In this superb book, Thomas L. Sexton and his coauthors succinctly present the essence of functional family therapy, while also updating this work in the context of these times. They bring a lifetime of experience in delivering this evidence-based treatment in the context of larger systems such as juvenile justice, child welfare, and other community settings. With insights and methods that have great utility beyond the practice of the specific model, this book should be in the library of everyone who works with adolescents and their families or is in training to do so.

—Jay Lebow, PhD, Clinical Professor and Senior Scholar, The Family Institute at Northwestern and Northwestern University, Evanston, IL

Sexton, van Dam, and Anderson portray and promote FFT as the most relevant, accessible, innovative, and inclusive model for all clinicians, from graduate students learning to think and practice systemically, to seasoned clinicians new to family psychology, and those already using the model. This is a must-read for those treating adolescents, young adults, and their families in private practice, child welfare, and community mental health settings!

—John W. Bakaly, PhD, Professor, California School of Professional Psychology at Alliant International University, Los Angeles, CA

Functional family therapy (FFT) is the epitome of a scientifically proven family therapy model that has stood the test of time. The demonstrated effectiveness of FFT with a plethora of challenging families makes this book a must-read for anyone committed to conducting evidenced-based treatment. From trainees to seasoned clinicians, learn FFT and you are guaranteed to increase your effectiveness in working with complex families!

—Anthony L. Chambers, PhD, ABPP, Chief Academic Officer and Clinical Professor of Psychology, The Family Institute at Northwestern University, Evanston, IL

Clinicians and students who want to effectively help families address the challenges of contemporary life will find a treatment road map in *Functional Family Therapy*. This book provides practical information about the mechanisms and stages of change, with a focus on using real-time client feedback to enhance the therapeutic alliance and inform clinical decision making to achieve desired outcomes. Case examples throughout the book bring the principles and techniques of FFT alive in a way that makes them easy to understand and adopt in clinical practice.

—Mark Stanton, PhD, ABPP, Professor of Psychology, Azusa Pacific University, Azusa, CA, and coauthor of *Family Therapy: An Overview*

Contents

1 THE EVOLUTION OF FUNCTIONAL FAMILY THERAPY

Working With Contemporary Families

Youth, families, and communities face immense challenges in the contemporary world. Economic pressures and challenges resulting from the recent pandemic, cultural divisions, and the barriers in education and work make it difficult for families to survive adequately and provide basic needs, much less to thrive. For those families raising children, it is increasingly difficult to do one of the primary jobs of any family: to provