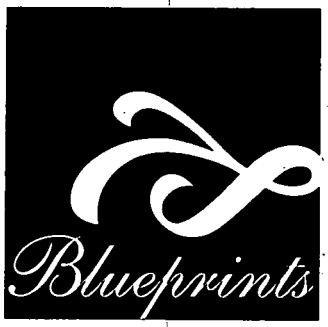
Life Skills Training

Life Skills Training is a drug use primary prevention program (cigarettes, alcohol, and marijuana), which provides general life skills training and social resistance skills training to junior high/middle (6th or 7th grade) school students. The curriculum includes 15 sessions taught in school by regular classroom teachers with booster sessions provided in year two (10 class sessions) and year three (five class sessions). The three basic components of the program include: (1) Personal Self-Management Skills (e.g., decision-making and problem-solving, self-control skills for coping with anxi-

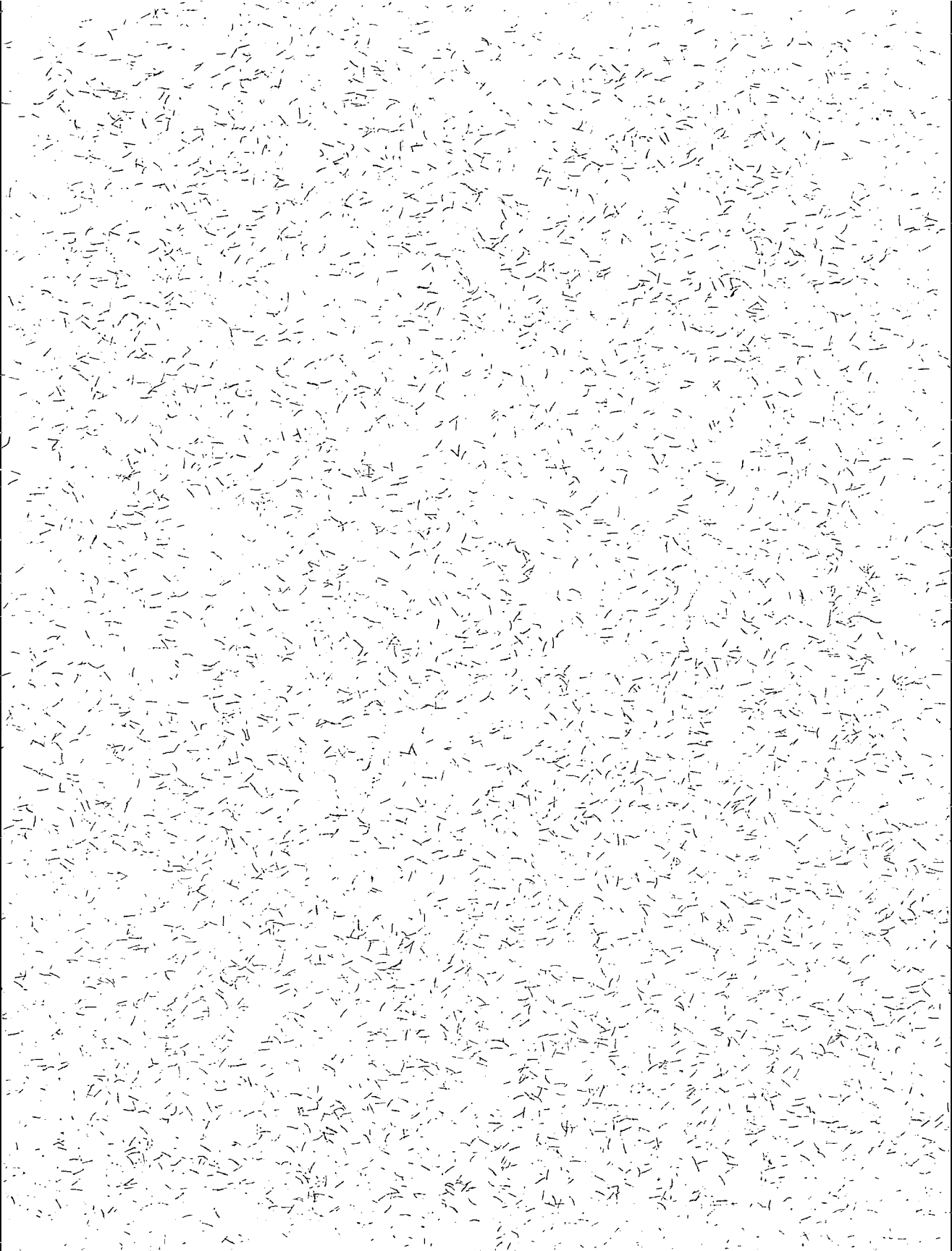
ety, and self-improvement skills); (2) Social Skills (e.g. communication and general social skills); and (3) Drug-Related Information and Skills designed to impact on knowledge and attitudes concerning drug use, normative expectations, and skills for resisting drug use influences from the media and peers. Life Skills Training has been effective at reducing alcohol, cigarette, and marijuana use among young adolescents. The effects for tobacco and heavy alcohol use have been sustained through the end of high school.

Multidimensional Treatment Foster Care

Social learning-based Multidimensional Treatment Foster Care (MTFC) is a cost effective alternative to residential treatment for adolescents who have problems with chronic delinquency and antisocial behavior. Community families are recruited, trained, and closely supervised to provide MTFC placements, treatment, and supervision to participating adolescents. MTFC parent training emphasizes behavior management methods to provide youth with a structured and therapeutic living environment. After completing a preservice training, MTFC parents attend a weekly group meeting run by a program case manager where ongoing supervision is provided. Supervision and support is also given to MTFC parents during daily telephone calls to check on youths' progress. Family therapy is provided for the youths' biological (or adoptive) families. The parents are taught to use the structured system that is being used in the MTFC home. The effectiveness of the MTFC model has been evaluated, and MTFC youth had significantly fewer arrests during a 12-month follow-up than a control group of youth who participated in residential group care programs. The MTFC model has also been shown to be effective for children and adolescents leaving state mental hospital settings.



Program Overview



FUNCTIONAL FAMILY THERAPY

Program Overview

Functional Family Therapy (FFT) is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes.

Program Targets:
Youth, aged 11-18, at risk for and/or presenting with delinquency, violence, substance use, Conduct Disorder, Oppositional Defiant Disorder, or Disruptive Behavior Disorder.

Program Content:
FFT requires as few as 8-12 hours of direct service time for commonly referred youth and their families, and generally no more than 26 hours of direct service time for the most severe problem situations.

Delivery modes: Flexible delivery of services by one and two person teams to clients in-home, clinic, juvenile court, and at time of re-entry from institutional placement

Implementation: Wide range of interventionists, including para-professionals under supervision, trained probation officers, mental health technicians, degreed mental health professionals (e.g., M.S.W., Ph.D., M.D., R.N., M.F.T.)

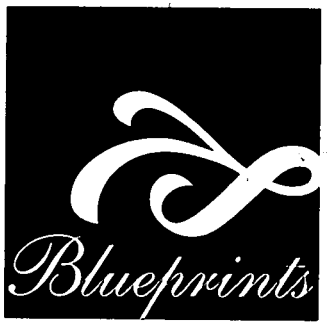
FFT effectiveness derives from emphasizing factors which enhance protective factors and reduce risk, including the risk of treatment termination. In order to accomplish these changes in the most effective manner, FFT is a phasic program with steps which build upon each other. These phases consist of:

- *Engagement,* designed to emphasize within youth and family factors that protect youth and families from early program dropout;
- *Motivation,* designed to change maladaptive emotional reactions and beliefs, and increase alliance, trust, hope, and motivation for lasting change;
- *Assessment,* designed to clarify individual, family system, and larger system relationships, especially the interpersonal functions of behavior and how they relate to change techniques;
- *Behavior Change,* which consists of communication training, specific tasks and technical aids, basic parenting skills, contracting and response-cost techniques;
- *Generalization,* during which family case management is guided by individualized family functional needs, their interface with environmental constraints and resources, and the alliance with the FFT therapist/Family Case Manager.

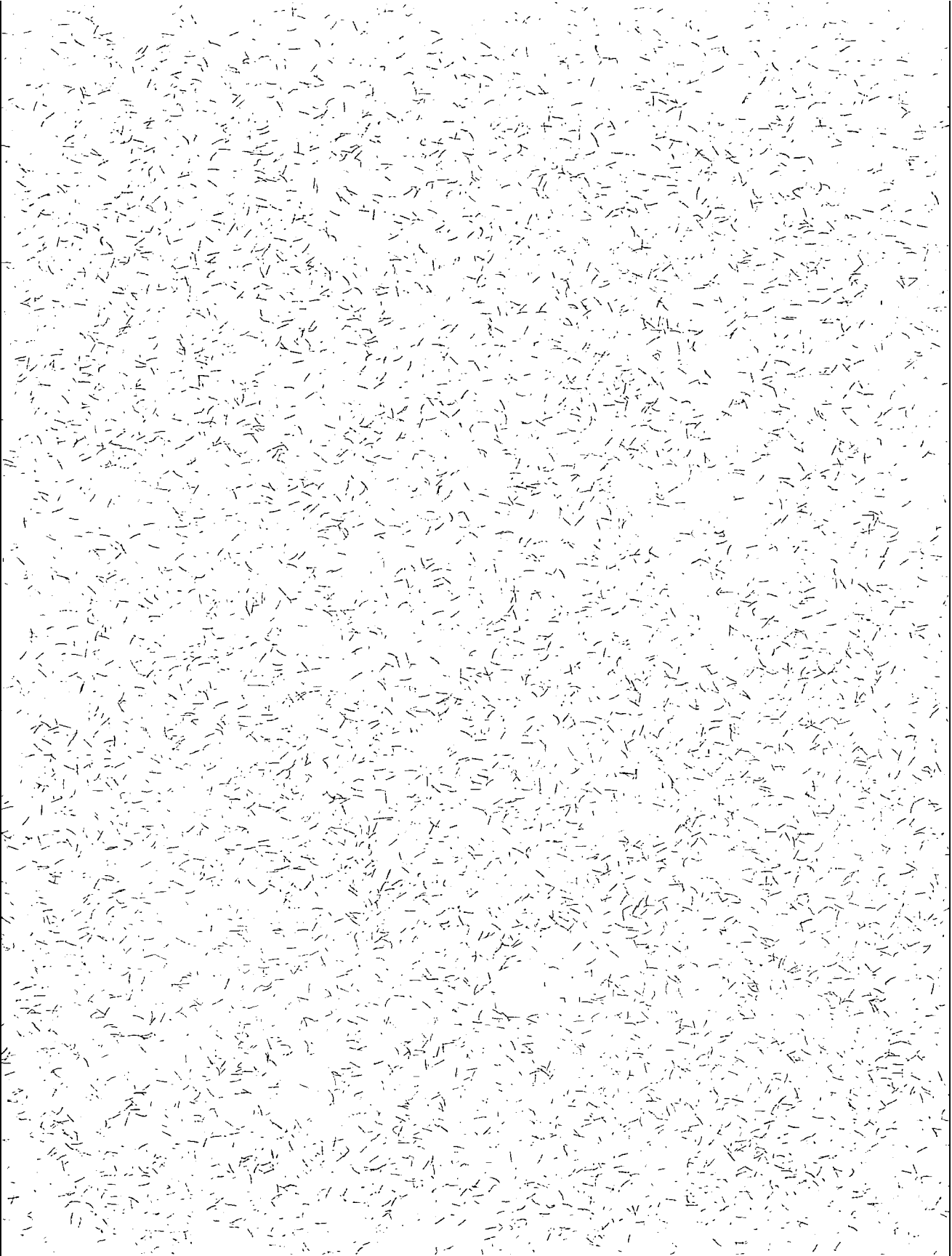
Evidence of Effectiveness:
Clinical trials have demonstrated that FFT is capable of:

- Effectively treating adolescents with Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavior Disorder, alcohol and other drug abuse disorders, and who are delinquent and/or violent;
- Interrupting the matriculation of these adolescents into more restrictive, higher cost services;
- Reducing the access and penetration of other social services by these adolescents;
- Generating positive outcomes with the entire spectrum of intervention personnel;
- Preventing further incidence of the presenting problem;
- Preventing younger children in the family from penetrating the system of care;
- Preventing adolescents from penetrating the adult criminal system; and
- Effectively transferring treatment effects across treatment systems.

Program Costs:
The 90-day costs in two ongoing programs range between $1,350 to $3,750 for an average of 12 home visits per family (see Funding and Program Costs).



CHAPTER ONE
Executive Summary



EXECUTIVE SUMMARY

Background and Rationale

Many therapies are named to reflect a theoretical perspective (e.g., behavioral, object relations) or a primary focus (e.g., multiple systems, cognitive). *Functional Family* Therapy (FFT) is named to reflect the *core unit* which represents the primary focus (*family*), and an overriding allegiance to positive outcome (*functional*).

The dictionary defines the term *functional* as "capable of performing, stressing functions over extraneous embellishment, designed for a particular activity." Since the inception of the University of Utah Psychology Department Family Clinic in 1969, wherein FFT was developed, we have preferred function over frills, determination over drama, and responsibility over "hype." This philosophy runs counter to much of the history of treatment development for delinquency, adolescent substance abuse, violence, and related problems. Then (and unfortunately often now), many experts argued for elaborate, but often untested, theories and politically popular solutions to the problems of youth, and the problems have become worse! Social scientists and religious leaders have argued over the causes of problem behaviors, naming such factors as poverty, divorce, racial prejudice, and spirituality.

In contrast, the developers and replicators of Functional Family Therapy, have recognized that solutions require integration, not rhetoric, and the *functional* goals of:

1. Effectively changing the maladaptive behaviors of youth and families, especially those who at the outset may not be motivated or may not believe they can change;
2. Reducing the personal, societal, and economic devastation that results from the continuation or exacerbation of the various disruptive behavior disorders of youth;
3. Doing so with less cost, in terms of time and money, than so many of the more expensive (but not necessarily effective) treatments currently available.

Thus, in 1969 we began the process of integrating the most promising theoretical perspectives, the empirical data available, and hours and hours of direct clinical experience with the troubled youth we wanted to help. Unlike many other therapies, FFT was not developed on college students, or neurotic individuals who could afford many hours of individual therapy, or inpatient adults with psychopharmocological involvement, with an attempt to then transfer it to difficult to treat adolescents. It has been developed for youth and families who are often unmotivated, hopeless, and with limited resources. FFT is *not* designed to make more money by lengthening treatment; instead *FFT is designed to increase efficiency, decrease costs, and enhance our ability to provide service to more youth.* We accomplish this by:

- targeting risk and protective factors that we can, in fact, change, and then programmatically changing them;
- engaging and motivating the families and youth so they participate more in the change process;
- entering each session and phase of intervention with a clear plan and by using proven techniques for implementation;
- constantly monitoring process and outcome so we don't fool ourselves or make excuses for failure; and
- believing in the families we see and then believing in ourselves.

At the time of the inception of Functional Family Therapy, the major theoretical perspectives and services available for treating troubled youth in a family context were rudimentary, though promising. Early on, FFT represented an integration of systems perspectives and behavioral techniques. The *systemic background* of FFT emphasized dynamic and reciprocal processes which needed to be identified in referred families. This led to early observational research on the interactions of delinquent and nondelinquent families using a systemic framework. The *behavioral background* of FFT provided not only specific, manualizable interventions such as contracting, but it also featured an urgent awareness of the need for rigorous treatment development—a scientific imperative to systematically examine the effects of intervention and develop strategies for identifying positive change processes. These origins led to a continuing series of studies involving controlled outcome evaluations and additional replications. During the mid-1970's, FFT also began addressing issues of therapist characteristics and in-session processes from an integrated clinical/research perspective, both reflecting and contributing to the training of therapists for subsequent interventions.

Brief Description of Intervention

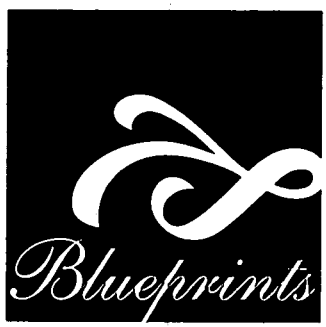
FFT is a family intervention which focuses primarily on youth at risk for institutionalization and their families. FFT treats youth primarily between the ages of 11-18, although sometimes younger siblings of referred adolescents are treated. The duration of FFT treatment generally ranges from 8-12 one-hour sessions (first session generally lasts 1½ hours) for mild cases and up to 26-30 hours of direct family contact in severely dysfunctional situations. In most programs, contacts are spread over a three month period, with initial sessions occurring more frequently and later sessions becoming more spaced. As it developed, FFT has been readily adopted in many contexts due to its clear identification of *specific phases,* each of which includes descriptions of goals, requisite therapist characteristics, and techniques. The phases of intervention, and their component activities, have developed in the context of many clinical hours with many families of various characteristics, coupled with intensive supervision and clinical case discussion. As a result, each phase involves clinically rich and successful interventions that are organized in a coherent manner and allow clinicians to maintain focus in the context of considerable family and individual disruption. The phases consist of:

1.& 2. ***Engagement and Motivation.*** During these initial phases, FFT applies reattribution (e.g., reframing) and related techniques to impact maladaptive perceptions, beliefs, and emotions. This produces increasing hope and expectation of change, decreasing resistance, increasing alliance and trust, reduction of the oppressive negativity within family and between family and community, and respect for individual differences and values.

3. ***Assessment.*** During this phase, characteristics and relationships (individual, family, and larger system) are elucidated, especially *interpersonal functions* and their impact on behavior and change.

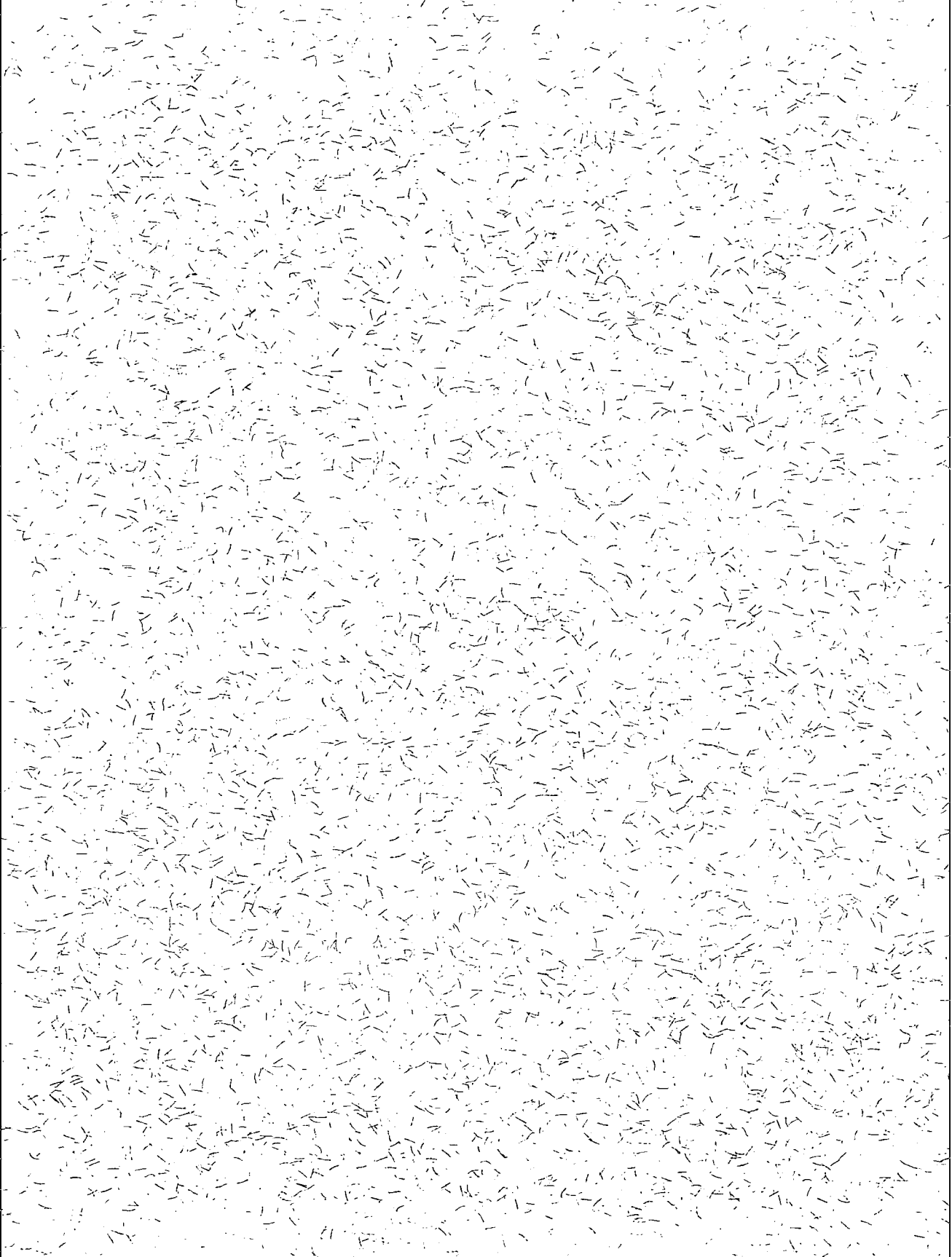
4. ***Behavior Change.*** This phase applies individualized and developmentally appropriate techniques such as communication training, specific tasks and technical aids, basic parenting skills, and contracting and response-cost techniques.

5. ***Generalization.*** In this phase, Family Case Management is guided by individualized family functional needs, their interaction with environmental constraints and resources, and the alliance with therapist.



CHAPTER TWO

Program As Designed And Implemented



Each of these phases are described in FFT treatment manuals and literature, and each involves clear identification of therapist qualities and representative activities necessary to facilitate movement into the next phase and, finally, successful termination of therapy.

Evidence of Program Effectiveness

To date, thirteen studies in referenced journals (plus one in preparation) demonstrate dramatic and significant positive treatment effects, including follow-up periods of up to five years. Rates of offending and foster care or institutional placement have been reduced at least 25 percent and as much as 60 percent in comparison to the randomly assigned or matched alternative treatments, or base rates. One study also demonstrated a positive three year follow-up effect on siblings. Additional formal program reports (e.g., county and federal funded projects) from completed and ongoing replications reflect similar positive outcomes, and five currently funded trials (National Institute of Drug Abuse, National Institute of Alcohol Abuse and Alcoholism, Government of Sweden) promise additional data regarding generalization of effects for FFT across more contexts and populations. Studies have also identified specific FFT based interventions and direct changes in family functioning which relate to the outcome findings.

One major factor in the successful evolution of FFT has been the continuous (29 year) involvement of its progenitors and many of its co-contributors in various university settings. This context has not only maintained a standard of scientific scrutiny, but has also contributed to the conceptual integrity of the major constructs and techniques. The prime example of this impact is the extensive work on reframing in FFT, informed by other well-developed theoretical perspectives such as information processing theory, social cognition, and the psychology of emotion. Laboratory based research has identified specific components of this critical technique, which in turn has led to applied research on cognitive set and attributional processes in referred adolescent families. Further, investigations have identified in-session therapist characteristics and family interaction processes relevant to the phases of FFT which are predictive of positive change. Most notable process changes appear to be in family communication patterns, and especially negative/blaming communications and "withholding" types of silence. With respect to therapist characteristics, process and outcome data demonstrate that FFT therapists must be first relationally sensitive and focused, then capable of clear structuring and teaching, in order to produce significantly fewer dropouts during treatment and lower recidivism.

More recently, FFT has been widely adopted because it has evolved an increasingly multicultural perspective, and has added effective home-based intervention. In the home-based Clark County, Nevada, Youth and Family Services program, for example, referred adolescents are roughly 30 percent African American, 20 percent Hispanic/Latino (mostly Mexican American), and just under 50 percent European American with a few American Indian and Asian American youth. Preliminary data on the first year of FFT involvement indicate no difference in reoffense rate among the different ethnic/racial groups, supporting the generalizability of FFT effects across cultural/racial groups. The Fayetteville, North Carolina, program has involved primarily White and African American families and therapists, including a significant number of mixed race relationships and offspring. The two clinical trials being conducted in New Mexico involve Hispanic/Latino and White youth, and the home-based program in urban Willow Run, Michigan, involves a large proportion of African American and mixed families. (See replication information in later sections for more details.) As the model has been increasingly adopted in multicultural contexts, focus is being placed on issues of culture and ethnicity, with much of this recent work undertaken in the context of the multisite National Institute of Drug Abuse (NIDA) funded *Center for Research on Adolescent Drug Abuse* (CRADA, Howard Liddle, P.I.).

Taken together, 28 years of data and clinical experience with FFT involving hundreds of therapists and thousands of families have provided strong empirical support for this family-based intervention with adolescents. In addition, the research has demonstrated that intervention must include a major focus on changing emotional and attributional, especially blaming, components of family interaction, then provide a program of specific behavior change techniques that are culturally appropriate, family appropriate, and consistent with the capabilities of each family member.

PROGRAM AS DESIGNED AND IMPLEMENTED

Goals and Measurable Objectives

The major goal of FFT is to produce positive outcomes by preventing the continuation of targeted activities in identified youth (i.e., delinquency, violence, substance use). In order to accomplish this, FFT has four specific objectives: Engagement, Motivation, Behavior Change, and Generalization. These objectives and the phases of intervention that relate to them will be introduced here, then expanded in later sections discussing specific techniques.

Objective 1. ENGAGEMENT. Engage and retain families and targeted youth in prevention/intervention activities. Focus especially on maximizing factors which enhance the perception that positive change might occur (intervention credibility), and minimize factors (e.g., poor program image, difficult location, insensitive referral) that might signify insensitivity and/or inappropriate resources.

Objective 2. MOTIVATION. Identify and quickly begin to modify the pattern of changeable intrafamily risk factors, especially negativity, hopelessness, and blaming; initiate and/or strengthen intrafamilial protective factors that can mitigate the effect of risk factors that cannot be changed.

Objective 3. BEHAVIOR CHANGE. Develop long term behavior change patterns that are culturally appropriate, context sensitive, and individualized to the unique characteristics of each family member. Foci include cognitive (i.e., attributional style, coping strategies), interactive (i.e., reciprocity of positive rather than negative behaviors, competent parenting), and emotional components. Provide concrete resources (e.g., checklists, telephone lists of resource people, pictures of role models, post-it notes, audiotapes) that both guide and symbolize specific changes in behavior. Emphasize positive communication and parenting.

Objective 4. GENERALIZATION. Enhance the family's ability to impact multiple systems in which the family is embedded; alternatively, intervene directly with such systems until such time as the family develops sufficient efficacy that the family can maintain positive impact. Mobilize community support systems (e.g., recovery services, nurse visitation) and modify deteriorated family-system relationships (e.g., with school, probation officers).

Measurement of Objectives

The Functional Family Therapy model has a 28 year history of attempting to empirically identify and measure various components of FFT process and outcome. Positive outcomes can be measured via such indicators as rearrest, urine screens, and hospital admissions. Many FFT objectives are measurable by overt and relatively nonreactive/objective ways. For example, Objective 1 (Engagement) can be reflected in attendance vs. dropout from scheduled sessions and being unavailable for home visits when scheduled; Objective 4 (Generalization) can be assessed by attendance in community meetings, contacts with school personnel, responding to probation officer requests. The process-mediational Objectives 2 and 3 (Motivation and Behavior Change) can be measured through process analysis (self report, session checklists, analysis of live or recorded in-session interaction) and repeated measurement of individual and family level in-home and community behavior (via self report inventories, diaries, symptom checklists, etc.). Specific measures involved in different studies will be described in detail when appropriate.

Comment about Objectives. The extremely "functional" nature of FFT also prioritizes outcomes in terms of the behaviors that place youth and families at risk and/or bring them negative attention and/or sanctions. Thus, we are organized more around eliminating violence than we are in creating a family form that approximates someone's ideal, unless that ideal form also eliminates violence. We are much more interested in helping a youth stop drug abuse and re-enter school than we are interested in imposing someone else's view of which parent figure should be the wage earner or nurturer. We are much more interested in enhancing a mother's self-esteem and ability to parent in a positive manner, both quite measurable outcomes, than we are in giving her a DSM IV (Diagnostic and Statistical Manual) diagnosis that may satisfy record keeping and reimbursement requirements but which may, in fact, interfere with her changing her child's maladaptive behaviors. Thus, much of what is traditionally measured in mental health (e.g., diagnoses, objective test profiles, and personality inventories, etc.) is measured in FFT only to the extent that it directly contributes to identifying behavior change targets and intervention strategies.

Comment about Family. Note that the term "family" refers to an extremely wide range of forms and structures. Generally the term refers to youth who reside with one or more adult figures (parent, guardian, group home staff) who are deemed by relevant officials (juvenile court, school system, etc.) as responsible for the conduct of the youth. It is not uncommon, however, for living arrangements to exist which represent a reality for the youth but not an entity recognized by relevant officials (e.g., single parent with occasional live-in adult partner, gay/lesbian couples with child(ren) living in the same structure, multiple families or part families living in the same structure with multiple adult figures that may or may not be related in a biological or legal sense. In general, FFT initiates intervention with the unit that represents the current reality for the identified youth, especially since externally induced (e.g., via Social Services) changes in such units require intensive intervention and considerable time.

Targeted Risk and Protective Factors

The multilevel objectives introduced above require a coherent, phasic, and performance based intervention sequence; performance based in that each intervention phase includes specific criteria which must be considered in order for the next phase of intervention to be implemented. In addition, FFT is a prevention/intervention model designed for youth and family participants who have already demonstrated maladaptive behaviors and/or high risk factors. Thus FFT, based on the levels above, involves a series of risk factor targets, the first being those factors that predict failure to engage and retain the family in intervention.

Objectives 1 and 2 (Engagement and Motivation): Risk Factor Targets

Many of the risk factors that recur in the literature with respect to youth violence, substance abuse, and delinquency (e.g., poverty, disrupted caretaker history, family conflict) also place youth and families at risk for low engagement and non-retention in change programs. Unfortunately, many of these factors cannot reasonably be modified until intervention is well underway, and other variables such as poverty are simply not amenable to intervention in a short term context. FFT has demonstrated significant positive impact by responding to this problem by first focusing almost exclusively on the motivation family members experience to participate in change. In particular, FFT emphasizes cultural and family and individual respect and sensitivity, alliance with each family member, and the reduction of the toxic effects of blaming, anger, and hopelessness. As described

below in the Motivation Phase, interventionists avoid a message that they are attempting to impose change; instead, the Motivation Phase emphasizes the use of relationship skills to reduce defensiveness in all family members, including when they are blaming each other. Further, it is emphasized that the interventionist is an advocate for all family members, not the ally of one against the other.

Objective 3 (Behavior Change): Risk Factor Targets

The Behavior Change Phase involves specific, individualized change programs that are concrete, measurable, and focused on two synergistic processes. First, the reduction of intrafamilial risk factors, and second, the enhancement of intrafamilial protective factors (see Tables 1 and 2). FFT can decrease the intrafamily risk factors (e.g. conflict) and at the same time create protective factors (e.g., family cohesion) that will mitigate some of the negative effects of extrafamily risk factors (e.g., negative peers). Table 1 summarizes the major classes of risk factors that appear in the developmental psychopathology literature with respect to Disruptive Behavior Disorders, with full references available in Reference section. Table 2 represents the FFT strategy for targeting risk and protective factors in each of the FFT phases.

As can be seen in Table 2, additional context factors are acknowledged and integrated into the individualized behavior change strategies, although they are not impacted directly. Thus, context factors such as race, single parent status, income level, intelligence, all of which appear in many risk and protective factors lists, are not direct targets for change. However, the manner in which they act as mediators is modified by FFT. For example, less intelligent family members are provided more structure and concrete representations of tasks; more intelligent family members are often better served by the provision of themes, concepts, and metaphors. When race and income result in less access to resources, FFT helps train family members in appropriate assertion skills, and/or FFT representatives engage extrafamily systems directly to reduce the lack of access to resources (Generalization Phase). Single mothers are not helped to learn parenting in the way the literature indicates successful married mothers parent; instead, single mothers learn how to influence their children using the styles of successful single mothers (e.g., using expert vs. position authority and, if they are working mothers, negotiation and mutual goal setting more than direct monitoring and establishing immediate consequences for their child's behavior). FFT asserts that well functioning single parent families operate differently, in many important ways, than well functioning two parent families; successful two career families involve parenting strategies that are often quite different than the parenting practices of successful, conservative traditional families; well functioning families with considerable discretionary funds and a nanny for the children engage in different processes than well functioning farm families with few financial resources beyond the value of their land. This reflects the "matching to sample" philosophy that individualizes intervention targets for the unique context of each family, rather than providing a uniform package of change targets that are often based on research with very different samples.

FFT individualizes the change program for the unique risk, protective, and context factors that characterize each family. Note again, however, that Objectives 1 and 2 above do involve the generic processes of blaming, negativity, and hopelessness. These represent initial factors that characterize almost all our FFT families upon referral and which must be reduced before the individualized change activities of Objective 3 can be undertaken.

Table 1. Risk and Protective Factors with Empirically Demonstrated Links to Disruptive Behavior Disorders (References include empirical studies and review articles/books)

Risk Factors

Child

- **Temperament** (Magnusson & Bergman, 1988; Reitsma-Street, Offord, & Finch, 1985)
- **Intelligence** (Farrington, 1991; Moffitt, Gabrielli, & Mednick, 1981; Moffitt & Silva, 1988)
- **Neuropsychological Factors** (Moffitt, 1993)
- **Attention Deficit Hyperactivity Disorder** (Hinshaw, 1987)
- **Early Onset of Disruptive Behaviors/Substance Use** (Hawkins, Catalano, & Miller, 1992; Loeber, 1991; Patterson, DeBaryshe, & Ramsey, 1989; Reid, 1993; Robins,1978; Robins & Przybeck, 1985)
- **Insecure Attachment** (Greenberg, Speltz, & DeKlyen, 1993)
- **Social Cognitions/Perceptions** (Dodge & Coie, 1987)

Intrafamilial

- **Disciplinary Practices: Poor Parenting Skills, Management & Socialization Practices, Punitive Parenting, Failure to Monitor** (Bates, Bayles, Bennett, Ridge, & Brown, 1991; Campbell, Pierce, March, & Ewing, 1991; Loeber & Dishion, 1983; McMahon & Forehand, 1988)
- **Family Relationships: Negative/Blaming Communications & Reciprocity, Lack of Warmth** (Jouriles, Murphy, & O'Leary ,1989; Patterson, 1982; Pettit & Bates, 1989; Werner & Smith, 1982)
- **Parental Psychopathology** (Campbell, 1990; Williams, Anderson, McGee, & Silva, 1990)
- **Parental Substance Abuse** (Kandel, Kessler, & Margulies, 1978; Kazdin, 1987)
- **Family Structure/Size & Marital Disruption/Discord** (Baumrind, 1983; Kazdin, 1995; Robins, 1984)
- **Family Beliefs/Attitudes** (Brook, Gordon, Whiteman, & Cohen, 1986)

Extrafamilial

- **Poor School/Peer Relationships** (Coie & Jacobs, 1993; Parker & Asher, 1987; Reid, 1993)
- **Low Social Support** (Wahler & Dumas, 1984; Webster-Stratton, 1985)
- **Socioeconomic Status/Unemployment/Poverty/Overcrowded Housing/Minority Status** (Hawkins, Catalano, & Miller, 1992; Kazdin, 1987; Sameroff, Seifer, Zax, & Barocas, 1987)
- **Neighborhood/Community Crime** (Simcha-Fagan & Schwartz, 1986; Coie & Jacobs, 1993)

Protective Factors

Child

- **Academic & Social Competence** (Wills & Filer, 1996)

Intrafamilial

- **Positive Parenting Skills** (Luthar & Zigler, 1991)
- **Supportive Family Communication/Relationships/Bonding** (Hawkins, Catalano, & Miller, 1992; Pettit & Bates, 1989; Wills & Filer, 1996)

Extrafamilial

- **Positive Peer & School Relationships** (Dishion, French, & Patterson, 1993; Rae Grant, Thomas, Offord, & Boyle, 1989)
- **Positive Community Relationships** (Hawkins, Catalano, & Miller, 1992)
- **Community Resources/Social Support** (Sandler, Miller, Short, & Wolchik, 1989)

Table 2. Targeted Risk/Protective Factors and Other Contextual Factors by Functional Family Therapy Phases

FFT Targets	Engagement and Motivation (Objectives 1 and 2)	Behavior Change (Objective 3)	Generalization (Objective 4)
Risk Factors	• Negativity/Blaming • Hopelessness	• Poor Parenting Skills • Negative/Blaming Communication	• Poor Relationships - School/Peers - Community • Low Social support
Protective Factors	• Credibility • Alliance	• Positive Parenting Skills • Supportive Communication	• Positive Relationships - School/Peers - Community • Community Resources
Context Factors	• Treatment Reputation in the Community • Treatment Availability - Clinic/In-Home - Transportation - Hours • Staff	• Temperament • Interpersonal Needs • Parental Pathology • Family Structure • Family Beliefs/Values • Developmental Level (early vs. late onset)	• Socioeconomic Status • Unemployment • Minority Status • Neighborhood & Community Crime

Objective 4 (Generalization): Risk Factor Targets

During the Generalization Phase, we once again face context factors that require creativity and individualization. Despite the increasing appreciation in the literature of the multisystemic factors that impact the youth and families we see, the practical truth is that many of these variables cannot be changed directly (e.g., presence of gangs in the neighborhood, institutional racism). Other factors, such as responsiveness of school personnel, may be modifiable for a given family, and such factors are targeted during the Generalization Phase of FFT. However, FFT first emphasizes engaging and motivating the family (Objectives 1 and 2), and increasing intrafamily protective factors (Objective 3). Then, after the family has begun to change internally, we address additional systems such as school, peers, community organizations, police, and the like. We also initiate referrals to a variety of additional supportive, educational, and therapeutic resources. It should be noted, however, that the term *referral* pertains to much more than providing pieces of paper with names and telephone numbers. During the Generalization Phase we work with the family, for example, to instruct and role play how family members can initiate contacts with school counselors, self help groups, neighborhood police, community recreation centers, and the like. We suggest and discuss solutions to problems such as transportation and prior negative experiences family members have

had in such contexts. Finally, when appropriate (e.g., the school principal may in fact be racist or otherwise prejudiced) we intervene directly, sometimes with the hope of changing the system, other times only to help insulate the family from the effects of such systemic factors that do not respond positively to our interventions.

Targeted Population

FFT primarily targets youth, ages 11-18, at risk for institutionalization. FFT has been used at the prevention level for youth with early behavioral indicators of delinquency (e.g., Conduct Disorder, Oppositional Defiant Disorder, or Disruptive Behavior Disorder) to youth who present with serious, chronic crimes (e.g., delinquency, violence, substance use). FFT has been applied with a wide range of population demographics, with non-White youth (African Americans and Hispanic/Latinos) sometimes representing less than 10 percent of the sample and as much as 50-60 percent of the sample. Similarly, females have represented between 10 and 50 percent of youth in different projects, with the overall male to female ratio (since 1970) being between 2:1 and 3:1. In addition, while two-parent families were the norm in the early 1970's, recent projects have sometimes experienced a preponderance of single-parent or otherwise "nontraditional" family forms.

Core Elements and Major Techniques

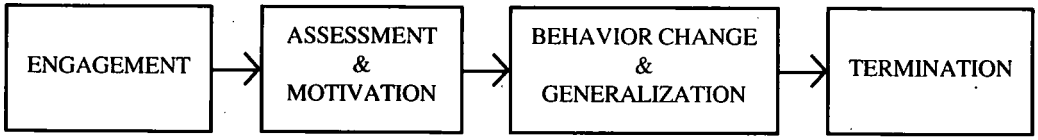
The impact of FFT derives not from its techniques per se, but its careful sequencing of techniques that build one upon another and unfold across time. Stated differently, positive change is a function of **technique and timing**. Thus, within the FFT framework, techniques cannot be simply listed in an aggregate fashion; instead, FFT therapists learn not only *how* to apply each technique, but also *when* and *in what form* to apply it. To do so successfully, interventionists must be aware of the degree of engagement of each family member in the change process, as well as the particular approaches that are more likely to be appropriate for each family member (see Table 3).

For example, if a youth is less oppositional and engaged in the change process, the therapist may be able to simply give him a set of instructions about how to initiate positive behavior change toward a parent or teacher. However, a more independent or autonomous youth may respond negatively to such overt instructions. Instead, s/he may need to be engaged in a problem-solving dialogue as a way to help her figure out a better approach on her own. As these simple examples demonstrate, each straightforward technique (e.g., the process of initiating positive behavior change towards authority) may be applied quite differently according to each circumstance.

As readers review the techniques already introduced and additional technical components that follow, they are urged to remember that specific techniques are, above all, a means to an end. More important than the techniques themselves is the moment-to-moment awareness of what *intervention phase* each family member is in, and the specific *outcome the therapist is trying to achieve with each intervention/technique*. FFT therapists are not trained to follow a specific behavioral template. Instead they must be sensitive to each family member, clear about the goals for each family member in each intervention phase, and able to initiate techniques that family members experience in a productive way. Thus, while FFT is very conceptually grounded and behavioral in its focus, it is client driven in its execution and experiential in its targets.

Table 3. Functional Family Therapy—Basic Components

PHASES & TASKS OF INTERVENTION



ENGAGEMENT PHASE	
GOAL	Enhance perception of responsivity and credibility
SKILLS REQUIRED	Qualities consistent with positive perceptions of clients
FOCUS	Immediate responsivity, family expectations
ACTIVITIES	High staff availability, telephone outreach, language and dress appropriate, proximal services, or adequate transportation
ASSESSMENT PHASE	
GOAL	Elicit and analyze information, develop plans
SKILLS REQUIRED	Perceptiveness, conceptual model that includes interpersonal functions of behavior
FOCUS	Intrafamily & extrafamily context and capacities (e.g., values, attributions, functions, interaction patterns, sources of resistance, resources, and limitations)
ACTIVITIES	Observation, questions (e.g., Who? What? When?); inference re: the functions of negative behavior (What if?, What is the outcome?)
MOTIVATION PHASE	
GOAL	Create positive motivational context, minimize hopelessness and low self efficacy
SKILLS REQUIRED	Relationship/interpersonal skills
FOCUS	Relationship process, separate blaming from responsibility
ACTIVITIES	Interrupt highly negative interaction patterns and blaming (Divert and Interrupt) Change meaning, usually through: Relabel/reframe: 1. Validate negative impact of behavior, but 2. Introduce possible nonmalevolent motives for behavior 3. Introduce themes & sequences that imply positive future
BEHAVIOR CHANGE PHASE	
GOAL	Skill building, change habitual interaction and other coping patterns
SKILLS REQUIRED	Structuring, teaching, organization
FOCUS	Communication training, use of technical aids, assigned tasks
ACTIVITIES	Model & prompt behavior, provide directives & information, develop creative programs to change behavior but remain sensitive to family member abilities and interpersonal needs
GENERALIZATION PHASE	
GOAL	Extend positive family functioning, incorporate community systems
SKILLS REQUIRED	Clear multisystemic model, strong therapeutic and nonjudgmental attitude, energy
FOCUS	Relationships between family members and multiple community systems
ACTIVITIES	Know the community, develop and maintain contacts, initiate clinical linkages

Engagement refers to any activity that can facilitate the family's willingness to show up for the first session and create an initial positive reaction.

Engagement

The Engagement Phase actually begins prior to first contact, and very quickly blends into the Motivation Phase. Engagement refers to any activity that can facilitate the family's willingness to show up for the first session and create an initial positive reaction. As indicated in Table 3, these activities can include "superficial" but important activities such as wearing clothes that seem appropriate for family members and providing therapists that would appear to be credible (e.g., gender and ethnic "matches" where this is relevant). FFT therapists also make their own initial appointments via telephone (when available) so therapists can listen for potential problems such as transportation, resistance, and confusion. Thus, the Engagement Phase is less characterized by a formal set of therapeutic techniques than it is reflective of an attitude on the part of FFT therapists that families should be shown as much respect as possible and be made to feel as comfortable as possible as the process of intervention is initiated.

Assessment

Assessment in FFT is an ongoing, multifaceted process that reflects the phasic and functional nature of FFT. As such, sections on the types of assessment characteristic of different phases will be included in the description of each phase of treatment. In general, important features include:

- Assessment occurs once actual face-to-face intervention commences. As such, much of the important assessment focus is simultaneous with early session engagement (Motivation Phase).

- Beyond the generic assessment generally obtained in educational, juvenile justice, and social service/mental health contexts, FFT emphasizes the identification of the *interpersonal impact* of behavior for each family member.

- FFT also identifies the major extrafamily relationships that become involved in problematic sequences in both adaptive and maladaptive ways.

- In order to facilitate the alliance process and motivation, interventionists enter the system in ways that provide information but also do not highlight individual deficits:
  - by exploring the interrelationship between behavior sequences, feelings, and cognitions (rather than listing negative behaviors as a major focus); and,
  - by exploring the process of relating in the session itself.

- FFT uses formal assessment (e.g., diagnostic tests, formal self-report instruments) only when necessary to answer specific questions that cannot be answered in sessions, or when necessary for legal and/or record keeping responsibilities (e.g., drug screens, documentation of reading scores to establish improvement, or appropriate school placement).

Specific agencies and systems, such as individual juvenile court systems have added their own assessment devices to meet their larger system needs such as validating their own assessment instruments, relating youth characteristics to census track data, or providing diagnostic information to funding sources. Major projects such as the clinical trials being conducted by Dr. Waldron (University of New Mexico) also involve considerable formal assessment, but again it is not for the purpose of clinical decision making. Instead, much of this assessment is designed to provide information as part of a national database and is required for funding.

Preintervention Information and Assessment. Referral information is generally already available for youth and families. Sometimes this information consists only of a name and a reason for referral (e.g., runaway, found in possession of drugs at school, parent called expressing concern that youth is becoming uncommunicative, social services receives referral regarding possible neglect). At the other extreme are cases involving youth with extensive diagnostic test information and perhaps even behavioral records in institutions, and families with a history of many social service contacts. FFT interventionists review such information, along with as much demographic information as is available, in order to understand as much as possible about the context in which intervention is to occur: Is there information available that might facilitate cultural sensitivity, be informative about multisystem pressures (e.g., poverty) and resources, and suggest individual constraints (e.g., learning disability, illiteracy) that must be considered in behavior change?

Assessment in Early Phases (Engagement and Motivation). It should be noted that in many clinical contexts the assessment information which is available in records is pathology based (e.g., DSM IV diagnoses) rather than strength based. As such, most of this information is not particularly useful in the early phases (Engagement, Motivation) of intervention. In addition, much pathology oriented information may predispose interventionists to label and focus on negative aspects of individual and family functioning (types of offenses and complaints, history of poor parenting) rather than emphasize possible strengths and reasons for hope. Thus, FFT sees much of the paper trail that follows youth and families through social services as antithetical to the atmosphere that must be introduced in the family context for true and lasting positive change to occur. Thus, assessment during the early stages of intervention is based much less on the problems and limitations that exist, and much more on the possible new interpretations and perceptions that can help youth and families develop hope, alliance, and the motivation to change.

Assessment during the early stages of intervention is based much less on available records which record the problems and limitations of a family, and much more on the possible new interpretations and perceptions that can help youth and families develop hope, alliance, and the motivation to change.

Because the emphasis in FFT is on building alliance immediately and reducing negativity and hopelessness, FFT interventionists pay particular attention to possible, and often very subtle, cues of positive qualities. Often this information is woven into reframes, for example:

A youth with a long history of offending without getting caught is assessed as reasonably bright; a single parent who often promises to get off drugs, fails to do so, and repeatedly contacts law enforcement to deal with her son is assessed (i.e., reframed) as

overwhelmed and feeling incapable of coping, but still attempting to get her son the help he needs that she knows she can't provide.

As can be seen in these examples, what is usually seen as formal assessment information is de-emphasized in early FFT sessions in favor of creating a positive atmosphere. FFT interventionists are well aware that challenging hopeless, angry, and unmotivated people with their shortcomings has the paradoxical effect of not motivating them to envision hope and positive change. In addition, FFT interventionists understand that issues of trust and alliance, during early sessions, are much more important than exact information about "who did what to whom, and when." Thus youth and family member reactions to overt qualities of the interventionist (age, ethnicity, gender, socioeconomic status, etc.) become a critical issue for assessment. If these reactions are negative, early intervention must address these as quickly, nondefensively, and productively as possible. For example, a White FFT therapist, sensing hostility and distrust from an African American youth and other family members, might suggest the following:

I'm worried that because I'm White you won't feel comfortable with me. I think that is a fair reaction, and I appreciate that you are honest in letting me know that (note that the messages of distrust may have been all nonverbal). I will try to arrange for someone you might feel more comfortable with if you still want me to after today, but for now I will apologize for seeming to be real slow with you. I just need to listen very carefully so I can do my best to understand what you are feeling and what we can do to help the situation.

Therapists must be attuned to their own unique qualities and how they might be affecting a family member. For one of our primary therapists, who happens to be 6' 7" and a former football player, a wink and a grin towards an aggressive gang member may signal an awareness of the "game" the youth is playing and may serve to limit his in-session acting-out. However, the same wink and glance towards a sexually and physically abused adolescent female may represent a total lack of understanding, empathy, or sympathy to the trauma and pain she has experienced and the powerful feelings that motivate her behavior.

Assessing Interpersonal Functions. Functions, in FFT, represent a short-hand term for the powerful relational needs, whether they are inborn or learned, that underlie individuals' motivations for distance/autonomy and connectedness/interdependency with others. These patterns become evident over time in relationships, and often differ for a given individual in different relationships. Individual family member behaviors, feelings, and cognitions/attributions combine with those of other members into specific relational sequences with predictable payoffs for each family member. Payoffs take myriad specific forms, but all represent some blend of contact-closeness (or merging) and distance (or separating). They represent the degree of relatedness, or interdependency a person attempts to create in a relationship with another person. *Connectedness* behaviors increase psychological intensity, enhance opportunities for interaction, and strengthen intimacy in either positive or negative ways (e.g., asking for help, expressing tenderness, physical affection, dressing seductively, smothering, dependency, symbiosis, overprotection). *Autonomy* behaviors decrease psychological intensity, lessen interaction, decrease contact, and lessen dependency (e.g., working two jobs, becoming independent, emancipating, running away, being unresponsive, developing extrafamilial relationships, being preoccupied). *Midpointing* behaviors consistently produce a blend of contact and distance, e.g., couples who do a lot together but usually with other people, "come here—go away" messages such as given by classically hysterical or depressed clients, message centers on

refrigerators (*"I love you, I'm not here now"*), alternating times away (e.g., during the week for dual-career marriages) with time together on weekends. Substance abuse for youth often represents alternating cycles of distancing (avoidance) and dependent connectedness (being rescued, bailed out, etc.)—see Stanton et al., concept of pseudo-individuation.

Difficulties with Functional Assessment

- Functions are polydyadic—a behavior of a given person can simultaneously produce different functions with different people (e.g., father's supporting behavior towards daughter produces contact-closeness with her, and simultaneously distances wife).

- Functions are relationship specific–sexual innuendo may function to seduce someone in one family yet in another family may elicit disgust.

- Family members often distort and forget their explanations about behavior—sometimes through ignorance and sometimes purposefully. Identify functions based on what happens, not what family members *say* they want or what you would like them to want.

- As observers, we can only hypothesize what functions are because:
  - Functions are an internal construct which are embedded in the meaning structure(s) of the individual. We cannot see them directly, but only infer them.
  - Though they are an individual construct, they only exist in relationships which are mutually defined by two or more people.

Functions are not the same as "personality," although the pattern of interpersonal needs (functions) expressed by a person across a wide variety of situations would add up to their personality. For some people, their behavior is sufficiently consistent across situations that their functions and their personality seem to be one and the same; for example, a teenager who is consistently dependent, whiny, submissive, and easily led in all situations, whether by peers or parents. For others, however, situations seem to elicit very different functions, as in the case of alienated youth who consistently distance themselves from their parent(s) and behave very autonomously in the home, yet they are very close (if not enmeshed) with particular (deviant) peers, and very distant from other peers. In this situation a single personality label will not provide sufficient detail to be useful to the treatment planner. Instead, the clinician will need to understand that the youth's behavior functions create distance from parent(s), distance from mainstream peers, yet exceptional closeness to deviant peers. As will be seen below, intervention will not attempt to change the youth's overall functional need pattern of distance and closeness, only the relationships involved. In other words, FFT will retain the youth's need for closeness, but after treatment the closeness will be with mainstream peers and parents; FFT will also retain the need for distance, but after treatment the distancing will be with respect to deviant peers.

Thus, unlike the concept of personality which presumes a core underlying motivational structure, FFT assessment of functions often identifies important differences within one person. Parents, for example, often have a favorite child (with whom they have considerable connectedness and might even be enmeshed), while at the same time have another child whom they reject. In such situations it is inappropriate to think of the parent in a unitary fashion (enmeshed, ... or is it distancing and rejecting?). Instead, the FFT interventionist understands that the motivational needs of the parent

with different children are markedly different. As a result, behaviors that would be comfortable for the parent with respect to the close child could be quite unacceptable with respect to the distanced child. Thus prescriptions for good parenting cannot be simply homogeneous, since the behaviors through which the parenting is carried out will differ depending on the child in question.

In response to such situations, FFT would develop parenting strategies that would differ for the two children, but that would still represent a move towards good parenting with each. With close children, for example, parents can provide behavioral guidelines and consequences via little private discussions; in contrast, with distanced children parents may need to write out expectations, work through intermediaries, and provide tangible rewards (rather than hugs) early on in the change process.

Intervention becomes more difficult when the motivational structure differs for members of a dyad, for example, when a parent retains strong affiliation (connectedness needs) towards a youth, while the youth is emancipating (distancing from the parent) and developing much stronger connectedness needs outside the family. FFT believes that behavior change strategies, in order to be maintained, must be rewarding, i.e., consistent with their relatedness needs, for both participants. Thus, FFT therapists develop interaction patterns that can be simultaneously experienced by the parent as more connected, yet at the same time by the youth as protecting the youth's autonomy. Examples of such arrangements come from healthy families, where parents often know where the youth is (*"Call me as soon as you get there and get a ride home before 9:00, or I will have to come and get you"*), but the youth spends the great majority of her time with friends. Another example would be: *"You must be home with us from 7:30 on, but you can still talk on the phone with friends for 30 minutes between then and 9:30."*

Most relationships represent more of a blend of the two major components, ranging from:

- Total autonomy (total uninvolvement, extreme avoidance—except for brief periods, this is rare in intact relationships)
- More autonomy than connectedness needs
- A balance of connectedness and autonomy needs (Midpointing)
- More connectedness than autonomy needs
- Total connectedness (e.g., extreme dependency and/or enmeshment).

Note that no interpersonal function, especially in the 2, 3, and 4 range (above), is inherently dysfunctional. A high need for connectedness in a marriage can be very positive when expressed through caring messages, respect, and validation of the other. In contrast, the same high connectedness need can be very dysfunctional when expressed through incompetence, suicidal behavior, and too much dependency as seen in a dependent personality disorder.

As will be seen below (Behavior Change techniques), the assessment of functions is essential if therapists want to insure rapid compliance with change interventions. Prescribing tasks or change strategies for one family member with respect to another member will elicit considerable resistance if the prescriptions are implicitly or explicitly inconsistent with the family members' interconnectedness needs (functions).

Motivation Phase Techniques of Intervention (Making the Emotional and Attributional Context More Positive: Reframing and Related Techniques)

As already mentioned, the Engagement Phase consists primarily of transitory activities that are designed to get the process of intervention "off on the right foot." As direct contact is initiated in the first session, however, therapist interventions move as quickly as possible beyond such introductory impression activities. Instead, therapists initiate interventions that relate to the family itself and their sense of how the therapist is actually relating with them. For example, FFT therapists initially send the message that they are more interested in hearing the family than in telling the family what they do wrong and how they should change it. Thus, at the point of first contact, FFT therapists de-emphasize, in fact avoid, sending the message to family members that s/he will initiate the intervention by imposing change instructions. Such interventions at the outset are contraindicated and, in fact, may have negative consequences. Instead, several tasks must first be accomplished before the family can begin to change violent, delinquent, drug-involved, and similar lifestyles. According to FFT theory, the primary objective of the Motivation Phase of intervention is to create a motivational context within which change can occur; the family members are helped to experience a reduction in anger, blaming, and hopelessness. Decreasing negativity is essential in this early phase of intervention, prior to initiating formal behavior change techniques, because family members' intense negative emotions preclude them from making a realistic commitment to change. Often family members have developed rigid defensive schema through which all information is filtered, and their interactions are characterized by cycles of coercive and defensive interchanges that reinforce their automatic negative processing patterns. ***Thus, the dominant role of negative behaviors and emotions in the family are the first priority for change.*** At the same time, the salience of the family system is increased, including individual needs both for connection with the family system and autonomy within it. Finally, the relational needs (or "functions," see Assessment section) of each family member are identified, respected, and integrated into specific change programs.

The primary objective of the Motivation Phase of intervention is to create a motivational context within which change can occur; the family members are helped to experience a reduction in anger, blaming, and hopelessness.

Reframing. One of the primary techniques used in the initial Motivation Phase of intervention is that of reframing. A reframe usually involves the therapist portraying unacceptable, illegal, noncompliant, violent, delinquent, and other negative behaviors in a different light. The therapist describes alternative properties of a behavior, points out possible new interpretations of the behavior, or describes the context in which the behavior occurs differently. As defined by Paul Watzlawick, a reframe is a change of "the conceptual and/or setting or viewpoint in relation to which a situation is experienced and to place it in another frame... and thereby change its entire meaning" (Watzlawick et al., 1974). Reframing is among the most powerful techniques available to therapists. When successful they establish new interpretations and meanings of behaviors primarily through casting members and their motives in a more benign light, and through creating plausible alternative explanations for behavior, especially the motives of the behavior. Therapists initiate positive interactions by establishing a relational focus by switching attention from referral problems to relationships through questions, comments, and interpretations. In the context of successful reframes, family members are more willing to turn nagging into prompting, sullen withdrawal into more constructive (e.g., verbal) expressions of confusion or hurt, and violence into requests for change.

Reframing is essential in early sessions because overt attempts to decrease negative affect directly by requesting that family members stop its expression generally elicit direct resistance or are effective only temporarily. Instead, the FFT therapist interrupts argument sequences before they become too heated or intensive, and avoids asking specific questions that amplify descriptions of blame (e.g., *"Why did it bother you so much when he stole the car?"*), and *reframes* the motivation behind negative behavior.

A common feature of reframes is that they link emotions, and often relational needs, to the experiences and beliefs of family members, but in new ways. Often FFT therapists suggest a theme as a reframe which can provide a new lens through which family members can interpret patterns of maladaptive behavior. The following non-exhaustive list of themes provides examples of how FFT therapists reinterpret family relational patterns in a new light:

- ***Anger implies hurt.*** Almost every time we see/feel anger, it almost always reflects an underlying hurt. Unfortunately, we tend to hide the hurt with anger, so others don't understand the hurt, only the anger.
- ***Anger implies loss.*** Anger may reflect a fear of hurt or loss of love, control, sense of trust, sense of family, etc.
- ***Defensive behavior implies emotional links.*** Your mate (child, parent, etc.) acts defensively when he lies because it is difficult for him/her to lie to you. That implies a relationship and sense of caring that s/he can't express directly.
- ***Nagging equals importance.*** S/he nags (criticizes, argues) because you are so important and because s/he does want you to be close, available, and nondestructive to the relationship, etc. Unfortunately, people tend to drop out/forget the underlying positive reason for the nagging, so all the others hear is the criticism.
- ***Pain interferes with listening.*** When someone seems insensitive, selfish, etc., it may reflect the fact they are in too much pain (fear, sadness, etc.), to be able to consider others. This is particularly hard to understand when people cover their pain with anger, selfishness, etc.
- ***Frightened by differences.*** Some individuals are afraid of differences per se because they fear that differences will lead to lack of commitment, loss of control, an unwillingness to continue the relationship, etc. People are frightened by differences because they don't trust the process of dealing with differences.
- ***Need to feel OK about self in the context of problems.*** Some people behave in a controlling, apparently insensitive manner not because they know that this will change others' behavior, but because they feel that they are doing the best they can.
- ***Protection.*** Sometimes people do bad things (e.g., fail to support their mate, act out, etc.), in order to protect someone else by taking the focus off of them and/or forcing the family to get outside help.

Unlike some other intervention models, FFT is not problem focused until motivation is enhanced, negativity decreased, and positive alliance (which results from successful reframing) established. Specifically, FFT therapists strive to ensure that, very early in treatment, each family member will experience the following:

- "We are not inherently bad! It is the way we have done things that has not worked."
- "Even though I have made mistakes, the therapist 'sided' as much with me as everyone else."

- "Even though we experience the problems differently, we must all contribute to the solution."
- "Even though I may have a lot to change, the therapist will work hard to protect me and everyone else in the family."
- "I want to come back to the next session because it finally seems that things might get better."

Thus, reframes typically attempt to link emotions to beliefs held by family members, but expand the interpretation of the behavior. **Interactional** reframes provide a benign description of the interpersonal impact of one's behavior (*"It looks like as long as you are furious at what you call Sally's bullshit, you don't have time to face how desperately alone you feel"*). Second, a **motivational** reframe recasts one's motives in a nonmalevolent light (*"I wonder if all this acting out might not be her way of letting you know how much she needs you to still be very involved in her life? She might even be protecting you by not putting you on the spot directly, though she knows you'll stay involved as long as she can't seem to make it on her own"*). Finally, the **systemic** reframe emphasizes that all the family members are sharing a common experience (e.g., loss, pain) but are manifesting their internal emotional experience in different ways: *"So everybody feels bad about how the weekend fell apart, but Jose deals with it by slamming the door, Maria starts sulking and doing housework, and Angel puts on gang colors and starts to go out. It is so sad to see three people all in pain, but who show it in ways that say: 'I'm hurt, I'm angry, I give up, there is no hope.' Is it because you each need to be heard by each other so much that you can't stop to listen, only express the hurt?"* This sort of reframe alludes to problems of depression and withdrawal, storming out, and even gang membership, but does so in a way that places the major emphasis on an emotional interior of the family and each member. The interventionist sends the message that *"I want to share with you beyond the superficial layers that everyone can see, and hear the lonely places in you that I believe we can help."*

Finally, reframes are not presented in order to avoid the issue of negative behavior. It is essential that therapists, prior to presenting reframes as possible alternative explanations for behaviors or motivations, first validate the negative impact of the behavior. Reframing doesn't minimize the negative impact of bad behavior; bad behavior is bad! Reframes merely add a focus on motivation which implies that the motives may not be completely evil or malevolent. This distinction is key to helping interventionists respond to negative behavior but in a way that lowers defensiveness and resistance, and enhances alliance. For example, when hearing about one family member slapping another, the therapist must first validate the physical and emotional pain: *"Clarice, you must have felt awful, physically and emotionally. Lots of people who hit don't realize that it is humiliating as well as painful"* (validation of behavioral impact, which then can be followed by the reframe). *"Anthony, when you hit Clarice did you imagine how it would hurt her, or were you more focused on your own feelings, like maybe out of control because she was getting the upper hand."*

Note that in this example the victim's pain was first validated, then the situation was broadened to suggest motivations beyond simply inflicting pain, such as feeling out of control. Reframes such as this do not excuse the behavior, but they provide more of an affiliative and alliance based context of change than the message: *"You are a bad person for hitting; you must stop this behavior; when you feel anger like this you must...."* Instead, the reframe allows the therapist and family, especially the offender, to clarify the underlying motivational structure and develop alternative sets of internal and external cues as a basis for change. It should be noted that often reframes are presented as alterna-

tive hypotheses and metaphors which allow the therapist to be assertive but at the same time remain flexible and not stuck with an assertion the family doesn't accept.

It should also be noted that some clinicians and other criminal justice workers may become concerned that reframes will be taken as excuses by that subset of youthful offenders (and/or abusive and neglectful parents, siblings, etc.) we identify with such labels as sociopath. In response to this concern, FFT reminds clinicians that reframes have been developed as part of the Motivation Phase, so if certain reframes do not serve to motivate, then they should not be used. If a clinician fears or experiences a reframe as producing harmful motivations (e.g., *"See, I couldn't help myself,"* or *"She (the clinician) says it is OK"*), then the reframe should be avoided. At the same time, it must be emphasized that FFT also prioritizes alliance formation, so therapists must develop an alliance with a person, even a sociopathic person who many believe are incapable of alliance. Our data support that by following the premises and techniques of FFT, the large set of youth seen as intractable in other programs become much less so. This subtle process is accomplished by first letting the youth know *"we've been there."* Much in the manner of Alcoholics Anonymous sponsors, an FFT therapist can say things like:

> *I know you did that not because you are evil, but because you want so desperately to belong, and I know you are scared of rejection, and I know you don't even know it yourself. I've been there, and I know what it feels like to fool myself.*

Or, if the clinician hasn't been there, s/he might say:

> *I've sat in this room with too many like you, and seen what finally comes out, to be fooled by you even if you are still fooling yourself.*

The clinician then goes on by saying to a parent something like:

> *So he feels like he beat the hell out of the other kid because the other kid came up on him, and I feel like he did it to prove he was bad to his friends, and I also know he is terrified of rejection. What do you see—the rage, the fear, the need to belong, or other things like the awful fact that his father didn't seem to care at all what he felt?*

The above examples demonstrate that reframes are not simplistic and unreal. They are sometimes blunt, complex, and they deal with the ugly reality in which many of our youth and families live. It could be that a true sociopath might hear the above and use it nonproductively, but our experience is that such reframes send a message of honesty and commitment to the youth and family, and often produce an increase in alliance and an increase in change motivation. In contrast, when such youth are challenged with their negative behavior, it is under those circumstances that they become defensive, oppositional, and even less responsive to change. Thus, for the FFT therapist, the reframe represents a means to continue the process of becoming more and more a part of the family system, not an excuse that simply sends the message, *"Gee, we are all wonderful here."* Instead it sends the message that *"I know how awful you can be, but I know there is more, and I'm committed to finding it."*

It is imperative that therapists, when developing reframes, are careful to be culturally (ethnically, racially, gender related, sexual preference related, spiritually) sensitive and express an openness to value systems which may be quite different than their own. When in contexts that are quite different from theirs, therapists must often think in ways similar to a cultural anthropologist: *"My culture*

doesn't do things this way, but in this culture there can be found happy and adaptive families that do things differently than I would. Those families will be my guideposts, rather than my own biases." In FFT we identify this as a value-independent, "matching to sample" philosophy which is essential for helping the diverse families, cultures, classes, and contexts we encounter.

Finally, reframes are best thought of not as a technique, but as an attitude. They represent a commitment to not allow the content (descriptions of behavior, blaming attitudes, reasons for lack of hope) of early sessions to become the major focus of intervention.

Reframes operate by:

1. Providing a way out of defensive spiraling, and giving family members more adequate ways of modulating emotions which, in turn, opens the family to the possibility of increased emotional expressiveness in a positive manner.
2. Introducing sufficient confusion, protection, or distance to disrupt the automatic, top down processing that has evolved over time in the context of negativity, maladaptive behavior, and sometime worse behaviors (such as abuse).
3. Providing an alternative cognitive content for the powerful affective information. For example, a frequent therapeutic task is to reconnect the family members with the concern and love that underlies, and originally motivated, their anger and hurt.
4. Giving everyone some responsibility for the problem, but in a nonblaming way, thus making scapegoating more difficult.

Pointing Process. A second technique used by FFT therapists is pointing process. As FFT therapists observe and attend to each family members' perception of family processes, extrafamily interactions, and their experience of problems with each other and persons outside the family, they can comment on the process of how family members relate to each other. This is especially important with respect to those interactions that are characterized by negativity and blaming. By pointing process, FFT therapists are able to make explicit the inter-relatedness of family members' feelings, thoughts, and behaviors. In a recently seen family, for example, the therapist commented:

> *Dad...excuse me for interrupting, but I noticed something I'd like to check out with you. I noticed that when you talk to Tommy you tend to lean forward a little bit, whereas with Aaron you often point towards him with your finger. I can't figure out if you think Aaron "won't get the message" if you don't emphasize it, or you are already discouraged because you think he won't pay attention, or because he is more important than Tommy so you put more emphasis on him. Maybe the three of you know how to interpret all this, but I'm still trying to find out why and how you all take turns feeling so isolated. I also want to make sure that Tommy and Aaron don't misinterpret you, because it is tough to be a father anyway, and even worse if you are misinterpreted.*

Notice that the therapist "pointed out" a process for Dad, but then used this observation to first "put him on the spot," but then also to work on the alliance with Dad by acknowledging his difficulties in being a father. Finally, notice that the alternative explanations offered by the therapist about the pointing contained both perjorative ("won't pay attention") and affiliative ("more important") elements, so neither Tommy nor Aaron would hear all this as an indictment of one versus the other.

Divert & Interrupt. Another important method for disrupting family members' negative interactional sequences is the therapist technique of divert/interrupt. Therapists *divert* family negativity when they intercept a negative speech act made by a family member instead of allowing the family member to whom it was directed to answer. Therapists *interrupt* family negativity when they do not allow a family member who is making a negative or defensive speech act to complete a blaming diatribe. Research from our laboratory has shown that if a therapist simply diverts or interrupts a family member's negative speech acts, then the subsequent family member's speech act is almost twice as likely to be positive than if the therapist allows a family member to respond. It is important to note that the technique of divert/interrupt is not defined based on the content of the therapist's verbal behavior as is the case with the reframe technique. That is, regardless of what the therapist says, when a therapist disrupts the negativity by either diverting or interrupting, the following family member speech act is considerably more positive.

Sequencing. Sequencing behavior is a method used to assess what happens and who does what within a family. Sequencing or circular questioning is usually done around the specifics of a presenting problem. Because it is drawn out in a circular fashion it is visually easier to see the context in which behavior occurs. This information is rich in knowledge about all the participants, the action each took, and the meaning of each participant's behavior. When a sequence is completed to include what occurs before, during, and after an event, there is often an identifiable outcome that can be tied to a theme or function of the participants.

Sequencing, although commonly used as an *assessment* tool, can be used to determine themes and to generate reframes within FFT. When used as an aid in applying FFT, the focus is not on the presenting problem but on a family member's interactions. For instance, when dad steps in to punish the son after he has talked back to his mother, dad's actions can be framed as protective of mom or as the holder of the family value that children are not to show disrespect to their parents. When used in the *Motivation* phase of treatment the goal is for dad to feel acknowledged for having a positive intent. Sequencing can also reveal family patterns which reflect either positive or negative outcomes. Sometimes the sequence when drawn and shown to the family can in itself act as a reframe. Family members can see their own patterns when sequencing is accompanied with non-blaming, contextual narrative. Interventions can be explored in the same manner when family members are asked where they might choose to change the sequence. Another variation is to sequence a positive behavioral outcome so that family members recognize what they do that works for them. This is definitely a fine opportunity to reframe.

Sequencing is also a handy *supervision* tool. A beginning therapist may find the concreteness of sequencing helpful in many ways. The trainee can use sequencing as a way to structure and guide the session. Armed with "what," "when" and "how" questions, the trainee can easily track the therapeutic discussion. Raw data collected by the trainee is used in the supervisory session to formulate hypotheses around themes and functions. When the trainee collects this information for the sequence it tends to be a fairly reliable description of family interactions. Trainees often confuse what family members say about a

behavior with the actual behavior. Trainees may need encouragement to ask family members about specific behaviors, such as *"what did you do?"* or *"what happened next?"*

As with family members, the trainee can also benefit from the visual picture a sequence provides. The step-by-step process of obtaining a sequence can be replayed in the supervisory session and used to generate clinical judgment questions. As the therapist develops his/her perceptual and structuring skills, the need for a sequence based on past behavior can make way for a sequence observed in the moment.

Behavior Change Phase Techniques and Targets

Parent-Child Process. Therapeutic success during the Behavior Change Phase is dependent upon gains made in family motivation (decreased negativity, increased hope) and accurate assessment. With respect to parent-child process, FFT change techniques can be broken into two broad categories, communication training and psychoeducational/parent training. As mentioned in an above section, FFT is designed to be applied in a manner sensitive to the unique needs of each family. This flexibility is especially salient in the Behavior Change Phase, during which therapists need to consider a number of family characteristics to determine which broad category and specific techniques will receive the greatest emphasis. Characteristics that require consideration include the developmental levels and functional needs (closeness/distance) of family members.

With respect to parent-child process, FFT Behavior Change techniques can be broken into two broad categories, communication training and psychoeducational/ parent training.

The developmental level of the referred child or adolescent influences therapeutic decision making during the Behavior Change Phase. Developmental level in this context refers both to the adolescent or preadolescent status of the referred youth, and the level of cognitive development/sophistication of each family member, including the referred youth. Decisions based on developmental level include whether communication training or psychoeducation/parent training receives the greatest emphasis during the Behavior Change Phase and the relative levels of complexity or sophistication of the specific techniques to be utilized.

Adolescent/preadolescent status is an important consideration because it heavily influences the family structure that is the desired endpoint of family therapy. In terms of FFT theory, it is important to "match-to-sample" based on developmental level, such that families with troubled preadolescent children are helped to learn to interact like families of non-troubled preadolescent children, and families with troubled adolescents are helped to behave like families of non-troubled adolescents. To emphasize the point, a single mother on welfare in a deteriorated urban environment who has an acting out preadolescent is helped to develop parenting skills that are the same as a single mother on welfare in a deteriorated urban environment who has a non acting out preadolescent. We can't change the family's income, ethnicity, location, religion, and so on. However, we can use the wisdom of a parent with this income, this ethnicity, this location, this religion, and this style of adaptive parenting to provide our template for change... and we can change parenting behavior! However, the behaviors of an effective parent of a nine-year old in this environment may be quite different than the effective behaviors of a parent of a sixteen-year old.

For example, in typical non-dysfunctional families the power differential between parents and children changes over the transition from preadolescence to adolescence, and adolescents and their parents engage in much more symmetrical communication about family issues than preadolescents and their parents. Thus, in families with adolescents, communication training is stressed because two-way communication and increased adolescent power and responsibility are developmentally appropriate. In fact, in families with late-onset acting-out adolescents, family difficulty adapting to the changes of adolescence is often a core issue and potential contributing factor to the behavior problems. For example parents no longer know how to control their adolescent's behavior physically (as they could when the child was younger; e.g., through the use of time out, physical removal, and mild spanking), and parent behavior often escalates into more powerful forms of violence, or they simply give up!

In adaptive and functional families with younger children, parents appropriately take greater power and responsibility, and the psychoeducational/parent training aspects receive greater emphasis. In contrast, families in which the referred child is a preadolescent are often struggling with basic parent training issues, and have often failed to establish a developmentally appropriate family structure. Negative coercive cycles, inappropriate reinforcement, failure to monitor the child's whereabouts, harsh/punitive and inconsistent parenting, and other family and parent-child interactions characteristic of young externalizing children's families are heavily targeted.

It should be noted that the developmental considerations are general guidelines, not absolute prescriptions. Almost every family benefits from both the psychoeducational and communication aspects of the Behavior Change Phase, but one aspect typically receives greater emphasis, and the different emphases lead to sessions that look very different from one another. It should also be noted that communication training requires emphasis whenever two powerful members of a family system are unable to resolve problems verbally. Thus, in two-parent families in which there is serious marital/relationship strife, communication training will require emphasis within that marital subsystem, regardless of the developmental level of the referred child. ("Marital subsystem" is used as a conventional relational form, but the principles apply to any system in which two adult figures represent the parenting context for a child, or even adolescent figures who are in the position of having responsibility for parenting a child. Note also that in many cases two adults do not overtly acknowledge parent status [e.g., a single mother and occasional live-in boyfriend], but during the Behavior Change Phase interventionists must take into account the influence of the non-parent on the behavior [and emotions and beliefs] of the youth).

The following example demonstrates the relationship between using communication training to enhance the marital context, and parent training to enhance appropriate parent-child process:

> *A low socioeconomic status, two-parent White family with three young children, ages 8, 6, and 1½ years, was court-referred to the FFT clinic following substantiated reports of physical abuse of the 8-year old boy. The boy and his 6- year old sister had both had long-term disciplinary difficulties at school, and he had recently been suspended for peer problems. The mother and father disagreed vehemently about almost all aspects of parenting, and attempts to talk to each other about parenting quickly escalated into two-way verbal abuse. Following the successful Motivation Phase, the Behavior Change Phase with this family consisted of two sessions of basic communication training during which the parents were provided with photocopied guidelines to communication and*

joint problem solving and practiced the techniques both in-session and as homework assignments. In addition to enhancing their communication process in general, they developed a more supportive style in which the mother helped her husband with job seeking activities, which then resulted in his obtaining employment. Then, using their newly acquired communication skills, these parents were able to identify and discuss important parenting issues. Basic parent training and psychoeducation were then provided to help the parents understand and appropriately manage their young children. Techniques were practiced in-session and as homework assignments, and were quickly generalized by the family to the many day-to-day marital and parent-child interactions that had previously been characterized by stress and physical and verbal abuse.

Developmental level as an issue of cognitive development/sophistication of family members also requires consideration, as it determines the complexity of the specific techniques to be utilized during the Behavior Change Phase. Issues of cognitive development overlap but are not entirely confounded with issues of adolescent/preadolescent status. Highly sophisticated preadolescents and lower functioning adolescents require specific techniques adapted to their abilities, while the developmentally appropriate family power structure remains largely determined by adolescent/preadolescent status.

Communication Training. Communication training is commonly used in FFT. In some families the training represents a focus on a true skill deficit; the family members truly do not know the basics of interpersonal communication. In many other families, however, family members know how to communicate quite well (e.g., some have been effective teachers, professors, clergy, girl scout leaders, etc.). However, in the current individual/family/community context they are unwilling or unable to communicate in the effective ways they can demonstrate in other contexts. With skill deficit types of family members, emphasis is on explaining and practicing the positive elements of communication listed below. When instead the problem is one of performance rather than ability, emphasis is placed on the reattribution (e.g., reframing) interventions described above, and providing constant reminders of the rationale behind positive and effective communication.

Elements of Positive Communication

- ***Source Responsibility***. Needs and reactions are expressed in "I" statements which facilitate the centering of responsibility on the speaker. Family members are helped to avoid "non-I" statements such as, *"In this house...,"* *"Kids shouldn't...,"* *"It's not right for you to ...,"* *and "It would be nice if...."* Instead, family members are taught to say *"I want...,"* and *"When (this particular) thing isn't done, I feel...."* Keeping statements at a personal level reduces blaming and defensive communications.
- ***Directness***. Directness is the complement of source responsibility involving the specific identification of "you" in expressions. This helps avoid third-person comments, innuendo, and inappropriate generalizations. To be avoided are such "non-you" expressions as, *"No one around here...,"* and in front of husband, *"He never...."* In place of this third person invisible process, families are encouraged to directly say, *"I don't want you ...,"* or *"You are not to...,"* and the like.
- ***Brevity***. Communications must be short to avoid overloading and facilitate listening. Family members are often literally asked to state their needs or reactions in ten words or fewer. By requiring members to do this, it reduces unnecessary statements and the op-

portunity to blame others or make provocative accusations. Statements such as, *"I want you to help around the house,"* instead of *"You never do anything around here, except come home and read the paper, and if you think the lawn stops growing just because you're at work, you're crazy,"* reduce defensiveness and increase the opportunity for change. An effective therapist will quickly seize on the idea that mowing the lawn and doing some evening chores will provide the husband with distance and private time while giving the wife the necessary help, thus providing desired change without disrupting functions which regulate intimacy levels.

- ***Concreteness and Behavioral Specificity***. Abstractions such as "being responsible" must be translated into specific behaviors to be performed at specific times. When trust is only emerging, or still not present, an ambiguous situation provides too many opportunities for failure. Helping family members translate their feelings and demands into specifics facilitates negotiation, contracting, and presenting alternatives.
- ***Congruence***. Family members are helped to present messages that are congruent, or consistent, at the verbal, non-verbal, behavioral, and contextual levels. For example, an assertion that husband wants wife to spend more time with him should be spoken in a friendly manner, and he must make it contextually possible by being available. Family members are assisted by the therapist to provide congruent verbal and non-verbal cues, then helped to learn how to help each other to do this in the absence of the therapist.
- ***Presenting Alternatives***. By presenting alternatives, the atmosphere moves away from non-negotiable demands, and helps all family members see the benefit of flexibility in their problem-solving attempts. An example is, *"How about you coming home every night at 8:30 or possibly coming home four nights at 8:00 and staying out one night until 10:30?"* Presenting alternatives transmits a message of, *"We can solve this,"* rather than, *"You must solve this for me."* They allow the presenter to retain a sense of control, yet also provide the recipient with a sense of having options.
- ***Active Listening***. The art of active listening as developed by Rogers and Farson involves the presentation of cues, by the listener, both during and after the time someone else communicates. These cues reflect accurate listening and include eye contact, nodding, leaning forward, and restating or rephrasing what was communicated, in content as well as in the feelings expressed. Good listening and expressiveness is not an innate skill, however, and must be practiced. At the beginning of training it is best to practice active listening one sentence at a time.
- ***Impact Statements***. In response to someone else's communication, impact statements provide feedback in terms of personal reaction that require no justification from either party. Their expression helps family members break up what often seems to be wired in relationships between feelings and behavior. Examples of impact statements include: *"When you do_____, the effect on me is _____"; "The impact on me when _____, is that I feel _____."*

Basic Parenting Principles/Techniques. Forehand and McMahon along with Webster-Stratton and Herbert provide technical descriptions of several basic behavior change techniques. Positive reinforcement/praise, negative reinforcement, ignoring, distracting, clear limit-setting with consistent follow-through and a reasonable number of limits, parent-child special time, and parental monitoring of activities/whereabouts are applied when deemed appropriate during the Behavior Change Phase of FFT. On their own, parent management techniques appear to be more effective with younger children than adolescents and

are most often used in FFT sessions with families of preadolescents. Because FFT is a systemic model and all family members are included in therapy, choosing and relaying these techniques to family members needs to be done in a sensitive and flexible way. The educational descriptions of reinforcement principles that are sometimes used in parent-training are likely to come across as manipulative to a child or adolescent who is in the session, and should be rethought/rephrased by the therapist prior to presentation in the family setting. In general, the use of these basic parenting principles is encouraged in FFT through incorporation into the more systemic and collaborative techniques of response-cost and contracting. Therapists should keep these principles in mind, but their application is most commonly conducted through more systemic means than classic parent-training.

Contracting. Contracting involves having family members identify specific things they would like other family members to do in exchange for interactions/behaviors or tangible rewards. This procedure is especially important with adolescents (as opposed to young children. In fact, ***other than basic communication training, contracting is the parent-youth interaction/influence technique that is most commonly used by FFT therapists*** because it is systemic (e.g., involves and is rewarding to all members of a system or subsystem), can be initiated inside the therapeutic environment, and can be adapted for use with children at all developmental levels. Contracting should initially be conducted within the therapy session, since therapists need to do a number of things to make early contracting as positive an experience as possible. Therapists need to collaborate with family members to identify desired actions and rewards that are specific and realistically attainable. A family that decides to contract with an older child to provide a family trip to Disneyworld in exchange for good behavior throughout the school year is likely to experience failure. The goal is very nonspecific—the good behavior desired by the parent(s) is too vague to be monitored and subject to each person's individual definition of the behaviors that define good and the contexts in which the behaviors are to be displayed. The goals of all parties are not realistically attainable—the parent(s) might not realistically be able to provide a trip to Disneyworld or might provide it regardless of the child's behavior, and unless the end of the school year is near when the contract is entered, the child will quickly determine that it is unrealistic to be good for such a long period of time. A more specific and attainable contract would involve having the child call a parent to report his whereabouts after school and be home by 6:00 on school nights in exchange for a desired parent-child activity on the weekend. Therapists also need to monitor contracts to make certain they are attainable based on the *functional relationship needs* of each participant. Finally, therapists need to monitor the in-session contracting process to maintain the decreased negativity attained during the Motivation Phase. To this end, therapists often refer back to specific reframes from the Motivation Phase that were particularly helpful in creating positive attributions in family members. If communication training was conducted earlier in the Behavior Change Phase, the therapist will also model and remind the family to use communication techniques during their in-session contracting discussions.

Response-Cost Techniques. Especially effective with children and preadolescents, the specific approach to reward and punishment identified by Webster-Stratton and Herbert as *Response-Cost Techniques* provide a wonderful framework that helps a parent or parents learn how to set clear penalties (typically loss of privileges/current rewards) for inappropriate child behaviors or failures to perform. Expected behaviors and penalties should be fair and clearly stated, and augmented by visual aids whenever possible. For example, if a preadolescent will lose TV time for swearing at her parents, a chart might be made to represent her normal weekly TV time in such a format that specific blocks of time can be crossed off the chart for each incident of swearing. Response-cost techniques

should also include rewards contingent on prosocial behavior relevant to the target behavior. The response-cost system will be clearer if the rewards are not the same as the revoked privileges. In this example, the preadolescent girl might receive a mark on a different area of the chart for each day that she expresses a problem or angry feeling to her parents without swearing. The reward for marks on this area of the chart should not be returned TV time, but might be a movie or some other desired activity. Again, these techniques should not be used by FFT therapists without prior establishment of family motivation and consideration of functional relationship needs.

Additional Intervention Strategies. In addition to providing communication and parent skill training, FFT interventionists prescribe specific activities and behaviors that will enhance the family's experience of positive change. In particular, interventionists utilize as many *technical aids* as possible. These technical aids include such simple items as sticky-type notes that can be put on mirrors to remind family members about a particular behavior, audiotape recordings of communication practice sessions that can be taken home for review, commercially available manuals on parenting, a wide range of similar free information provided by social service agencies, training in the use of answering machines to leave messages for family members, a schedule of reminder telephone calls made by a volunteer to families who need additional structure to change old behavior patterns, and so on. As programs have replicated FFT formally and informally, the various technical aids and props that have been adopted seem endless, and interventionists can become very creative in developing materials that are consistent with the particular needs, abilities, and resources of the specific population with whom they deal. Interventionists are reminded to be very creative and energetic with respect to providing specific and concrete resources for families as they enter the change process. Many interventionists send families (many of whom have only limited resources and few good work habits) out of sessions with no more than suggestions about how to change behavior. In contrast, FFT agencies often buy sticky-type notes and inexpensive audio cassettes to give to families to use between particular sessions, ask social service and educational agencies to forward pamphlets, etc.

In addition, FFT interventionists prescribe specific *interpersonal tasks*, often involving the technical aids. As has been discussed throughout, these interpersonal tasks (e.g., setting up a specific plan to supervise homework) must be tailored to the interpersonal needs and abilities of all family members involved. The following is a recent clinic example:

> *The mother was an accountant and the father a blue collar laborer, and they were intent on improving son's math performance which was several grades below his age. With respect to the parents' abilities, the mother was the clear choice to tutor; however, her interpersonal needs with respect to this son were quite a bit more distant/autonomous than were those of the stepfather. The son, in turn, seemed to have ambivalent (i.e., midpointing) needs with respect to both parents. Thus, the FFT therapist suggested that stepfather and son struggle with the math together, with stepfather consulting with the mother when necessary. This interpersonal task was certainly less efficient with respect to talent, but was much more consistent with the interpersonal need configuration the participants had with respect to each other. Note also that son's midpointing functions was respected in that stepfather and son would, in the beginning of the program, work for only 30 minutes together, stopping even if nothing had been accomplished. This allowed the son to have contact while maintaining autonomy. Over time, of course, successful experiences allowed both stepfather and son, and then mother, to increase positive contact time, as well as improve grades.*

This example once again demonstrates the "functional" nature of FFT; early behavior change targets are those that can provide success experiences, even if modest by others' standards. In the long run, FFT theory asserts that these successful experiences provide a basis for accelerated future change. In contrast, more impressive, but unrealistic, change goals, if promoted early in the Behavior Change Phase, are more often associated with failure, frustration, and decreased alliance. ***Thus, FFT works first to develop inner strength and self-efficacy in families, even if only modestly at first, in order to provide a platform for change and future functioning which can extend beyond the direct support of the interventionist and other social systems. In the long run, this FFT philosophy leads to more self sufficiency, fewer total treatment needs, and considerably less cost.***

The Generalization Phase

The FFT Therapist as "Family Manager." Families are entwined in a vast array of social eco-systems. FFT not only accepts and understands this fact but also incorporates specific principles which govern the inclusion as well as exclusion of these systems in the treatment planning process. Unlike generic treatment planning which wraps services around families and family members with little consideration of family dynamics, FFT focuses on each individual family's interpersonal and systemic needs when considering adjunctive support services. In addition, before ideas with good face validity are implemented to advance a treatment plan, it is necessary for a therapeutic alliance to exist for the family to view these ideas as valid, and the idea must be based in an understanding of the functional aspect of family behavior. For example, if job training for a sixteen-year old male is considered valuable in that it increases protective factors, supports emancipation, and provides necessary skill building, that adolescent's participation in such a program may or may not be supported by the mother if it replaces the father's role with his son and in doing so enables the father to further disengage from the family. Often, situations like this are associated with low support (e.g., mother becomes too busy or forgets to drive the son to the job training site on the third day). According to FFT, this sort of noncompliance is predictable if the son's previously disruptive behavior functioned to pull the father into parenting and, more importantly, into supporting the mother. If for this same mother, however, taking her son to the job training program is coupled with increased support and involvement from the father to the mother, then she will be very likely to facilitate the increased system involvement of the son with the job training.

During the Generalization Phase, the FFT Family Manager works from within the family system to promote change and then maintains that change with family specific support services and people. In doing so, the FFT Family Manager helps anchor the family and the family members to a larger supportive community.

Family Therapist as Family Manager—Interpersonal Characteristics. The characteristics of therapists who obtain the best outcomes are well documented in the FFT literature. When looking at what qualities are important for a therapist to have when he or she begins prescribing wrap around services or interfacing with community providers, organizations and groups, many of the same characteristics which produce good outcomes with families also produce good outcomes with these extended services, agencies and people.

- ***Theoretical Understanding of FFT.*** FFT requires that all therapists representing this model are well grounded in the theoretical tenets of FFT.
- ***An Absolute Willingness to Maintain Consistency of Therapeutic Focus.*** All interactions that the family or family members have with outside social systems are fair game for comment, support or modification, but always in terms of the unique characteristics and needs of each family member.
- ***Non-judgmentalness.*** FFT therapists are not judgmental and refrain from criticism. Family functions are the sacred property of the family, and an emotional attunement to them is a requisite for this work.
- ***Non-blamingness.*** FFT therapists are trained to look at behavior from a functional point of view, i.e., what does it accomplish. All behavior is an attempt to solve a problem. All problems are inherently life affirming as they are designed in service of need fulfillment. Therefore, individuals who are being a problem are not to be blamed.
- ***Humor, Warmth, and Acceptance.*** FFT therapists use reframing as a tool for change. Reframing requires taking the toxic element out of a communication and restating it in a more positive fashion. Often this stretches a family's belief system, and humor can bridge that understanding.
- ***Reasonable Intelligence.*** Reframing, managing many people at one time, understanding the goal and direction while having the ability to engage each individual in the family requires above average intelligence but it does not require superior intelligence. It is better to be sensitive than extremely smart, and better to have social skills than math skills.

All of these skills are necessary when interfacing with community gatekeepers, providers and organizations. There will also be a wide range of individuals with which the FFT Family Manager will have contact—relatives, neighbors, friends, Alcoholics Anonymous sponsors, members of the clergy, teachers, employers, former spouses, and even family pets are all eligible for inclusion into the Generalization Phase of FFT Family Therapy.

Specific Activity Requirements of the Family Manager

1. Know the community
    a. Current list of community providers
    b. Current list of community agencies
    c. Schedule of 12 step meetings
    d. Public transportation information
    e. Names, addresses, and phone numbers of community gatekeepers (e.g., probation officers and other juvenile court officials, school principals and administrators, mental health service providers)
    f. School district policies, procedures, and programs
    g. Knowledge of laws regarding juveniles
    h. Services available in the community
2. Develop contacts
    a. Social agencies such as Mental Health Services
    b. School district and specific schools

c. List of potential sponsors for 12 step programs
d. Physical Medicine support. Individual or group practice which can provide appropriate medication and detoxification services
e. Juvenile Probation Officer
f. Childrens' Protective Services
g. YMCA\YWCA or other youth recreational programs
h. Educational\vocational counseling service or contact person

3. Ethical Clinical Practices

a. Release of Information and informed consent
b. Exceptions or limits to confidentiality with informed consent
c. Knowledge of reporting laws for your state
d. Signed consent for the treatment of minors
e. Therapy contract with termination parameters
f. Development of treatment plan with family members

Contraindicated Activities for the Family Manager

1. Do not act as an agent for special interests.

2. Do not engage an adjunctive service without first understanding the impact this service may have on family functions. This aspect of FFT is unique and critical to successful long-term maintenance of the positive effects of intervention. Families may for a short while respond well to many forms of larger multisystem involvement, but for multisystemic changes to be maintained, the changes must be consistent with the intrafamily member-functions of behavior.

3. Do not force your agenda on families. Persuade, debate, plead, or nag but do not force.

4. Do not begin adjunctive services without having the full commitment and support of the community agency, provider, and the individual.

5. Do not fail to demonstrate to family how community services augment the treatment plan.

6. Do not forget to monitor the efficacy of the service.

Special Considerations for the Generalization Phase of Treatment

Multiproblem/Multiagency Involvement. Families referred for services with highly disruptive behavior problems and substance abuse issues fall within a range from relatively low risk, low intensity to high risk, high intensity. For those families in the severe or high risk end of the continuum it may be necessary to alter the course of treatment to account for complexity of presenting problems. This is especially true when issues of immediate danger and/or severe neglect are present. In such cases, it is necessary to reverse, in a sense, the Behavior Change Phase and the Generalization Phase. For example, consider the following case:

> *A single mother with boys ages 12 and 16 is referred to the local community mental health center by the Department of Childrens' Protective Services for suspected child*

neglect. The oldest son is currently on probation for possession of marijuana and residential burglary. The youngest son has been diagnosed as Attention Deficit Hyperactivity Disorder, Combined Type, and is currently on psychostimulant medication. Both boys are academic failures and most recently the 16-year old has been evaluated for Depressive Disorder, Not Otherwise Specified. There is collateral information to support the diagnosis of substance abuse for the 16-year old, and the 12-year old was recently suspended from school for substance use on school grounds. The mother is unemployed and currently on public assistance. It is alleged that she entertains men in her home, and there has been an earlier conviction for prostitution. Both boys report alcohol and drug abuse by their mother and that they routinely leave home when she "entertains." Both boys have previously been diagnosed as having a Conduct Disorder.

In this type of case, FFT begins the case management or Generalization Phase of treatment before initiating the Behavior Change Phase of intervention. The family therapist will at this time begin case management and treatment planning services with the respective social service agencies involved with this family. The family will be expected to participate in this process, including the various legal entanglements, and they will be more likely to do so because the FFT interventionist will already have done the requisite Engagement and Motivation Phase activities (described above). The therapist's focus can then be on:

- Organizing the service providers into a treatment planning team, often including Probation Officer, Mental Health Case Manager, Social Service Case Manager, School Psychologist, and Attending Psychiatrist(s)
- Clarifying family functions, especially as they relate to extrafamily involvements
- Identifying with the treatment team and the family appropriate adjunctive services; organizing treatment team members and services around family functions
- Assigning tasks and developing a reporting system
- Identifying individual needs
- Identifying areas of potential splitting and communication breakdown

After this task is completed the FFT interventionist can proceed with the Behavior Change Phase of treatment while continuing to provide oversight of the treatment planning process. As the family behaviors toward each other begin to change in a positive manner, the FFT interventionist can begin to terminate her/his role in the treatment. This process shortens the time in treatment, effectively mobilizes resources, and greatly enhances the treatment effect.

Developmental Considerations. Although FFT does not generally alter functions or attempt to restructure them, it is sometimes necessary to attach functions to different subsystems within the family in order to meet a developmental need of the family. For example, when the substance abuse problems of a 17-year old son have recruited mother into an overly enmeshed relationship with her son, thereby functioning to serve her closeness needs and father's distance needs but impeding son's healthy emancipation, it is necessary to help the family reattach those functions to another subsystem in order to facilitate the sobriety and emancipation of the son. First, by fostering a relationship between the mother and an Alanon Sponsor, for example, and later by re-engaging the husband-wife subsystem, the interdependency (closeness) function for the enmeshed mother can be separated from her son's behavior, and anchored in appropriate adult subsystems as a more adaptive alternative. This allows the son to begin appropriate emancipation work while preparing the family

for his inevitable departure. Failure to do this would leave the family ill prepared for this developmental step and risk regression in the treatment trajectory. It is important to note, however, that this sort of realignment process cannot take place until after positive change has begun, and the functional needs which were first identified have been integrated into the treatment plan.

Conjoint Case Management. In today's world of managed care the emphasis on cost savings has required service providers to rethink the ways in which service is delivered. A cost savings strategy which can be highly effective is to include a case manager, who is not the FFT interventionist, into the Generalization Phase of treatment. By including a case manager into the final sessions with the family, an FFT interventionist can oversee the Generalization Phase and ensure that case management services are in service of family functions. The family and the new case manager can develop their working relationship, agree on a course of action and begin identifying appropriate wrap around services. This greatly enhances the generalizability of the treatment and anchors the family in appropriate community-based services. The cost for this service is considerably less than if the FFT interventionist were to be solely responsible for this phase of treatment.

Summary of Generalization Phase. FFT extends or exports family functioning into a variety of community systems, which helps the family as well as the community. It is our belief that adjunctive services must be developed in order for the treatment effect to generalize. We also believe that if this is done without looking to the family functions for guidance that these efforts will fail. The FFT Family Manager works from within the family system to promote change and then maintains that change with family specific support services and people. In doing so, the FFT Family Manager helps anchor the family and the family members to a larger supportive community.

At the same time, successful intervention cannot begin with this phase of intervention. To simply wrap services around a family or family member without considering the impact on family functioning is to risk destabilizing the already precarious family process. Thus, the accomplishments of the Generalization Phase are predicated on successful handling of therapist-family *core therapy processes* described above and once again summarized below.

Review of the Flow of Intervention

Functional Family Therapy is a multisystemic, multitechnique, multilevel, and multiphase intervention approach which requires a clear overview and sense of where the therapist and family members are with respect to each other and the requisite stages and core requirements for positive therapeutic change. Many of the families seen by FFT therapists are experiencing multiple system stresses (such as unemployment or working poor status, justice system interventions, family disruptions in many forms, and intense negativity from within and without). Without a clear framework within which to operate, interventionists can become overwhelmed, and if so, even the availability of multiple resources will not be able to overcome inconsistent and sometimes even contradictory delivery of services. The FFT framework provides the necessary clear framework, organizing into identifiable yet still interconnected segments the different tasks that are required to help families change.

The following table, Anatomy of Intervention (Table 4), represents information which is redundant with the basic elements of FFT already described, but is provided to further elucidate the contextual, integrated, and sequential flow of FFT. In addition, it can represent an excellent tool or checklist for use by therapists, supervisors, and evaluators to monitor adherence to the FFT protocol.

Table 4. The Anatomy of the Functional Family Therapy Intervention Model

COMPONENTS OF INTERVENTION					
THERAPIST DIMENSIONS	Engagement	Assessment	Motivation	Behavior Change	Generalization and Termination
Goals	Maximize family's initial expectation of positive change	Understand family parameters and potential for change	Create motivational context for long-term change	Institute individual & interactive change programs	Maintain change & facilitate independence
Central Tasks	Appear appropriate & credible to family members	Elicit, structure, & analyze information, develop plans	Use interpersonal sensitivity to impact negativity	Structure and monitor performance in & outside sessions	Facilitate generalization of change into future
Attributes and Skills	Superficial qualities that reflect expertise	Intelligence, perceptiveness, & conceptual model	Relationship/ interpersonal skills	Structuring/ teaching skills	Multisystemic perspective & skills
Representative Activities	If possible, present stimulus qualities that this particular family will see as appropriate (e.g., type & location of treatment center, clothing, office trappings, therapist appearance)	Identify the extrafamily & intrafamily context and function of problematic and adaptive patterns, including stressors, support, constraints, and family value systems. Evaluate resistance & cooperative responses	Modify adverse reactions to therapist. Provide rationale for treatment techniques. Change meaning & attribution, usually emphasizing the positive (e.g., reframe & relabel)	Provide directives & apply behavior change techniques (e.g., communication training, relaxation tasks). Modify antecedents & consequences, describe and model appropriate interactive behaviors	Insure attainment of spontaneous & adaptive family processes & problem solving styles, as well as problem cessation. Anticipate future & extra-family stresses and intervene if necessary

Planning and Implementation

Needs Assessment

Since FFT focuses primarily on youth at risk for institutionalization, FFT is very suitable to implement in a community or agency which has as its emphasis a reduction in institutionalization, either incarceration or foster care. FFT intervention techniques focus on family communication skills and effective parenting techniques, and has developed specific approaches to multiproblem families and youth who experience low motivation, high negativity, and little initial hope for change. Hence, it would be most appropriate for communities which have assessed poor family relationships and negative parenting practices as risk factors to consider implementing FFT.

Interagency Linkages and Collaboration

FFT therapists maintain contacts with all persons or agencies with a vested interest in the youth undergoing treatment (e.g., clergy, teachers and school administrators, employers). The linkages may differ depending upon the setting in which services are delivered and the population targeted. For instance, for court-mandated referrals, frequent contacts with the juvenile court administrator and probation officer ensure strong juvenile court support of the therapy. During the Generalization Phase of treatment, contacts with outside agencies are important in anchoring the family to a larger supportive community. This makes it important for the therapist to have extensive knowledge of community providers.

Funding and Program Costs

FFT is a low cost treatment that can be administered by lower cost professionals. Recent analyses of two ongoing FFT programs and their available alternatives demonstrate FFT 90-day program costs of $3,750 per family (Willow Run, Michigan, program) and $1,350 per family (Clark County, Las Vegas Juvenile Court program); on a per diem basis these costs are $41 and $15 per day respectively, and cover an average of 12 home visits per family. The cost savings resulting from this treatment are profound and dramatic, especially as they prevent institutionalization and residential treatment. Comparable costs for a 90 day stay at a court program or a residential treatment program in Michigan are $13,500 ($150 per day); these figures go as high as $660 per day for hospitalization in a psychiatric treatment facility. In turn, comparative costs for youth placed in residential treatment in the Clark County program range between $160 and $220 per day, over ten times the daily costs of the in-home FFT program.

Resources Necessary

The primary resource integral to implementing FFT includes therapists who are trained and well-grounded in the theoretical tenets of the FFT model. Since FFT has demonstrated efficacy in home-based as well as clinic based programs, the only other requisite resources are therapist characteristics that include relationship and teaching skills, multicultural sensitivity, and persistance. In order to add direct monitoring of program integrity and direct clinical supervision, it is necessary to have clinic rooms which are large enough to accommodate families, as well as videotaping/audiotaping equipment. In home-based programs where traditional approaches to training, supervision, and monitoring has been difficult, FFT has relied on audiotape recording and the use of intervention teams wherein a senior FFT therapist is paired with a trainee, and home visits are "processed" immediately after the visits. Therapists can also be provided Progress Note forms and Final Case Evaluation Forms (see Appendix B) in order to maintain constant monitoring.

Staffing and Supervision

FFT has been implemented with a variety of service providers, including graduate student therapists, undergraduate students in psychology, and experienced and credentialed social workers, and marriage and family therapists.

Therapists may be part-time or full-time and should be supervised by an FFT supervisor who should be at least a Master's level therapist. Full-time therapists work with caseloads normally averaging 12-16 "active" cases at any given time. Because FFT moves so effectively through intervention phases, full-time FFT therapists can average 150 cases per year. An FFT supervisor should manage no more than five therapists.

The characteristics of successful FFT therapists were described earlier. They include a thorough understanding of the FFT model, willingness to maintain therapeutic focus, non-judgmentalness, non-blamingness, reasonable intelligence, humor, warmth, acceptance, and the ability to structure.

Training of Staff

Minimum training to be an approved FFT-trained site generally consists of an initial two to three day workshop with mostly didactic information presented. The agency should then arrange at least one on-site follow-up training/consultation by an approved trainer within a year of initial training,

involving a minimum of a three hour group meeting and one hour of one-on-one consultation with each interventionist (the duration of the follow-up will depend on the size of the staff). The follow-up can include, if desired, review of case notes and recordings. Finally, during that same time frame each intervention staff must experience two separate 45-50 minute telephone consultations.

To continue as an approved FFT site, the agency must arrange for at least one follow-up on-site training annually (as defined above), plus at least one telephone consultation per already trained staff. The agency must arrange with their FFT contact person/trainer how to institute new training with staff additions as they join the program.

Initial training cost is $2,600 plus expenses for the three-day workshop. The follow-up training costs include expenses plus $1,200 for one day, $2,000 for two days, and $2,600 for three days, if necessary. Telephone consultation costs are $75 per hour.

Recruitment/Selection of Target Population and Retention Strategies

FFT has been implemented among diverse populations including conduct disordered/oppositional youth, pre-delinquents (at-risk for delinquency), court-mandated referrals, and chronic delinquents released from state institutions. Substance use/abuse has been prevalent in roughly 80 percent of the treated youth across 28 years of program application. Retention of youth and families is a major focus of treatment. The Engagement and Motivation Phases are specifically geared to decrease resistance to treatment and increase hope and expectation of change. This is accomplished by changing the meaning of behaviors (primarily through various forms of reframing and introducing themes), by showing respect to the family, by making them feel comfortable (e.g., appropriate dress, gender and ethnic matches, when possible), and by helping them feel in control of the intervention process, all of which help families to experience a reduction in negativity (e.g., anger, blaming, and hopelessness) and increase therapeutic alliance. Decreasing such negativity and creating a respectful alliance in the early phases of treatment help families to make a realistic commitment to change.

Setting

During its 28 year history, FFT has been implemented in a variety of contexts including a mental health setting, a family and youth services agency, a family preservation program, a family outreach center, and within the juvenile justice system.

FFT can be delivered in a clinical setting or in the home. Its effectiveness has been demonstrated in both settings. Replications have determined that the no-show rate is higher in the office than in the home. When there is an option for where the sessions will be delivered, the decision regarding the location is made by both the client and the therapist, taking into account the family's comfort level, transportation issues, therapist's schedule/availability, and safety issues.

Sequence of Intervention Activities

FFT identifies specific phases: Engagement, Assessment, Motivation, Behavior Change, and Generalization. Each phase has specific goals, therapy techniques, and activities necessary to facilitate movement into the next phase. These have been described above. Table 5 provides the sequence of FFT intervention.

Table 5. The Sequence of Functional Family Therapy Intervention

Session 1	• Establish relationship with family • Initiate Motivation (therapy) Phase and, simultaneously, • Begin assessment • End Session with assignment of simple tasks and reschedule soon
Between Sessions 1 and 2 (Done in weekly supervision meetings)	• Review each family member's behavior, feelings, & beliefs • Identify unclear relationships • Identify resistance patterns • Hypothesize functions for each family member • Plan specific techniques to complete assessment • Plan specific therapeutic interventions based on the above
Session 2	• Repeat techniques of Session 1 in order to clarify areas of confusion • Continue assessment • Hopefully complete Motivation Phase goals • Assign tasks and reschedule soon
Between Session 2 and 3 (Done in weekly supervision meetings)	• Develop intermediate and long term change goals that will allow each member to remain within their preferred interpersonal functional range but change the family patterns around their functions • Review and develop specific behavior change & educational techniques that produce intermediate and long term goals
Middle Phases	• Apply Behavior Change technology • Resistance is feedback that one or more family members' functions have not been met—must return to Motivation & Assessment • Look for matching-to-sample with steadily decreasing assistance from therapist
Later Phases	• Differentiate subsystems • Interface with extrafamilial systems to enhance temporal and setting generalizability of positive intrafamily changes • Evaluate quality of life issues and plan for future, if family members want to change functions at this point
Termination	• Problem cessation—verbal report and observed • Spontaneous family process • Mutual payoff of new interaction styles and attributions for all family members

Changes/Modifications

The core program elements (i.e., adherence to the five phases) has remained constant in FFT. Over its 28-year history, FFT has undergone several minor modifications, however. One modification has been the provision of in-home services. FFT has been evaluated and found to be effective when implemented both at home and in a clinic setting. Another modification, which has been evaluated and found effective, has been to use trained paraprofessionals rather than licensed clinicians or professional social workers to implement FFT. As youth populations have become more "difficult"

(greater violence, more multiproblem families with fewer resources), FFT has placed increasing emphasis on multisystem involvement during the Generalization Phase and developed the model of the "FFT Therapist as Family Case Manager."

Implementation Problems

FFT has been successfully replicated with diverse populations in a variety of contexts, with a number of different replication issues that emerged in each setting.

In one mental health setting, state licensure laws imposed restrictions on supervisors' license requirements. These requirements were independent of FFT in particular, but such situations can occur as FFT or any other program, is instituted in agencies that have state licensing oversite relationships. Another issue that arose in this site, as well as in others, was the resistance of some therapists to implement a model which focused on behavioral change strategies. Some therapists are concerned about "prescribing and manipulating" behavior. These problems can be addressed by carefully selecting clinicians who are conceptually in line with FFT and vested in the model.

Some difficulties have been experienced when therapists come from widely varying backgrounds and experience levels. The lack of a common knowledge base and skill base makes supervision more difficult.

Therapists who work within a correctional juvenile justice setting often encounter problems when dealing with the negative and punitive mindset of many of the staff in the correctional system. Open lines of communication are important when two philosophically different ideas come into contact. Confidentiality has also been a difficult issue faced by therapists working within a juvenile justice setting. Maintaining a working relationship with Probation staff, who wanted to be privy to confidential information about their youth, while maintaining a trusting relationship with these youth and their families was difficult. The best answer came through the establishment of a good, solid, therapeutic model and the committed, hard work of staff.

There were logistical challenges such as clinic rooms not being large enough to accommodate families, and resistance by staff and security officers toward staying after hours. Videotaping was problematic in that equipment wasn't always available, and when a videotape observation suite was constructed, families and clinicians found it to be a sparse, uncomfortable room with glaring lights. Selecting staff who consider the program more than just a job as well as providing incentives such as time off on another day for extra hours will increase the likelihood staff and security officers will stay after hours when needed. Care must be taken in constructing clinic rooms that have enough space and are warm and comfortable.

One site struggled with having a sufficient client base. In this case, treatment was offered in a university setting in the context of a research project, where links to community agencies were not well-established. This has not been a problem in other replications. Many replications have begun work with a specified referral base and, over time, have grown to receive referrals from many other departments. This has occurred as the reputation and success of FFT becomes known within a department or system.

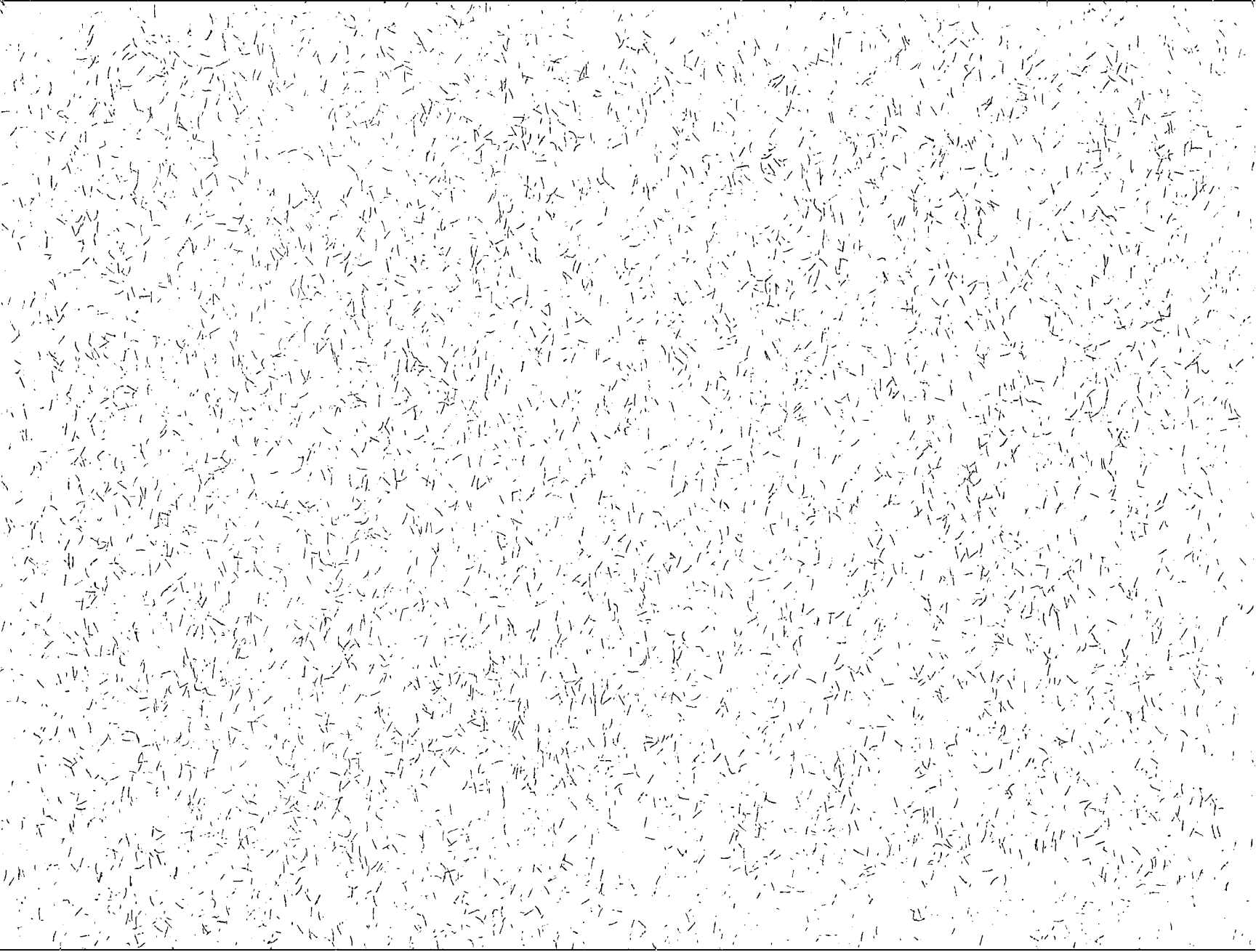
There were also difficulties with population differences in the replication for adolescent substance abusers. While equal numbers of telephone calls were received from White and Hispanic/Latino

clients interested in the program, nearly half of all Hispanic/Latinos who scheduled appointments did not complete the assessment process. Once families completed the assessment, no treatment engagement differences for Whites and Hispanic/Latinos were observed. Within the research literature, similar ethnic differences have been found with respect to treatment utilization. Research has suggested that these differences in completion of the assessment process may be due to practical problems such as transportation and child care, which can be addressed by FFT staff.

Monitoring Implementation and Treatment Integrity

Therapists often audiotape their sessions as well as complete process forms on each family after each session. These are used in weekly supervision meetings with the therapist or with the treatment team. In many cases, these are sent to one of the FFT certified trainers to review prior to his follow-up consultation visits with the staff. Follow-up consultation visits are also videotaped to be used in future training. These consultation visits review family therapeutic processes as well as therapist techniques and processes employed in FFT. As stated earlier, Appendix B provides examples of materials for monitoring treatment sessions.

CHAPTER THREE
Evaluation



EVALUATION

Overview

Multiple field tests demonstrate FFT can be administered by a wide range of licensed professionals and paraprofessionals with equally robust outcomes. Multicultural and multiethnic in its approach, the efficacy of FFT is supported by 26 years of rigorous investigation (nationally and internationally) and has demonstrated superior results with difficult to treat adolescents and their families in a wide range of settings and delivery sites. Tests of effectiveness routinely demonstrate reduced rates in criminal behavior, recidivism, reinstitutionalization, and attendant behavior patterns such as substance abuse and conduct disorder. Due to the emphasis placed on engagement and retention by FFT, this program historically experiences low drop out rates and high completion rates.

The outcomes from the controlled, empirical clinical trials and field tests, plus additional replications, have demonstrated that FFT is capable of:

- Effectively treating adolescents with the entire range of Disruptive Behavior Disorders
- Interrupting the matriculation of these adolescents into more restrictive, higher cost services
- Reducing the access and penetration of other social services by these adolescents
- Preventing further incidence of the presenting problem
- Preventing younger children in the family from penetrating the system of care
- Preventing adolescents from penetrating the adult criminal justice system
- Effectively transferring treatment effects across treatment systems

The following table (Table 6) describes the published studies that have evaluated FFT outcomes. Some of these studies have represented well-controlled investigations with random assignment to treatment conditions, some have involved matched but not randomly assigned comparison groups, and some have compared outcomes for families treated by FFT with base rates for that population. Appendix C contains greater detail about each of these studies. Additional replications of FFT are described in a later section; they are not contained in the following table because they have yet to produce independently evaluated (e.g., journal) publications. However, they already have provided important information about implementing FFT in a range of new treatment contexts, new and multicultural populations, and with an increasingly varied cadre of intervention specialists.

Table 6. Summary of Evaluation Results

Location	Subjects	Comparison/ Control Group	Assignment Procedure	Follow-up Period	Risk/Protective Factors	Outcome	Reference
Salt Lake City, UT	40 delinquents arrested and detained for run away, ungovernable, or habitually truant 13-16 yrs. old	4 groups (10 family therapy + individual therapy (FT+IT); 10 family therapy only (FT); 10 individual therapy only (IT); 10 control with minimum attention from probation officer (CG)	random	10 Weeks	Reduce negativity, enhance positive communication, improve parent-child process	**Risk/protective process:** Family therapy and family therapy plus individual therapy produced significantly greater improvements in communication style than other conditions.	Alexander, 1971 See also Alexander & Barton 1976, 1980
Salt Lake City, UT	99 delinquents arrested and detained for run away, declared ungovernable, or habitually truant 13-16 yrs. old	4 groups: 46 short term behavior therapy (FFT); 19 client centered family therapy; 11 eclectic psychodynamic family therapy; 10 non-treatment control group; 46 post hoc selected controls; 2800 countywide	random	6-18 mos.	Reduce negativity, enhance positive communication, improve parent-child process	**Recidivism:** FFT recidivism was 26%, compared to 50% for no-treatment controls, 47% for client-centered family groups, and 73% for eclectic psychodynamic family therapy. Risk/protective process: FFT produced significant improvements in family interactions compared to all other comparison conditions.	Alexander & Parsons, 1973
Salt Lake City, UT	40 families Mean age 14.1	3 groups: 20 FFT, 10 client centered family therapy , 10 no treatment control	random	treatment termination	Reduce negativity, enhance positive communication, improve parent-child process	**Risk/protective process:** FFT families displayed significant changes in interactions. No improvements in controls.	Parsons & Alexander, 1973; Alexander & Barton, 1976; 1980
Salt Lake City, UT	27 status offender delinquents (referred for 3-6 status offenses: soft drug use, shoplifting, ungovernable status, or chronic school difficulties)	District base rates	n/a	13 mos.	Reduce negativity, enhance positive communication, improve parent-child process	**Recidivism:** 26% for the FFT group, compared to the 51% population base rate Risk/protective process: Significant reductions in family defensiveness	Barton, Alexander, Waldron, Turner & Warburton, 1985; Study 1

Table 6. Summary of Evaluation Results (continued)

Location	Subjects	Comparison/ Control Group	Assignment Procedure	Follow-up Period	Risk/Protective Factors	Outcome	Reference
Salt Lake City, UT	325 status delinquents at risk for out-of-home placement	2 groups: 109 assigned to FFT trained therapists; 216 assigned to social workers with traditional training	non-random: assigned based on availability	treatment termination	Reduce negativity, enhance positive communication, improve parent-child process	Reduction in foster care placement referrals FFT (11%) versus non-FFT (49%) Reduction in units of service per family to less than half (14.7 - 6.2)	Barton, Alexander, Waldron, Turner & Warburton, 1985; Study 2
Salt Lake City, UT	74 seriously delinquent adolescents who had been incarcerated for serious and repeated offenses (average of 20 adjudicated offenses)	2 groups: 30 FFT; 44 alternative treatment	non-random	15 mos.	Reduce negativity, enhance positive communication, improve parent-child process	**Recidivism**: 60% for the FFT group, 93% for those who received regular services. Those in the FFT group who did reoffend did so at a lower rate/frequency than those in the regular services group (.202 vs. .474).	Barton, Alexander, Waldron, Turner & Warburton, 1985; Study 3
Salt Lake City, UT	Siblings in families of 99 delinquent adolescents referred for soft offenses.	4 groups: 46 FFT; 19 client centered family therapy; 11 eclectic-psychodynamic family therapy; 10 no treatment controls	random	30-40 mos.	Reduce negativity, enhance positive communication, improve parent-child process	**Recidivism** in siblings of those who had received FFT was 20%, compared to 40% for no-treatment controls, 59% for client-centered family treatment, and 63% for eclectic-dynamic family treatment	Klein, Alexander, & Parsons, 1977
Philadelphia, PA	166 drug abusing adolescents 89% White Mean age: 17.8	2 groups: 91 FFT; 75 parent group	random	> 15 mos.	Self esteem, symptomatology, communication, relationship quality, etc.	FFT produced greater involvement of parents , lower family dropout rate	Friedman, 1989
Lafayette, IN	55 adolescents diagnosed with ADHD, referred to child protective services	3 groups: FFT, group therapy, no treatment control	random	pre-post (end of treatment)	family concept, ADHD behaviors at home and school	FFT and group therapy produced significant improvements in ADHD behaviors at home and at school, but only FFT also led to positive increases in family concept	Regas & Sprenkle, 1982

Table 6. Summary of Evaluation Results (continued)

Location	Subjects	Comparison/ Control Group	Assignment Procedure	Follow-up Period	Risk/Protective Factors	Outcome	Reference
Ohio	54 rural , lower SES delinquents (misdemeanors and felonies), and status offenders (e.g., habitual truancy, petty theft, vandalism) Mean age 15.4	2 groups: 27 FFT, 27 probation services as usual	non-random but matched, more severe assigned to FFT group	2-1/2 years and a 5 year follow-up of adult convictions	Improve communication, positive parenting	**Recidivism:** At 2 1/2 year follow-up, the FFT group had 11% recidivism compared to 67% in the regular services group. At 5 year follow-up, the FFT group had 8.7% recidivism compared to 41% in the regular services group. Note: a cost-benefit analysis on these groups indicated that FFT had significantly lower direct costs than treatment as usual.	Gordon, 1995 Study 1 See also: Gordon, Arbuthnot, Gustafson, & McGreen, 1988; Gustafson, Gordon, & Arbuthnot, 1985; Gordon, Graves, & Arbuthnot, 1995.
Ohio	17 & 18 year old chronic offenders with an average of 3 to 4 prior institutional commitments	40 FFT subjects; statistical control with data used to determine risk of recidivating based on age of onset, number of offenses, and age at referral	n/a	1 1/2 years	Improve communication, positive parenting	**Recidivism:** the FFT group had 30% with a new conviction after treatment, (compared to 60-75% average expected) and 12% with a new institutional committment (compared to 50-60% average expected)	Gordon, 1995 Study 2 See also: Gordon & Arbuthnot, 1988
Ohio	16 & 17 yr old delinquents, upon release from institution for juvenile offenders	2 groups: 27 FFT; 25 regular probation services	non-random but matched	16 mos.	Improve communication, positive parenting	**Recidivism:** the FFT group had a 33% rate, compared to 64% in the services as usual group	Gordon, 1995 Study 3
Salt Lake City, UT	46 delinquents	2 groups: 22 FFT; 24 alternative treatment	random	treatment termination	Reduce negativity, enhance positive communication, improve parent-child process	**Recidivism:** 50% in the FFT group and 88% in the control group Out-of-home placement: 18% in the FFT group and 72% in the control group	Lantz, 1982
Lund, Sweden	95 adolescents referred following arrest for serious offenses	2 groups: 45 FFT; 50 services as usual (social work)	random	2 years	Reduce negativity, enhance positive communication, improve parent-child and overall family process, improve parental mental health problems	**Recidivism:** 50% in the FFT group, 80% in the control group Risk/protective process: reduced maternal depression, somatization, and anxiety in FFT group.	Hannson, 1998

Summary of Outcome Studies and Replications: What We Have Learned Thus Far

The original FFT outcome studies, conducted at the University of Utah, provide scientifically sound data that demonstrate the efficacy of the model. Subsequent studies performed elsewhere have enhanced the impressive picture of FFT treatment effectiveness. Taken together, the combination of formal outcome studies and other replications have provided remarkable consistency with respect to FFT across populations, treatment sites, and years. In the 11 studies (spanning 1973-1997) that have included matched and/or randomly assigned control/comparison groups, representing an extremely wide variety of alternative programs (16 total comparisons), FFT has produced reductions in recidivism, out-of-home placement, or subsequent sibling referral of at least 25 percent, and as much as 55 percent (average = 34.6 percent). These studies have included some follow-up periods of one, two, or three years, with one study involving a five year follow-up period (arrest rate as adults for FFT treated youth = 9 percent compared to a 41 percent rate for alternative treatment; Gordon, 1995).

Some particularly intriguing findings emerged from the outcome studies. For example, it was demonstrated that the model can be effectively delivered by people without graduate level education. FFT also was demonstrated to prevent the development of conduct problems in the siblings of target adolescents. Additionally, real-world therapists who were compared before and after FFT training experienced significant reductions in the percentage of cases they referred to foster care after training. The outcome studies also included initial measurements of the family processes targeted by FFT, processes that differentiate families with an acting-out adolescent from those without. Much of the more recent research at the University of Utah has been focused on the identification and study of the specific therapist characteristics, family characteristics, and in-session behaviors that are linked to changes in family process during early sessions of FFT.

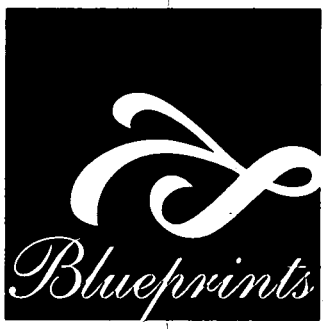
FFT has now been implemented at a number of sites outside Utah by a number of different replicators. The characteristics of the replication sites vary widely, and it is a testament both to the structure and flexibility of the model that it has been well received and utilized by such diverse organizations (including University programs, community mental health centers, and integrated state/private sector programs such as Family Preservation). Many of the replications represent collaborative efforts between two or more agencies (e.g., juvenile courts and universities). All replication efforts have indicated that FFT can be learned through a two to three day training workshop, as long as adequate follow-up consultations and supervision commensurate with training level are provided.

Additional clinical trials, from which data are not yet available, are being conducted in New Mexico and University of Nevada at Las Vegas. In the first of four replications in Sweden, FFT demonstrated a 30 percent reduction in recidivism. For many other replication sites, described below, indices of the utility of the model aren't available in the traditional, scientific form (for example, service providers often simply can't run control groups), but take the form of descriptions of effectiveness that are clinically compelling. Findings that FFT appears to reduce the number of sessions needed in a course of treatment, results in a 90 percent retention rate for families with severe youth, an 86.5 percent success rate in family preservation, and is well-liked by recipient families are important to therapists and administrators.

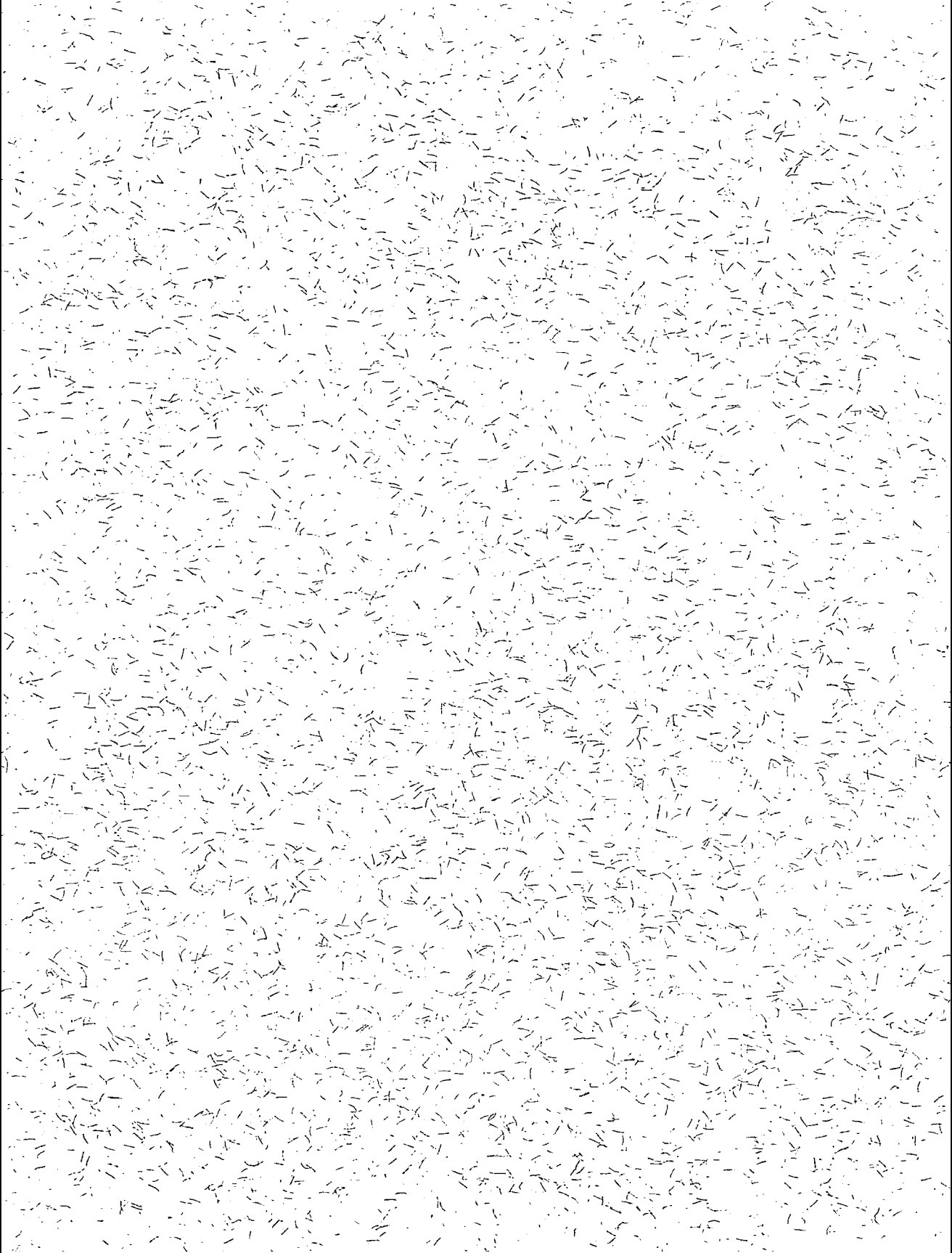
The replications have also provided additional information about FFT's generalizability beyond the populations included in the original studies. The model has now been applied to populations varying

from rural Appalachian adolescents to those living in major urban centers. Families of White, African American, Hispanic/Latino, Asian American, Native American, and combined heritage have participated in Functional Family Therapy, as have families in Sweden. The data available thus far indicate that there are no differences in recidivism rate based on race/ethnicity of clients or therapists. The replications have provided indications of the viability, effectiveness, and efficacy of FFT applied in clients' homes, and with a wide range of family constellations. Replications have been conducted with youth with presenting problems ranging from the early behavioral indicators of delinquency (prevention level) to serious, chronic crimes. What becomes clear from surveying the replications, in all their complexity and diversity, is that the Functional Family Therapy model provides both the structure (in the form of the Analysis of Intervention model and techniques) and the flexibility (techniques tailored and sensitively applied based on the characteristics of each family) necessary to provide effective therapy to widely varying populations.

The replications have provided some important insights into issues that should be considered in implementing FFT in service agencies. It is clear from the replications, and probably obvious to most administrators, that the staff that will be utilizing the model should be approached with the same sensitivity and respect as client families. At the heart of the model is a non-blaming, respectful, sensitive, and non-punitive philosophy, and it is difficult for therapists who feel threatened or coerced in their jobs to take this stance with clients. A related point is that it must be feasible for staff to adhere to the FFT philosophy, sometimes referred to as fearless empathy, with the populations that will be served by the agency. In one site implementing FFT, difficulties were encountered with session attendance when inner-city clients were asked to attend sessions at a University clinic, and therapists were reluctant to go to clients' neighborhoods to provide in-home services. The graduate student therapists undoubtedly had legitimate concerns. Regardless, sensitivity, respect, and empathy were able to overcome the clinical constraints that so often interfere with alliance formation and retention in treatment. In particular, the Las Vegas Family and Youth Services (Clark County Juvenile Court) site has taught us that with many families in severely disadvantaged contexts it is important to very clearly acknowledge the severity of the offenses and living conditions, but then provide the reframes and themes that generate hope and alliance. This then must be followed by individualized, family sensitive behavior change procedures, and Family Case Management that builds upon, not replaces, the initial family work.



CHAPTER FOUR
Program Replication



PROGRAM REPLICATION

Overview

Functional Family Therapy has been replicated by different investigators upon diverse populations. In particular, the following report includes written contributions by *Cole Barton*, Davidson College, North Carolina; *Don Gordon*, Ohio University; *Rich Harrison*, Clark County Family and Youth Services in Las Vegas, Nevada; *Susan Mears*, Family Preservation in Las Vegas; *Stewart Schulman*, Francis O'Brien Center for Youth Development in Ann Arbor, Michigan; *Tom Sexton*, University of Nevada at Las Vegas; *Holly Waldron*, University of New Mexico; *Kjell Hansson* in Lund and Växjö, Sweden. These investigators provide accounts of their experiences conducting replications of Functional Family Therapy within the following contexts: (1) a mental health setting in a military community; (2) court-mandated youth referrals; (3) a family and youth services agency; (4) a family preservation program; (5) a family outreach center; (6) within a collaborative partnership of employer-agency-university; (7) adolescent substance abusers; and (8) adjudicated youth in Sweden.

Note that some of these replications involve published data, and are therefore described in Table 6 and Appendix B. What is described in this section are the less formal aspects of the replications involving implementation issues. This sort of information is rarely available in scientific outlets, but is essential for program replication.

Program Replication in a Mental Health Setting

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Introduction

The following describes two replications of Functional Family Therapy in Fayetteville, North Carolina. The motivations for implementing Functional Family Therapy (FFT) were prompted by the training needs of the agencies described, and any support for empirical scrutiny or conceptual development of the model was, at best, secondary to the principal missions of cost-effective training and service delivery. These replications took place over an eight to nine year period. In the first, a classically trained Boulder Model clinical psychologist selected FFT to be implemented with conduct disordered/oppositional youth. This first replication was a series of one-year contracts, taking place over a three year period. Two years after this initial replication, key administrators and many of the clinicians in the original public mental health center were recruited to participate in a demonstration project funded by the State of North Carolina and the United States Army. In this instance, FFT training was requested to enhance the skills of clinicians who had already shown a commitment to practicing family intervention models, and who had participated in a less structured and less ideologically driven training experience.

The community. Fayetteville, North Carolina, is a town of about 40 thousand in the sand hills country of North Carolina. The town's economy is based on tobacco farming, cotton mills, and Fort Bragg. The economy is oriented to the spending habits of a military community (sports logo wear, tattoos, guns, media entertainments, used cars). The population is about 60 percent White, 30 percent African American, and there is a clinically visible population of approximately 10 percent Lumbee Indians.

Specific Challenges to FFT Training Encountered During the Fayetteville Replications

- In North Carolina, masters' level psychologists and social workers must be supervised by licensed Ph.D.s. Training has the potential to threaten existing clinician supervisors; a supervision model may therefore not only threaten someone's professional role, but may be a credentialing issue.
- FFT has a behavioral specificity associated with it, requiring some conceptual discipline which challenged some clinicians both conceptually and pragmatically. Some therapists resist the detail and attention associated with implementing behavior change technologies. Therapists with humanistic leanings get concerned about "prescribing and manipulating" behavior. Other therapists do not like to assume the accountability associated with behaviorally specific session process or clinical outcome.
- The clinical demands of performing FFT demanded more therapist accountability and sustained commitment to accommodating families than several traditional models. With respect to what might be labeled "countertransference" issues, some psychotherapists have either a conceptual or affective resistance to taking on the clinical responsibility demanded by the model. Some therapists maintain a seemingly ideological distance from taking on responsibility for managing or manipulating perceptions, as a humanist might. Some therapists seem

"dug in" on rhetorical or political issues that constrain them from the flexibility of clinical labeling or perceiving the "functional" properties of behavior called for in the model.

- There were vestiges of the "medical model" in these clinical settings. One of the corollaries of that model is that forms of treatment are tied directly to specific interventions. An implication of this corollary is that FFT was not always the treatment of choice in the agency, since clinicians were accustomed to treating a given modality with something else. In these circumstances it is necessary to accommodate both a competing etiology, and/or broaden the treatment plan to engage FFT as a system-enhancing intervention around the diagnostic label.
- There were some logistical challenges associated with FFT implementation:
  - Most clinic rooms were not large enough to accommodate families.
  - There was resistance from staff (and security officers) toward staying after hours, which was necessary to successfully convene families.
- The quality of supervisor-trainee issues became salient very quickly. Some clinicians did not embrace the model and didn't want to do it, but were afraid of their supervisor's sanctions if they did not appear invested. Some therapists tried to triangulate the supervisor with clinic administration. Some therapists brought clinical issues to supervision as challenges to the validity or utility of FFT.
- As in any clinical training enterprise, videotaping was an issue. Equipment was not readily available, and when a videotape observation suite was finally constructed, families and clinicians didn't like its overly open and sparse feel, nor the glaring overhead lights.
- Format tuning in videotape supervision was also an issue. Some therapists became angry when supervisor spent most of the hour on the first few minutes of tape, and didn't get to "the good stuff." Conversely, supervisors didn't have time to spend over an hour in tape review outside of supervision hour. The resolution was to have trainees identify and explain "clinical incidents" on the tape.
- Workshop experiences were not adequate to create credibility with some trainees. It was often necessary to debrief therapy sessions with clinicians who observed it. Many of the nuances of process were missed or misinterpreted by trainees who did not discern all the clinical moves in the videotape. Several trainees did not come to appreciate the value of the model and its potency until they got walked Socratically through some assessment epiphanies, got advice on relabels, and/or saw families respond. Many times the apprehensions of being observed will facilitate reluctant trainees' utilization of FFT advice, and certainly make it more salient. More sophistication from the staff means it is harder to earn their credibility and to create perceived expertise.

Lessons from the Fayetteville "Replications"

Before conducting an FFT replication, some important questions to consider are:

- Why is this model being brought to this agency, and who (besides the FFT group) wants it here? Powerful boss, and boss only? Staff with no clout or resources? People outside or inside the agency?
- Where does FFT fit in the service delivery profile of the agency? A supporting role? The conceptual centerpiece? The only model? How will it coexist with others?
- How do the demographics of the staff suggest enhancements or supplements for the model itself? How much indoctrination relative to supervision do they need? What are the incentives to sustain the impact of the training?

- What do I need to find out about the clinical profiles of the clients?
- How well can the system's policies and accountability accommodate training, supervision, and high "front end", lower "back end" cost-effectiveness of FFT?
- What are the outcomes, direct or indirect, that will accrue to differing constituencies with the replication?
- Are there any incentives for those involved for professional development or model packaging?

Program Replication for Court-Mandated Referrals and Addition of Interactive CD-ROM

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The following studies conducted by Don Gordon represent three independent replications at different sites (i.e., different populations, therapists, outcome measures, and follow-up periods). The youth served ranged in age from 15-18, 60 percent were male. The families' socioeconomic status was generally lower to lower-middle class.

First Replication: For outcome data refer to: Gordon, Arbuthnot, Gustafson, & McGreen (1988); and Gordon, Graves, & Arbuthnot (1995) in Table 6 and Appendix C

Graduate student therapists, largely novices to therapy, used the model with court-mandated referrals. The court served a rural, poor county. Therapists were supervised weekly on each case in group discussions, after the supervisor listened to audiotaped sessions. Resistant families received several additional months of therapy, and the supervisor optimistically focused on small improvements. The therapists and their supervisor frequently talked by telephone to the juvenile court administrator and probation officer about the families' participation in weekly in-home sessions. This ensured strong juvenile court support of the therapy. Occasionally, the probation officer would meet the therapists at the home for the first session to make introductions and differentiate roles (probation officer and therapist). After the first year, subsequent to the court's discovery of greatly increased savings to their foster care budget (due to FFT's success in keeping the delinquents in the home), court support and referrals increased to the maximum.

Principles for Dissemination. Regular contact between FFT supervisor and therapists with juvenile court administrator and probation officers, and close supervisor support for resistant families is important, as well as a prompt court to evaluate cost-effectiveness of program.

Second Replication: For outcome data refer to Gordon (1995) in Table 6 and Appendix C

The juvenile court in Delaware County, a community outside Columbus, Ohio, hired part-time workers to conduct FFT in the homes of chronic delinquents just released from a state institution. The Court was advised on qualities these workers-trainees should have. Workshop training was provided, followed by weekly phone supervision after listening to parts of each trainee's audiotapes of family sessions. On-site trainees met weekly for support and brainstorming, with the most advanced trainee serving as the group facilitator (this replaced direct supervision). Three to four times per year, booster workshops were provided on issues of interest to the trainees. This court-run program has expanded to serve more delinquents, including lower risk youth.

Principles for Dissemination. Repeat workshops, in addition to regular phone supervision over the course of the first few years helped maintain FFT integrity, group cohesion, and supervisor-trainee relationships. Several meetings with the court administrator helped insure upper-level support (he worked hard every year to get outside grant support for the FFT program). The FFT supervisor should be involved in the selection of trainees for FFT. Local support for trainees should include an

on-site supervisor and weekly team meetings to brainstorm tough cases, and an advanced or specially skilled trainee, who calls such meetings and networks with trainees. The on-site supervisor gets additional supervision from the FFT supervisor.

Third Replication: For outcome data refer to Gordon (1995) in Table 6 and Appendix C

Graduate student therapists went into homes of delinquents just released from a state institution. These Appalachian families were rural, poorly educated, and had low incomes. The training model was similar to that used in Study 1. Referrals came from four to six juvenile courts of the Ohio Department of Youth Services (DYS), which had control of delinquents until their probation expired. Quarterly contact between the therapist, FFT supervisor, and referring probation officer, and monthly meetings with DYS regional administrators kept a positive relationship with DYS. Absence of cost-effective programs in the region helped generate enthusiasm for FFT. In about a third of the referrals, FFT began a month in advance of the delinquent's release from the institution. Therapists worked in teams of two, pairing a more experienced (by a year) therapist with a novice. These teams discussed the case during their 40 minute drive to see the family. This project is ongoing.

Principles for Dissemination. Upper-level administrative support for the program is important. Therapist support is increased by working in pairs and discussing case outside of supervision. Early intervention with family (prior to delinquent's return home from institution) helps build rapport. If delinquent is re-committed, therapy continues if younger siblings are present. Initial referral gives priority to families with several younger siblings since behavior change with younger children is easier and motivates parents as well as meeting longer term delinquency prevention goals.

Integration of Interactive Video (CD-ROM) Training into FFT

Gordon and colleagues at Ohio University developed an interactive video program for parents of delinquents and pre-delinquents. There are nine problems (e.g., covering communication and problem solving skills, assertive discipline, reinforcement, contracting, chore and homework compliance, monitoring children who are hanging out with peers who are a bad influence, stepfamily and single parent issues, etc.) depicted in this two-to three-hour program. After viewing a scene, such as chores not being done, parents are asked when they would use a certain solution. By simply clicking a "mouse" to select the solution, parents then view what happens when that particular solution is used. All of the problems and their solutions are videotaped sequences of families in their homes, portrayed by actors, and are quite realistic. After each solution, a printed message on the computer screen tells the parents what was good and bad about the solution they chose. This message can be read aloud by the computer if they so choose. After the parents are finished viewing each solution (most parents elect to see all three solutions), the computer asks them questions about the parenting practices they viewed and gives feedback about their answers. More information on this video is avaiable from Don Gordon.

This program is based on FFT, and was developed to mimic the change processes of FFT. The effectiveness of the program has been tested in four studies. Recently, we have integrated this program, Parenting Adolescents Wisely (PAW), into our home-based FFT project with delinquents released from state institutions. We are also starting to refer parents to PAW prior to starting FFT, as well as those in FFT.

Parents of younger children (ages 6-12) show similar benefits from the program, as do their children. The program is being used as a preventive approach for children at risk. Mental health, children's services, and adult literacy programs have used the program successfully with non-court-involved families.

Program Replication in Clark County Family and Youth Services

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Clark County Family and Youth Services (DFYS) aspired to incorporate an intensive family counseling service into the Freedom Program for youth and their families. The Freedom Program was developed as an alternative program for youth who otherwise would be institutionalized in a juvenile correctional facility. The youth, considered to be the more severe, high risk cases whom judges would formerly have institutionalized, remain at home and are involved in intensive programming all day. Dr. James Alexander was consulted to investigate the possibilities of using Functional Family Therapy (FFT) as the model for this new counseling service, as the State of Nevada's Family Preservation Services was already using FFT as their model of choice.

In May of 1993, two therapists were hired to begin this new service at DFYS. Both were White, one male and one female. For the first month and one half these two therapists were immersed in FFT and began to put into place the protocol for this new venture. Some of the more unique features of this new service were its "co-therapy" approach, an emphasis on "in-home" sessions, multiple weekly sessions, a clearly defined plan of providing ninety days of service, the involvement of as many family members as possible (especially younger siblings), and the participation of at least one responsible adult family member.

During the first six months, the program dealt specifically with Freedom youth, their families, and the Freedom Probation staff, and involved a process of learning, experimenting, and adapting. Hours of service were set and later adjusted. Much time was spent in a variety of situations with staff and youth. The program was continuing its development when two additional therapists, both White females, were hired. One of these therapists had worked previously in the juvenile justice system for about seven years in the area of probation/diversion. The other had also worked with adolescents and their families, with an emphasis on substance abuse treatment. The teams were informal, that is, whoever had time in their schedule teamed up with whoever else had that time slot open. Thus, everyone had an opportunity to work with all three remaining team members, which expanded skills and styles and helped to maintain flexibility. Training sessions with Dr. Alexander were scheduled by the Division Director to familiarize everyone with the FFT model, and later to answer specific therapist questions about the model's applications.

Sessions are primarily conducted in the homes of the families; however, some families are seen at the Family Intervention offices. Decisions regarding location of the sessions are made by both the client and the therapist, taking into account the family's comfort level, transportation issues, therapist's schedule/availability, and safety issues. Since introducing in-office therapy, we have determined that the cancellation and/or no-show rate is higher in the office than in the home. Nevertheless, when time is an issue, being able to see families at the office allows us to see more families.

Family Intervention Services is now operating with only three full-time therapists, but we are also developing an intensive intern program through the University of Nevada at Las Vegas. Currently, we are utilizing two MFT post-master's interns, four graduate-level MFT student interns, and two graduate-level MSW student interns. All student interns are working in teams with professional full-time staff on Family

Intervention Services cases. They are able to work with all of the therapists in a rotating style, providing them a variety of therapeutic styles and techniques within a Functional Family Therapy model. The benefits derived by having full-time staff no longer working in teams, but instead utilizing interns as partners, is that many more families are able to be serviced. Current caseloads for each full-time therapist range from fifteen to twenty, with interns working on anywhere from one to five cases each, depending on availability, scheduling, and intern hours needed.

Referrals are now from any Division within the Department, including Intake, Probation, Child Protective Services, and Spring Mountain Youth Camp/Parole. Due to the increasing number of referrals that continue to filter in, we are faced with the need to frequently adjust schedules and consider starting a "waiting list." Although the high number of referrals is an indication of increasing acceptance of our program, we continue to face difficulties related to offering a therapeutic intervention within a correctional juvenile justice setting. Time, exposure, and positive results continue to help open minds and change attitudes.

Difficulties Encountered

- One of the most difficult issues the therapists faced was confidentiality. The foremost difficulty for these therapists was maintaining a working relationship with Probation staff, who wanted to be privy to confidential information about their youth, while maintaining a trusting relationship with these youth and their families. Setting and maintaining these boundaries was very difficult. These and other issues were worked on and are still being addressed. The best answer to most questions came through the establishment of a good, solid, therapeutic model and the committed, hard work of staff.
- Another difficult task was developing and implementing a new program, while at the same time adjusting to the new division to whom we had been assigned, Psychological Services. It was essentially the responsibility of the four therapists to format the new program of services.
- Those therapists who had not worked in the juvenile justice system were not prepared for the negativeness and punitive theoretical constructs of this system. Although individual probation officers and other staff were sometimes on our wave length as far as trying to help, rather than simply punishing these youth and families, these instances seemed to be the exception instead of the rule.
- One counselor left, leaving just three counselors, a growing case load, and word that the position would not be filled for several months. Out of necessity, we began doing cases alone, teaming only on cases which were very difficult, or in which safety concerns were a factor (due to extremely high risk areas). We also began seeing a few cases in the office, if scheduling was a problem; the rationale for this being that if we didn't have to drive across town we could see more families in a given day. We enlisted graduate level interns from the University of Nevada, Las Vegas. Within a few months, we had six interns, so we could again begin to work in teams, pairing one full-time therapist with one intern. We provided all necessary training, staffing, and supervision. This help was timely, as our referrals were increasing, and each therapist's caseload was at an all time high with respect to numbers of active cases.

Program Replication in a Family Preservation Program

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Functional Family Therapy (FFT) is the model utilized at the Las Vegas Family Preservation Program. This program works with families at two points of intervention in the child welfare continuum. At the "front end" the program works with families who are at risk of having a child removed from the home due to a substantiated report of abuse and/or neglect. The program receives referrals directly from Child Protective Services. Reunification referrals are made by foster care workers. The child has been placed in foster care and with intensive services in place, reunification with family members can be initiated. Reunification efforts are at the opposite end of child welfare continuum. Presenting issues vary depending on the point at which services are initiated.

The FFT model of family therapy is compatible with the philosophy of family preservation. Both emphasize identifying strengths of family members, in a non-blaming, non-judgmental approach. There is a shared belief in focusing on the system, not the individual. In FFT, as in family preservation, the therapist takes responsibility for motivating the family. FFT has a strong emphasis on education and skill building. This is imperative in family preservation services where families are taught such skills as parenting, communication, anger management, relapse prevention, etc. A shared common value of FFT and family preservation is that the family is the most desirable place for a child to grow when his/her security and safety can be maintained.

Implementing the FFT model of therapy within this family preservation program has been a process of stages. The initial stage was to become familiar with theory. This was accomplished through didactic presentation provided by Dr. James Alexander. Follow-up training came in the form of consultations where specific families were discussed or were brought in for live demonstrations. These case consultations allowed for experiential learning where therapists could "see" how the model was applied. In addition, conceptual learning included reading materials on FFT. Between consults with Dr. Alexander, staff attempted to apply the model and would generate questions and feedback for him at follow-up meetings. Interaction occurs when the student becomes the teacher. As a now mature program, new therapists are welcomed into family preservation and are expected to learn and apply this particular model of family therapy.

Teaching therapists the FFT model of family therapy within the context of a family preservation model is as difficult (or as easy) as teaching a systems approach. The first question becomes what does the supervisee bring to his/her job. What knowledge and experience do they possess? Most often the new family preservation therapist has some clinical experience but is probably a recent graduate. They are enthusiastic about clinical practice and want to earn licensure. The process of teaching the model follows the model itself. The first step is to assess what the therapist brings to the program. They are introduced to the model through reading material, videotapes, case staffing, and the co-therapy team.

The therapist begins the Assessment Phase with the family. In family preservation, genograms and sequencing are used as assessment tools to gather information on the family system in the past and

the present. Because there is a need for accountability, this information creates a "baseline" which allows for measuring change. Functions of family members are ascertained in preparation for the Motivation Phase. The therapist is also developing a working relationship with the family. The beginning therapist requires much structure, guidance and support at this point, not unlike family members. When support and encouragement is provided, therapists are more likely to allow themselves to be directed. A new therapist can be guided to collect information, and although they may not be yet able to discern what is relevant and what is not, they can be assisted in developing working hypotheses.

The Motivation Phase begins with identifying themes and simple reframes/relabels. The therapist is encouraged to encourage the family (parallel process). So often families are very discouraged and scared as they fear losing their children, although they express it in sometimes unrecognizable ways. The reframe/relabel is used to identify the strengths among family members. The therapist reframes the family's interactions in an effort to help them view their situation from a different, more positive perspective, and the supervisor uses the model to ground the therapist to view their interventions within this normalizing context.

Recently, a three-year staff member came to staffing requesting a reframe for a family who was struggling with reunification issues. The two adolescents had been separated from their mom, a drug and alcohol user, for five years. The daughter had been back in the home for the past year but the older son had just been returned home a week earlier. The mother was very frightened about having the son back in the home and was easily overwhelmed by his acting out behaviors. The therapist went back to the family with a reframe which pointed out how the son had not given up on her. He believed that she could parent him and was providing her with the opportunity to do so. The therapist went on to describe how important she is to her children (both children have voiced a strong desire to be with their mother, particularly the son). It should also be mentioned that these teenagers could easily choose to act out in other ways such as running away. Neither has opted to leave the family. In delivering this reframe the therapist reported that all family members listened intently and agreed with him. Thus, the reframe provided a context in which to move onto parent training and relationship building. The therapist, in turn, experienced the power of the reframe and felt success at this juncture in the therapeutic process.

The therapist was able to ask for and receive support from his supervisor and peers. He already had a working relationship with the family and his assessment had been accurate. He simply needed a creative approach to dislodge the family (and himself) from becoming too discouraged. Sometimes it is difficult to see progress when you're in the middle of process. This therapist, through his ability to ask for and implement feedback, was able to generalize his learning of the model.

This example brings up the issue of program structure. In family preservation, the caseloads are small, allowing for intensive (at least two sessions per week for 1 ½ hours each), brief (for approximately 90 days), home-based (sessions are conducted in client homes), and family-centered services. The program was originally created in the context of providing intensive, brief services and therefore supervision followed this format. Family preservation staff meet three times a week for 1 ½ hours each case presentation and discussion. Therapists are expected to present their cases in a structured format which follows the phases of FFT. A case staffing form is used to further reinforce the FFT model and the family preservation philosophy.

Although it can be difficult teaching FFT within this context due to the abstract notions of functions and systems thinking, the result can be very beneficial. It can produce true systems thinkers who can analyze and reframe not only family systems but organizational systems as well. These therapists can often see their own functions within the system more easily and are apt to be more proactive.

Independent evaluation (University of Nevada at Las Vegas) has demonstrated that with the first 52 families referred to FFT, 86.5 percent of the families were able to remain intact, a very positive impact of FFT given the traditional base rate of out-placement for such high-risk families.

Program Replication in a Family Outreach Center
The O'Brien Center Supportive Homebased Intervention Program

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Willow Run is in the eastern sector of Washtenaw County in southeastern Michigan and has been an economically disadvantaged, high crime area community. The sole law enforcement in Ypsilanti Township is provided by the Washtenaw County Sheriff's Department. There are several apartment complexes that, according to the Sheriff's Department, have been taken over by local gangs, and there are many fewer commercial enterprises than in other parts of the county. A large portion of the area is "landlocked" or surrounded by expressways, which further exacerbates mobility and access to services, recreation, and employment. Scores on the Michigan Education Assessment Program (MEAP) for Willow Run School District youth are low, with most tested categories receiving a "high needs" status. Recognizing the needs of this community, the O'Brien Center proposed a family outreach in-home program for pre-delinquent youth. FFT was joined with the existing Aftercare Program and became the O'Brien Center's main interventions in the Willow Run area. Dr. Alexander provided training and consultation in the implementation of our Supportive Homebased Intervention Program (S.H.I.P.). The program provided a new resource (where there were previously none) for the Juvenile Court, Sheriff's Department, and Willow Run Schools for families requesting assistance with their children. The project targets families with preadolescents in the Willow Run area who are already exhibiting some delinquent behaviors. Services are provided in the home by a two-person outreach team (bachelor's level social worker or equivalent) and a team leader (master's level social worker or equivalent). The outreach team is coordinated by a .50 full-time MSW employee under the direction of the Project Director.

Functional Family Treatment services for each family in the S.H.I.P. Program constitutes 30 contact hours from the outreach team during the first 90 days. After the initial FFT phase, a family can contract for an additional 90 days of service through our aftercare team. This less intensive service is designed for supportive work and skill building through the use of training modules which we developed. The scope of the aftercare services follows the discharge recommendations of the Functional Family therapists during the initial 90 days of treatment. The family can elect an additional 90 to 180 days of aftercare services bringing the total maximum length of service to nine months. Each outreach team is expected to service 40 families per year.

The Delinquency Prevention Grant outlined our primary program goals as:

- Decrease suspensions, expulsions, and truancy from school.
- Decrease the number of petitions filed in Juvenile Court.
- Increase reciprocity among family members.
- Establish clear and consistent communication between family members.
- Increase family members ability to specify what they desire from one another.
- Improve family members ability to negotiate constructively.

Initially two full-time BSWs were designated as Family Specialists, who would learn FFT and work as a team to go into the families' homes and provide counseling services. We then recruited social work interns and organized them into two-person teams to provide aftercare services following the S.H.I.P. services. The social work interns were also divided into work teams to develop training modules (e.g., communication, nutrition, etc.) for use in the aftercare program. Approximately 30 days after the staff were hired, Dr. James Alexander completed a three-day training workshop on FFT which was attended by both S.H.I.P. and Aftercare program staff.

Since this project has been funded, in part, by a federal grant through the Juvenile Justice Delinquency Prevention Act, all staff members were trained in procedures for data collection.

Family cohesivity was measured upon initial visit and was re-evaluated every 90 days of service (at the same time, families rated satisfaction with services). We also tracked school problems and expulsion rates within the school district of the target area as well as new court petitions.

Most referrals came from the schools and the Sheriff's Department, though some came from the state police, community churches, and the Public Health Department. We experienced a reduction of referrals during the summer months when school was not in session. We issued certificates of appreciation to individuals who were especially helpful in supporting S.H.I.P. services.

The paperwork requirements of any program are directly linked to accountability issues. Each S.H.I.P. case file includes:

1. Referral form
2. Consent for treatment
3. Consent to video/audiotape
4. Release of information form(s)
5. "My Three Wishes"
6. Emergency procedure to clients
7. S.H.I.P. status report
8. Progress notes
9. Treatment plan for family
10. Assessment
11. Two service treatment plans
12. Assessment summary
13. Client information form (data collection)
14. Family evaluation form
15. Incident report
16. School attendance
17. Discharge summary
18. Post test
19. Evaluation

Casework supervision is done twice weekly by the Social Worker and Outreach Team. One session is devoted to monitoring data collection, paperwork flow, and case file management. The other session reviews each family in the program in terms of appointment time, number of times seen per week, what phase of FFT the family is currently involved in, any possible recommendations for aftercare, and specific family issues and process.

Monitoring Program Integrity

Dr. Alexander's three-day training workshop on FFT was videotaped so that in the event of staff turnover, new employees would have the opportunity to view the original training.

The family specialists audiotape most of their sessions as well as complete process forms on each family. These are used in supervision meetings and are also sent to Dr. Alexander to review prior to

his follow up consultation visits with the staff. His consultation visits are also videotaped to be used in future training. These consultation visits review family therapeutic processes as well as therapist techniques and processes employed in the Functional Family Therapy modality.

Issues Specific to This Replication

Psychological Assessment. Because of the nature of FFT and how the phases are worked through with the family, conducting an ordinary psychosocial assessment would interfere with and be counter-productive to the Motivational Phase in FFT. A large part of a traditional assessment focuses on the individual's problems, set backs, difficulties, and failures they may have had. This type of shopping list goes against the philosophy inherently behind FFT. Agencies still need some type of assessment. The O'Brien Center overcame this dilemma by having the family specialists do an assessment at the end of 30 days based on the information that they had acquired in the context of doing FFT by focusing on the family's strengths and without subjecting the family to a formal assessment procedure. Although not as comprehensive as a traditional assessment, it is nevertheless sufficient and does not interfere with the therapeutic process.

Safety of the Family Specialists. A number of the families receiving services in their homes live in areas of high crime and gang violence. In order to provide a safe work environment the treatment is always done in two-person teams. Magnetic signs were printed and placed on the side of the outreach team's car identifying them as Washtenaw County O'Brien Center Outreach Team. The treatment team carries a cellular phone with them as well as pagers. The Sheriff's Department has community stations in these high crime neighborhoods. The Outreach Team has been introduced to the officers who staff these mini-stations. When the treatment teams go out into the area, particularly after hours, they contact the mini-stations and alert the officers that they will be in the area at a certain address for a certain amount of time.

Anecdotal Evaluation

As the first year of services has been completed, the program has been well received. There have been two very positive articles in the Ann Arbor News, and the evaluations filled out by the families have been very positive. Families report that having specialists come to their home is what they like most about the program. They report liking the audiotaping the least. The O'Brien Center is hopeful that the S.H.I.P. Program will be extended to cover all of Washtenaw County and that FFT will be used not just as a prevention initiative but become the treatment of choice for dealing with delinquency and families served by the Juvenile Court.

Program Replication Using a Collaborative Partnership (Employer-Agency-University)

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A Unique Collaboration

We have developed a unique model of collaboration through which we are continuing the development, elaboration, and verification of Functional Family Therapy. The collaborative model is unique in that it provides for a community-based approached designed to identify successful family intervention strategies while at the same time delivering needed services to high risk youth in troubled families. We think the collaborative model is a model that other communities might adopt in order to implement and measure new approaches to juvenile problems. Furthermore, this replication may serve as a future model for implementing and evaluating community-based family services.

The Context

Like other communities, Las Vegas has entered a new era of mental health and social services. We have increasingly limited county and state programs and funds for family services and a private sector in which mental health centers are dominated by the concerns of managed behavioral health care. We have a major University in which numerous independent researchers are investigating the efficacy of individual and family counseling approaches. As in other communities, these different players operate independently.

The major players in our collaborative effort each provided a unique contribution to the project. The Boyd Gaming Group is a major employer in the Las Vegas community. The group owns and operates eight gaming properties and employs over 15,000 employees. The company has a publicly stated commitment to providing a continuum of quality health care services to its employees. To that end, the company has an independently funded behavior health plan serviced by a single community center, Harmony Health Care, Inc. As a private company, Harmony Health Care has an interest and commitment to mental health services that are both high quality and fiscally prudent. The University researcher (Tom Sexton) provided the resources to coordinate the project, provided solid research principles to the project, and communicated results to the involved parties.

An Employer-Agency-University Collaboration

Our FFT replications are based on a collaborative partnership among an employer (Boyd Gaming), a mental health provider (Harmony Health Care), and a University (University of Nevada, Las Vegas). The employer funded the project. The funds came from those already allotted for behavioral health care for employees. The agency did the initial intake and access to other treatments that would serve as comparison groups. The University provided the training and supervision of FFT services as well as data collection and evaluation. The collaboration has allowed us to provide FFT to the employees of a large community employer, evaluating the efficacy of that approach, and feeding our results back to the community mental health provider so that they might make better decisions regarding the services they provide.

Our initial target population was juveniles diagnosed with Conduct Disorders. As documented elsewhere in the literature, Conduct Disorders are a pervasive cluster of problems that can have a major impact on families. For the employer, such family problems often result in an increase in the amount of time off work. For the mental health agency attempting to treat such families, services often involve a series of "revolving door contacts" or, as a last resort, expensive out-of-home placements. Thus, this population was of great interest to all collaborating parties.

The first phase of this project was guided by two research questions. First, we were interested in evaluating the efficacy of short term FFT (10 to 12 sessions) as a therapeutically effective treatment and cost effective service for conduct disorders. Along this line, we compared FFT treatment to individual treatment, generic family treatment, and inpatient hospitalization/ treatment. Our second question focused on the efficacy of providing treatment in the homes of the families. The evaluation phase of this study is in progress, and these questions will be answered in the near future as the data are analyzed.

Unique Replication Issues

In replicating FFT, treatment fidelity was our major concern. We were lucky in that we had access to a number of experienced clinicians who had been trained in FFT. However, the clinical research literature increasingly highlights the need to provide the treatment that one expects to investigate. In real life, treatment fidelity is a complex problem. Even though our therapists had previously been trained, each had developed their own unique twist to family treatment.

Our treatment fidelity plan involved three phases. First, our therapists went through a summer long training program that involved reading, discussion, and video presentations. The outcome of that training was a common Treatment Plan model that was to be used by each therapist. This model constituted the second component of our treatment fidelity plan. The intent was not to take out the unique contributions of individual therapists but instead to provide a common FFT foundation to the treatment. The Treatment Plan model was based on the phase nature of FFT and incorporated the essential treatment goals outlined elsewhere in this document. The Treatment Plan model became the "map" that each therapist followed as they progressed through the phases of FFT. To help with compliance, the model was translated to a written form that was completed by each therapist after each session. These forms constituted the basis of our treatment fidelity check. The final component involved regular supervision with the treatment teams. The focus of supervision was to remain focused on the phases, remediation of risk factors, and successful completion of treatment goals.

Program Replication for Adolescent Substance Abusers

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The Center for Family and Adolescent Research at the University of New Mexico has been awarded funding for five years from the National Institute on Drug Abuse to conduct a randomized clinical trial to evaluate family therapy for adolescent substance abuse using the Functional Family Therapy (FFT) model. Clients in the trial are randomly assigned to one of four treatment conditions. In one condition adolescents and their parents receive FFT, in a second condition the adolescents receive individual cognitive-behavioral therapy. In the third condition they receive family therapy in conjunction with individual therapy. In the fourth comparison condition adolescents participate in an education-based group. The family therapy and individual therapy alone protocols consist of 12 weekly sessions. Clients in the education group attend eight 90-minute sessions for a total of 12 hours of intervention. Clients in the combined therapy condition receive individual and family therapy weekly (from two different therapists) for a total of 24 therapy sessions in a 12 week period.

Therapist Characteristics and FFT Training

FFT is provided by three therapists. One is an Hispanic/Latino male currently working on his Master's degree in counseling. He has extensive experience working with the adolescent population in the form of alcohol and drug related interventions for the local public school system, but little formal training in family therapy. The other two FFT therapists are White females completing post-doctoral training in clinical psychology. Both have had some prior clinical experience with adolescents and the FFT model.

FFT at this site is intended to closely follow the FFT manual by Alexander and Parsons (1982). Other manuals utilized include the Functional Family Therapy with Families of Substance-Abusing Adolescents Training Manual, under development for this project, as well as the Functional Family Therapy Outline by Alexander. In addition to on-site training provided by Dr. Holly Waldron, the Principal Investigator of the project, training on the FFT model was provided by Dr. James Alexander during a two-day seminar in New Mexico. He also provided videotaped lectures and sample cases for ongoing review. Weekly clinical supervision, in both group and individual format is conducted by Dr. Waldron who completed her doctorate working directly with Dr. Alexander. All therapy sessions are videotaped and supervision consists of review of tapes and discussion of relevant issues. Treatment adherence is monitored by Dr. Waldron in the context of supervision and is assessed using a checklist developed to identify the presence or absence of core FFT features in each therapy session. Dr. Alexander provides additional clinical supervision via review of videotapes and visits to the treatment site.

Distinctive Features of the Program

The research client population is well defined: clients are between the ages of 13-17 and must have lived at home with their parent(s) for the past two years. Both one- and two-parent families are treated. The substance abusers in our treatment program must have a diagnosis of substance abuse or dependence. The majority of adolescents are predominantly heavy marijuana users, although we

have also treated more moderate users and those with an extensive history of polysubstance use. To date, at least 95 percent of the adolescents in the study use at least one other drug in addition to marijuana, usually alcohol. However cocaine, amphetamine, and hallucinogen use are also common. Approximately 50 percent of the youths have a non-substance use co-morbid diagnosis. Conduct disorder is seen most frequently, followed by anxiety and depressive disorders. Many of our clients are experiencing difficulty in school, often having been suspended and/or expelled. A number are also on probation and face threats of incarceration. In the family context, adolescent issues related to chores, jobs, trust, communication, and adolescent autonomy; and parent issues of supportiveness, limit setting, and adequate supervision frequently emerge.

Our clients represent an ethnically diverse group, drawn from Hispanic/Latino, Native American, and White sub-populations. The ratio of males to females is approximately 2:1. Referrals to the study come primarily from the Albuquerque Public High Schools, with some adolescents referred from outpatient mental health facilities, the criminal justice system, and self-referrals from newspaper advertising and publications describing the program.

Research Participation

Families who receive FFT at the Center agree to participate in the grant project in exchange for therapy provided at no charge. Thus, at the time they are referred for treatment, the nature of the study, the randomization procedures, and the participation requirements are explained. Families willing and eligible to participate then undergo an extensive assessment battery which includes diagnostic assessment for the adolescent and the parents, interview and self-report of substance use for the adolescent, parents, and siblings, videotaped family conflict-resolution discussions, urine toxicology screens for the adolescents and siblings, and a variety of self-report questionnaires and checklists to assess the psychological functioning of each family member. The assessment portion of the process ranges in length from three to six hours.

Following the initial assessment, adolescents are randomized to a treatment condition and are scheduled for their first therapy session within a week of the assessment. Follow-up assessments, replicating the intake assessment battery, are conducted four, seven, and eighteen months after the pre-treatment assessment session. Families are compensated for completing the assessments.

Implementation

Several issues have emerged with respect to implementing FFT in this project. The largest single problem for the study is client recruitment. Because treatment is offered in a university setting in the context of a research project, a steady referral stream had not been established at the beginning of the trial. Massive staff resources have been spent developing a client base for the investigation.

A second issue is related to the ethnic diversity of the sample and differential recruitment and engagement on the basis of ethnicity. Eligibility screening forms are completed for individuals inquiring about the program, allowing us to track clients who schedule appointments and then fail to appear for assessment and clients who complete the assessment but withdraw from the study before beginning therapy. Although we receive phone calls from equal numbers of White and Hispanic/Latino clients, nearly half of all Hispanic/Latino families eligible for the study schedule appointments but do not complete the assessment process. Once families complete the assessment, no treatment engagement differences for Whites and Hispanic/Latinos are observed. No data are collected

that would explain the differential participation rates. Within the research literature, however, similar ethnic differences have been found with respect to treatment utilization. We are in the process of developing a systematic engagement procedure for Hispanic/Latino families, joining with family members on the telephone, anticipating practical problems such as transportation and child care, and providing reassurances of consequences and that the problems they are experiencing are not unusual. Although the challenges we have encountered with respect to engagement across different ethnic groups may stem solely from aspects of the research and not from FFT, more systematic evaluation of this issue may be needed.

We have also experienced some difficulty with FFT training for therapists who come from widely varying backgrounds and experience levels. The lack of common knowledge base and skill base makes supervision more difficult. For example, the Behavior Change Phase of FFT is more challenging when therapists have little familiarity with the broader behavior change literature and the specific techniques used during this phase (e.g., communication training, contingency contracting).

Program Replications in Sweden

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These studies primarily represent clinical trials funded by the Swedish Government. FFT has been replicated in Sweden on four independent samples of juvenile delinquents:

1. Functional Family Therapy in Lund

This project began four years ago in collaboration with Dr. James Alexander, and is a controlled study including 45 families in the FFT group and 20 families in a control group. The group consisted of families of youth who had been arrested by the police in Lund. Excluded were (1) those who had been in treatment at the social agency or child guidance clinics; (2) those who could not speak Swedish (because interpreters were not affordable); and (3) those who had been caught by the police for very minor crimes such as shoplifting and breaking a window. Over two years, half were randomly assigned to FFT, and half were assigned to a control group who received traditional social work treatment. Four therapists have been involved in the project but two of them had the heaviest responsibility for the treatment. Information was gathered at the beginning of the study and after two years. Information was gathered about psychopathology (SCL-90, CBCL, YSR), family function (family climate, family relation scale), the actual social situation, sense of coherence, self-reported criminality, and antisocial behavior, etc. The same questionnaires were given to the families after two years. It was quite hard to motivate those families who had been randomly assigned to social work. Because of that we have only 20 families in that group. All of the follow-ups were completed by June, 1997.

Some preliminary results of this study are available. There are differences between FFT and the control group The mothers in the FFT group were much better than control group mothers on the SCL-90 (Anxiety, Depression, Somatization, and the total score). The fathers' scores did not change much, but they did reflect less irritability. Family function has been changed due to FFT, but there were no changes seen in the social work group. Two year follow-up of criminal records reflect a 30 percent reduction in subsequent criminal arrests in the FFT group (50 percent, compared to 80 percent reoffense rate in the control group).

It is extremely important to note that all of the families who have been assigned to FFT have fulfilled the treatment in a way that both the family and the therapist agreed on. This is particularly important because it is typical in Swedish culture for families to come to child guidance clinics if they are transferred to them, but to only come once or twice and never again.

2. Functional Family Therapy in Växjö

This project started two years ago by one of the therapists who worked in Lund. This study is a collaboration between the child guidance clinic and the social agency in Växjö and the surroundings in the county of Smîland. This study does not have a control group because the social agencies in Växjö did not accept that strategy. At the time of this writing, there are 50 families included in the therapy group. The therapy was conducted by four different therapists and the follow-up in that

project will take place after one year. In Växjö they have used the same evaluation instruments as in Lund. The results will be ready in 1998.

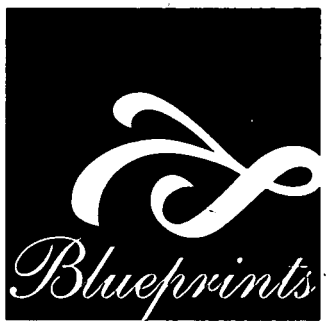
3. Multicenter Study of Functional Family Therapy

This study is done as a part of a psychotherapy educational program in family therapy. A group of 13 candidates are participating in a conjoint project with Functional Family Therapy. They are expected to do five FFTs each in their hometowns. The therapists come from different towns in the southern part of Sweden. We have now collected in the FFT group 27 families, and the report from this project will be ready in June, 1997. This group of families will be followed-up after two years by another family therapy educational group. Just as in Växjö we have no comparison group for the FFT group, but we use the same evaluation instruments as in Lund and Växjö.

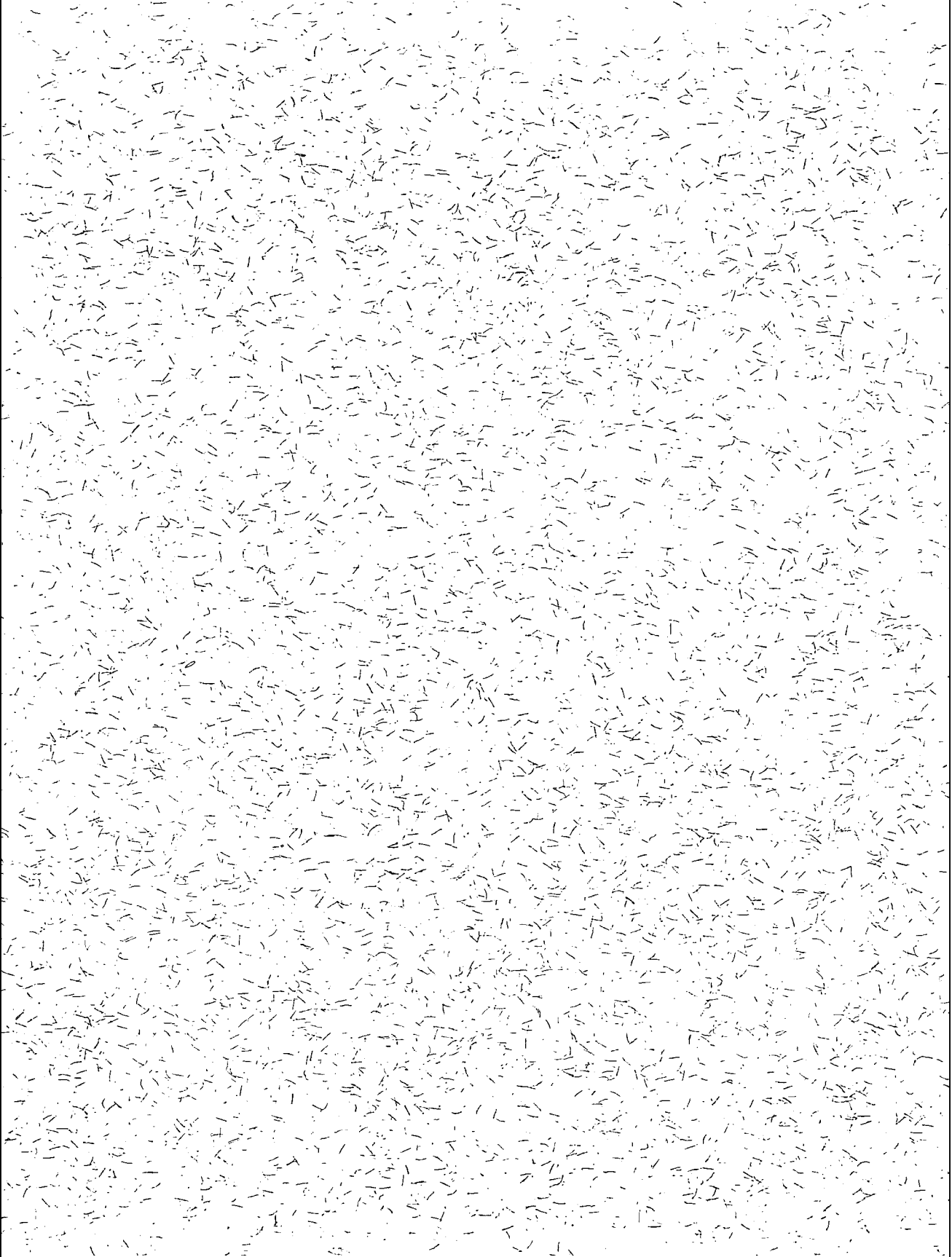
4. Functional Family Therapy with Serious Juvenile Delinquents

This replication consists of FFT with a severe delinquent group. The families and the patients in these groups are referred from St. Lars Hospital. All the patients have committed numerous crimes and many of them also have drug abuse problems. This is a small group with 10 families, and this is a continuous project in which we are trying to expand the group to at least 20 or 30 families. This group will be followed for five years after the intake at the hospital. In this group we have a comparison group with other patients that have not been included in the FFT group.

In all the replications in Sweden we use the same research battery. This allows us to examine the follow-up at different levels.



Appendices



APPENDIX A

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Full citations are located at the end of the document.

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APPENDIX B

Supervision Materials for Functional Family Therapy

The following materials are provided to serve as a format for supervising the continuing development of Functional Family therapists. Proper use of the materials requires considerable grounding and expertise in the FFT model, and helps maintain consistency with the model's principles. For therapists, the materials will serve as a reminder of the components of FFT that are important, and consistent use of the materials will prompt focused therapist appraisals of families and the therapist's own performance. For supervisors, this format is a vehicle for discussion of FFT criteria and a relatively focused structured format for feedback to therapists.

The creation of these materials should in itself communicate several important messages about Functional Family Therapy standards for effective therapy training and development. First, the process of supervision is an important one. Therapists, like most people, find it difficult to be objective about themselves. Supervision provides critical objective clinical impressions and novel solutions to problems that therapists can't create independently. Second, the service delivery demands on most therapists in most agencies are awesome. Therapists should be mandated the time to critically appraise their work with their clients, as well as to plan their next sessions with families. While at outset this may seem administratively expensive, in the long run careful and focused out of session activity leads to intervention which pays off in reduced re-referral, reduced dependency on agencies, and less social costs. Besides serving clients more effectively, supervision attenuates therapist burnout. Therapists receive personal attention, support, and opportunities for continued growth as professionals. Finally, the checklist and evaluative flavor of these instruments should communicate a sense of both clinical and data-based accountability. These instruments are a way to responsibly focus attention to important variables in Functional Family Therapy, to monitor aspects of the therapist, family, and the FFT model which are important. The quality and quantity of the data are of course subject to the commitment of supervisors and therapists to gather them. The therapist's independent pursuit of the data will make him or her a better therapist, just as the therapist-supervisor joint appraisals of the data can point to areas of strength and potential growth.

The materials included here are not all relevant for each session, but all of them are relevant for a total FFT case file. Materials such as "Administrative Setting Up" or "Termination" only need to be completed once, while "Session Sheets" are useful for each session. Each form has a cover sheet with some brief instructions/suggestions for its use. Many of the forms include FFT terminology which requires considerable familiarity with the model and the meaning of the terms. When possible, therapist and supervisor forms are the same. This is so that both can dialogue from a common set of dimensions, and with repeated experience and relationship building both can arrive at common evaluative scaling.

FUNCTIONAL FAMILY THERAPY CASE FILE CHECKLIST

Supervisor: _____ Therapist: _____

Start Date: _____ Family Name (Code): _____

	ACTIVITY		Date/Initial when complete
Task 1.	Preliminary relationship building meeting, scheduling, emphasizing fixed appointment, taping, getting referrals.		_____
Task 2.	Personalized presupervision trainee meeting, FFT training debrief, preliminary referral screening/planning.		_____
Task 3.	Supervision Session 1.	"Administrative Setup"	_____
		"First Session Checklist" Pre	_____
Task 4.	Supervision Session 2.	"First Session Checklist" Debrief	_____
		"Between Sessions Checklist" Pre	_____
		"Therapist Characteristics" Debrief	_____
Task(s) 5	Supervision Session 3.	"Between Sessions Checklist" Debrief	_____
		"Between Sessions Checklist" Pre	_____
		"Therapist Characteristics" Debrief	_____

*The format for "Supervision Session 3" is the same for each Supervision Session prior to the "Next-to-last Session." Anticipating the "Next-to-last Session" and Termination Sessions is possible if therapists and supervisors monitor "The Sequence of Intervention" for therapy progress, and anticipate the dimensions described on the "Termination Checklist."

Task 6.	"Next-to-last" Session:	"Between Sessions" Debrief	_____
		"Therapist Characteristics" Debrief	_____
		"Termination" Pre	_____
Task 7.	"Termination" Session:	"Termination" Debrief	_____
Task 8.	Paperwork Complete		_____
	Paperwork Filed		_____
	Audiotapes Coded, Filed		_____
Task 9.	Outcome evaluated:		Other follow-up data:

Date _____

Family rating _____
Therapist rating _____
Agency rating _____
Supervisor rating _____

"Administrative Setup" Form

The Administrative Setup form is intended to be a prompt for appropriate professional/ethical concerns, to ensure proper negotiation of a supervisory relationship, to serve as a reminder/commitment for therapists to overcome their reluctance to audiotape, and to prepare the therapist for a first session "set" and plan for an active FFT session.

For the therapist, the form creates a checklist for preparation.

For the supervisor, the form creates a vehicle for shaping professional behavior, negotiating supervision arrangements.

Suggested training/supervision experiences for the form:

1. Discuss the material on the form; is it all necessary?

2. Role play the "professional concerns."

3. Role play phone calls to clients, dealing with excuses for why the whole family can't/won't come in.

Therapist: _____

Date: _____

Family: _____

Administrative Setup Checklist

Supervision

Supervision arranged? Yes _____ No _____

With whom? _____ When? _____

Where? _____

Family

Do I have a presentation for phone contact to recruit all family members? _____

Family knows first appointment is when? _____ Time

_____ Date

Do they have instructions how to get to appointment? _____

Agency Concerns

Do I have a place scheduled for session?_____

Do I have a Tape Permission Form?_____

Tape Dec? _____

Tape?_____

Is receptionist notified of appointment?_____

Professional Concerns

Do I have an introduction prepared for myself and my agency I'm comfortable with? _____

Do I have a presentation of taping and of observation (if relevant) that I'm comfortable with? _____

Do I have a comfortable presentation of billing and charges? _____

FFT Preparation

Have I reviewed first session goals? _____

Does their problem, status, or age of their children lead me to:

Anticipate need for relabels for a sensitive issue _____

Anticipate a standard developmental issue _____

Am I "setting myself up" with preconceived biases or impressions? _____

First Session Checklist*

The first session is more effective when it is prudently planned, and the therapist is committed to goals, sensitive to status variables and interpersonal processes, and is committed to "making something happen." This checklist can be used in planning or anticipating the first session, but to be consistent with the "goal setting" behavior it should be critically reviewed with the supervisor after the session.

Training/Supervision issues associated with the form:

1. Therapist discuss three types of people, interpersonal styles, or forms of behavior that "push therapist's button."
2. Hypothesize what a family could do that would be most problematic for the therapist.
3. Plan a strategy for cuing therapist to talk to everyone as equivalently as possible.
4. First session must be planned/conducted consistent with "Functional Family Therapy Assessment Checklist."

* Use in conjunction with "Functional Family Therapy Assessment Checklist", and "Therapist Characteristics Form."

First Session Checklist

Therapist: _____

Date: _____

Family: _____

Family Fixed Characteristics	Identify the following "fixed characteristics" of the family: Developmental Stage(s): Who should be included in sessions: Gross fixed limits:
Therapist Fixed Characteristics	Identify how Therapist Fixed Characteristics "Match": Their expectations/stereotypes of therapist:
Family-Therapist Relationship	Did I accomplish credible presentation of myself, agency, why we're here?
	Was I able to influence and predict the style of responding from each?
	Who do I find "hooks me in"? Who "turns me off"?
Assessment	(See Assessment Checklist)
	Prior to session—have I reviewed what I need to get?
Initiating Therapy	At the *content* level, who/how did I relabel?
	Was I able to shift their focus from their definition of the problem?
	Did I use nonblaming words?
	Did I spread talking around to each?
	Did I create any confusion?
	Did I provide any novel interpretations that seemed to have impact?
Task Assignment	Did I assign a task?
	What hypotheses will task confirm, or disconfirm?
	When did I reschedule? (Do they need further contact to ensure coming in?)

Between Session Checklist: Filled out by Therapist Between Sessions _____ and _____

Therapist: _____

Date: _____

Family: _____

Understanding and "Therapizing" Family Members
(Alexander & Parsons, 1982)

Member	Clarify Meaning	Relabel-Nonblame	Relationship Focus	Interpersonal Impact/Function

Why are there missing cells?

What is my plan to fill them?

Sequence — Identify where I am relative to the "Sequence of Intervention" _____
Do I need to/How can I catch up?

Education Goals — What are my education goals for this family?

a. How does this education protect functions for each member?

b. How will the education be "packaged" for each member?

Resistance — Who's resisting? How?

Where is the "Fit" problem? How do I remediate it?

Improvement — Do they report out of session problem-solving?

Have I observed within-session appropriate communication?

Termination Session Checklist

Therapist: _____

Date: _____

Family: _____

Family Efficiency	Are all relevant dyads interacting adaptively?
	Have complaints or reports of problems ceased, or are they being described in benign and "workable" terms?
	Have I seen any evidence of the family's ability to spontaneously resolve conflict, or solve a problem?
	Do family members report or show evidence of behaving in ways that maintain: a. benign reattributions? b. functions?
	Has the family given any indication they would prefer to handle problems without the therapist's help or involvement?
Follow through Issues	Are subsystems in the family wanting to "change functions," or struggle with "quality of life" issues? (Referral?)
	Do I need to make a follow-up referral for a family member for some specialized education/technology (e.g., hypnosis, weight loss, sex therapy)?
	Have important outside resources been mobilized in ways which will support and maintain therapy (e.g., parole officers, school officials, employers)?
	Have I notified the family who and how to contact (including myself) for follow-up support or monitoring?
	Are there any special last minute reminders or prompts I should pass on to promote continuity (e.g., books, training procedures, having them schedule appointments with each other)?

Therapist Characteristics Form

		Rating	Good Example on Tape	Poor Example on Tape
Relationship Skills	"Linking" -			
	Humor -			
	Warmth -			
	Nonblaming -			
	Self-disclosure -			
Structuring Skills	Clarity -			
	Self-Confidence -			
	Directiveness -			
Therapy Skills	Creative Relabeling -			
	Integrative Interpretation -			
Process Skills Equivalent Talk Time				
	Drawing out "The Quiet One"			
	Slowing down "The Chatty One"			
	Successful Interruptions			
	Generating Effective Family Communication between Members			
Meeting "Between Session"	Progress in "Sequences of Intervention"			
	Completion of "Understanding and 'Therapizing' Family Members"			
	Protecting Functions w/Education			
	"Packing" Education			
	Dealing with Resistance			
	Identifying/ Reinforcing Progress			

Family Intervention Services
Session Progress Note
Developed by: Tom Sexton, Ph.D.
University of Nevada, Las Vegas

Case # _____ Date _____

Therapist(s)_____ Session # _____

Treatment Phase of this session (circle one or two)

1. Engagement
2. Assessment
3. Motivation
4. Behavior Change
5. Generalization (Termination)

Critical Session Incidents (Treatment Phase related)
Examples of critical incidents:

–Engagement Phase (Initial Session(s))

(1) positive
–eager acceptance of role of therapist and therapy
–statements of optimism or hope about process
(2) negative
–overt challenges to therapists's credentials, understanding, competence
–pessimism about family therapy process
–apparent racism
–participation/noncompliance refusals

-Assessment Phase (early sessions)

(1) positive
–acceptance of responsibility
–interpersonal sequences reported
–self-disclosure, emotional risk taking
(2) negative
–refusals to answer questions
–blaming attributions
–helplessness/hopelessness
–escalating/runaway processes
–constructive process "shut down"

-Motivation Phase (early sessions)

(1) positive
- –use of constructive attributions
- –responsiveness to therapy
- –requests advice/structure

(2) negative
- –refractory negative attributions
- –inability to sustain focus, derailing
- –complaints about lack of progress
- –denial, avoidance

-Behavior Change Phase (middle sessions)

(1) positive
- –follow through
- –improved efficacy
- –requests for feedback

(2) negative
- –overt non-compliance
- –passive-aggressiveness
- –"what is in it for me" attitude/questions bribery or control attributions

-Generalization/Termination (ending sessions)

(1) positive
- –spontaneous problem solving
- –plan for use of community resources

(2) negative
- –inability to apply skills
- –poor anticipation of challenges
- –unfinished issues

APPENDIX C

FFT Outcome Studies

1. Alexander (1971); See also Alexander and Barton (1976), (1980)

Clients: 40 families with court-referred juvenile delinquent adolescents, 13-16 years old, living in a moderate sized city. Predominantly White, lower to middle income.

Therapists: Social workers on the staff of the juvenile court, trained in family communication and contingency management techniques.

Treatment: 8 hours of family therapy provided in a clinic.

Outcome: **Risk/protective factors:** families that received family therapy or a combination of family and individual therapy displayed significantly greater improvements in communication style (less defensive, hostile, and submissive communication) than those who received regular probation services or individual therapy only.

2. Alexander and Parsons (1973)

Clients: 99 court-referred juvenile delinquent adolescents, 13-16 years old, living in a moderate sized city. Predominantly White, lower to middle SES.

Therapists: 1st and 2nd year graduate students in psychology. 4 weeks of initial training and 6 hours of training/supervision during the course of treatment.

Treatment: Approximately 10 weeks of therapy provided in a clinic.

Outcome: At 6-18 month follow-up, FFT families had a re-offense rate of 26%, compared to 50% for no-treatment controls, 47% for client-centered family group therapy controls, and 73% for the eclectic psychodynamic family therapy group. Overall, post-project court referrals were 50-66% lower in the FFT group. **Risk/protective factors:** FFT families were significantly improved in the process of family interactions compared to those who received other treatments. They displayed greater equality in interaction and talk time, less silence, and more positive interruptions for clarification and feedback.

3. Parsons and Alexander (1973); See also Alexander and Barton (1976), (1980)

Clients: 40 families with juvenile delinquents, court-ordered into treatment. 13-16 years old, living in a moderate sized city, predominantly White, lower to middle SES.

Therapists: 1st and 2nd year graduate students in psychology. 4 weeks of initial training and 6 hours of training/supervision during the course of treatment.

Treatment: 8 hours of family therapy provided in a clinic.

Outcome: **Risk/Protective factors:** Families who received FFT displayed significant changes in interaction patterns, including less silence, more equality in talk time, and greater frequency and duration of simultaneous speech. No improvements were seen in the interactions of families that did not receive FFT.

4. **Barton, Alexander, Waldron, Turner, and Warburton (1985), (Study 1):**
Undergraduate paraprofessionals trained in FFT

Clients: Status delinquents (adolescents with offenses including runaway, truancy, sexual promiscuity, possession of alcohol, and ungovernability). Referred by probation workers.

Therapists: Paraprofessionals (undergraduate students in psychology). 32 hours of training.

Treatment: An average of 10 sessions provided in a clinic.

Outcome: Equivalent to those obtained by senior/graduate level therapists in earlier studies. Recidivism (court referrals after treatment) 26% for the FFT group, compared to a population base rate of 51%. **Risk/Protective factors:** Changes in the family processes characteristic of families with delinquent youth, most notably decreases in family defensiveness, were seen with this sample, just as they were with the senior therapists.

5. **Barton, Alexander, Waldron, Turner, and Warburton (1985) (Study 2):**
Referral rates for out-of-home placement before and after FFT training

Clients: Children and adolescents at risk for foster care placement, referred by workers who investigate cases for protective or alternative custody. Status delinquent offenses, school problems, and custody issues/ineffective parenting.

Therapists: State Division of Family Services Social Workers. Trained in FFT after they had worked for Family Services for some time, and compared to their co-workers and to their own pre-training rates of referrals for foster care placement.

Treatment: Services provided to the cases as the workers saw fit, usually based on a crisis incident that would normally place the youth at risk for out-of-home placement.

Outcome: Comparisons of cases treated by the trained workers before and after their training showed significant decreases in rates of referrals (from 48% to 11%). Comparisons of cases treated by the trained workers following their training (11% referred to foster care) to those seen by co-workers during the same time period (49% referred to foster care) showed similar results.

6. **Barton, Alexander, Waldron, Turner, and Warburton (1985) (Study 3):** "Hard core"clients

Clients: "Hard core" adolescents, Conduct Disordered, with multiple felonies, heavy substance abuse, and considerable violence. Incarcerated in a state facility for serious and repeated offenses (an average of 20 prior adjudicated offenses).

Therapists: Graduate level psychology students.

Treatment: 30 hours of direct service, mostly home-based treatment.

Outcome: The FFT group had a 60% recidivism rate, compared to 93% for controls and an 89% average institutional base rate. Those from the FFT group who did reoffend did so with significantly less frequency than reoffenders in the non-FFT group.

7. **Klein, Alexander, and Parsons (1977)** Sibling study: multiple levels of prevention/intervention

Clients: Juvenile court-referred delinquents, primarily "soft" delinquency offenses. Primarily White, lower- to middle-SES clients.

Therapists: 1st and 2nd year graduate students in psychology. 4 weeks of initial training and 6 hours of training/supervision during the course of treatment.

Treatment: Approximately 10 weeks of therapy provided in a clinic.

Outcome: Reductions in recidivism of target adolescents are reported above (#2) in Alexander and Parsons (1973). The current study found that at the 2 ½ to 3 ½ year follow-up, siblings in the families that received FFT had a 20% rate of court referral. Siblings of adolescents in the other groups had recidivism rates as follows: no treatment 40%; client centered family therapy 59%; eclectic-dynamic family therapy 63%. **Risk/Protective factors:** At initial follow-up evaluation, families who received FFT were significantly improved in the process of their family interactions compared to those who received other treatments. Reductions in recidivism were linked to changes in family process. At the time of the current study, family process differentiated families with a sibling referral from those without. In other words, all families in which there was a sibling referral, regardless of treatment group, displayed family process that differed from those with no sibling referrals.

8. **Friedman, A. S. (1989):** An outpatient drug treatment population

Clients: 166 adolescents in an outpatient drug treatment program.

Therapists: Experienced family therapists, trained in a two-week workshop with follow-up seminars and case consultations.

Treatment: Up to 24 weeks of therapy provided in clinics. All subjects in both groups also received individual substance abuse counseling.

Outcome: Both FFT and parent group conditions produced positive changes in drug use, related symptomatology, family behaviors, and parent-child communication. 93% of families assigned to the FFT condition had a parent that participated in treatment. Only 67% of those assigned to the parent group had a parent that participated in treatment. FFT demonstrated significantly better engagement/retention of parents.

9. **Regas and Sprenke (1982):** An ADHD population

Clients: 55 ADHD adolescents at risk for out-of-home placement.

Therapists: Not reported.

Treatment: Not reported.

Outcome: The FFT group displayed significant decreases in hyperactivity post-treatment and at follow-up. **Risk/Protective factors:** Compared to group therapy and no treatment conditions, families that received FFT reported significantly improved family effectiveness on a self-report measure.

10. **Gordon (1995); See also Gordon, Arbuthnot, Gustafson, and McGreen (1988); Gustafson, Gordon, and Arbuthnot (1985); Gordon, Graves, and Arbuthnot (1995) (Evaluation Study 1):** Juvenile offenses at 2 1/2 year follow-up, cost-benefit analysis, and criminal offenses at adult follow-up

Clients: Delinquents with multiple offenses at risk for out-of-home placement, court-ordered into the family therapy treatment condition. Rural poor clients.

Therapists: 2nd to 4th year graduate students in psychology, 30 hours of training in FFT.

Treatment: Average of 16 sessions, in-home.

Outcome: **Study 1a:** Compared to juveniles who received regular probation services (n=27, 67% recidivism rate), clients in the FFT group (n=27) had an 11% recidivism (reconviction) rate at 2 ½ year follow-up. In any given 12-month period, the FFT group committed 1.29 offenses, and the treatment as usual group committed 10.29 offenses. **Study 1b:** A cost-benefit analysis of these recidivism data and additional data (including out-of-home placement costs and base numbers of offenses committed) on the same set of clients determined that FFT treatment had significantly lower direct costs than the probation group. **Study 1c:** At 5 year

follow-up, the same subjects were compared for rates of adult convictions. The group that received FFT had a 9% recidivism rate as adults, while the control group had a 41% recidivism rate as adults.

11. Gordon (1995); See also Gordon and Arbuthnot (1988) (Evaluation Study 2): Paraprofessional therapists: rates of reoffending and recommitment of severe conduct-disordered adolescents

Clients: 17- and 18- year old chronic offenders with an average of 7 offenses and 3 to 4 institutional commitments (in an institution for juvenile offenders) prior to treatment. Court-ordered into treatment upon release from a state institution for juvenile offenders. Rural poor.

Therapists: Paraprofessional trainees hired by the court with no graduate level training in mental health services. Training took place during a 2-day workshop, and was updated with a ½ day workshop every 4-6 months.

Treatment: In-home.

Outcome: Compared to regular services (recidivism 60 - 75%), juveniles who received FFT (n=40) had a 30% rate of re-conviction at 18 month follow-up. Of these same juveniles, 12% were re-committed, compared to the 50-60% rate among those receiving regular services.

12. Gordon (1995) (Evaluation Study 3): Recommitment rates of serious juvenile offenders

Clients: 16 and 17-year old delinquents with an average of 2 prior institutional commitments and 4 prior offenses. Court-ordered into home-based FFT therapy upon release from state institutions for juvenile offenders. Rural poor.

Therapists: 2nd - 4th year graduate students in psychology who received 30 hours of training in the FFT model.

Treatment: 18 to 24 sessions of FFT in-home.

Outcome: At 16 month follow-up, 33% of those who received FFT were re-committed, and 64% of those who received standard probation services were recommitted.

13. Lantz, B. (1982): West Valley City, UT

Clients: Adolescents at risk for out-of-home placement due to serious delinquency.

Therapists: Not reported.

Treatment: Not reported.

Outcome: The FFT group had significantly less removal from the home (18% vs. 72%) and significantly less reoffending/recidivism (50% vs. 88%) than the group that received services as usual.

14. **Hansson (1998):** Data from the first Lund, Sweden, FFT study

Clients: Predominantly male youth (average age 15) arrested by police in Lund, Sweden, for serious offenses.

Therapists: Professionals with graduate level training in mental health services who participated in a training workshop by Dr. Alexander.

Treatment: Treatment in a clinic, not time-limited.

Outcome: At 2 year follow-up, the FFT group (n=45) had significantly less recidivism (50% vs. 80%) than the treatment as usual group (n=50). **Risk/ Protective factors:** maternal improvements on symptom checklists evaluating depression, anxiety, and somatization in FFT group only.

FFT Replications

1. **Las Vegas: Family Intervention Services (Rich Harrison):** In-home therapy with serious juvenile offenders

Clients: Initially Freedom Program youth, high risk repeat offenders (ages nine to seventeen years) who chose an intensive supervision program (with FFT) rather than institutional commitment. Multicultural urban population, including White, African American, Hispanic/Latino, Asian American, and Native American youth and families. 25-30% female.

Therapists: Master's level counselors who received training in a 3-day work-shop and occasional supervision consultations by Dr. Alexander.

Treatment: In-home, duration not reported.

Outcome: 90% retention of families after initial contact. Initial data indicate equally successful retention in FFT for White, African American, and Hispanic/ Latino youth and their families. Enthusiasm of the Juvenile Court system has led to the program being used by not only Freedom Program youth, but probation services, intake services, Child Protective Services, judges, and other areas in the Court system.

2. **Las Vegas: Family Preservation (Susan Mears):** Preservation of families at risk for removal of a child; reunification of families with a child in foster care

Clients: Families at risk of having a child removed from the home due to substantiated abuse or neglect. Child Protective Services referrals. Reunification referrals by foster care workers. Multicultural urban population (approximately 24% African American, Hispanic/Latino, Native American, Asian American). Approximately 50% female children. In approximately 70% of families, females were identified as the child's primary caregiver. Children range in age from 0 to 18 years (familes referred for FFT if at least one child is school-aged or older).

Therapists: Family preservation therapists and social workers, trained through a 3-day workshop and follow-up consultations with Dr. Alexander.

Treatment: Therapy is provided in clients' homes, twice weekly for approximately 3 months.

Outcome: Independent evaluation reports that 86.5% of FFT families (n=52 in the first group) have been able to remain intact. Very positive impact given the traditional base rate of out-of-home placement for such high-risk families.

3. **Las Vegas: University of Nevada at Las Vegas, Harmony Health Care Agency, and Boyd Gaming Co. (Dr. Tom Sexton, UNLV, P.I.):** Treatment of Conduct Disorder through a collaborative, community-based approach

Clients: Juveniles (ages 12-17) diagnosed with Conduct Disorder whose parent(s) are employed by Boyd Gaming Company and receive mental health care services through Harmony Health Care Agency. The company and agency collaborated with UNLV in the provision of services. Multicultural urban population (25% African American, 25% Hispanic/Latino, 50% European American), half female juveniles.

Therapists: Trained and supervised by UNLV employees who had previously been trained in FFT. Type of degree and prior training not reported.

Treatment: 10 - 12 sessions at the health care agency.

Outcome: No data yet available.

4. **Urban Ann Arbor, Michigan: COPE/O'BRIEN Center (Stewart Schulman):** Delinquency prevention in a high-crime urban area

Clients: Preadolescents (must be age 10 or above) in a high-crime, low-income urban area, who display delinquent behavior. Predominantly White and African American youth, 1/3 female.

Therapists: Bachelor's level social workers, supervised by an M.S.W. Training consisted of a 3-day workshop that was videotaped for review. Follow-up consultations as needed.

Treatment: In-home, 12 weeks/30 contact hours of FFT service.

Outcome: Data are not yet available. Well-received by the community and press, and families that received the treatment filled out largely positive evaluations. Expected expansions to cover entire county and Juvenile Court cases.

5. **Albuquerque, New Mexico: University of New Mexico (Holly Waldron):** NIDA research, substance abusing youth

Clients: 13-17 year old substance abusing or dependent adolescents, frequently comorbid Conduct Disorder and internalizing problems, threat of incar-

ceration, school problems, and probation. White, Hispanic/Latino, and Native American youth and families, 1/3 female.

Therapists: Ph.D.- and M.S.W.- level therapists, trained in a 2-day seminar by Dr. Alexander. On-site supervision by Dr. Waldron, and follow-up consultations with Dr. Alexander as requested (approximately 2 per year).

Treatment: 12 weeks of therapy provided at the University of New Mexico.

Outcome: No data yet available

6. **Fayetteville, North Carolina: Community Mental Health Center (Cole Barton):** Treatment of aggressive/Conduct Disordered youth

Clients: Aggressive/conduct disordered adolescents, 60% White, 30% African American, 10% American Indian, in a low-SES military base/city, population 40,000. Of children aged 4-10, diagnosed predominantly with Attention Deficit Disorder and/or Oppositional Defiant Disorder, 75% boys. Of children aged 11-19, diagnosed predominantly with Conduct Disorder and/or substance abuse, 55% males. Females more likely than males to be diagnosed with affective or anxiety disorders as secondary diagnoses.

Therapists: Masters' level psychologists, Ph.D. supervisors. Trained in a 3-day workshop. Follow-up supervision by a Ph.D. level consultant once a month for 6 months.

Treatment: At the mental health care center. Varying duration.

Outcome: Fewer sessions needed, more people served, fewer residential service referrals made than there had been prior to FFT training.

7. **Lund, Sweden: 3 additional replications, all in different types of agencies, all underway (Kjell Hansson):** Treatment of arrested adolescents

Clients: Youth arrested by police in Lund for serious offenses.

Therapists: Graduate level training in mental health services. Training workshops by Dr. Alexander.

Treatment: At the mental health care center. Varying duration. Control treatment youth received probation services as usual.

Outcome: Significantly better treatment motivation and completion of treatment course in those assigned to the FFT condition. Maternal improvements on symptom checklists evaluating depression, anxiety, and somatization. Outcome data from Study 1 are reported above in the outcome studies section (see #14).

APPENDIX D

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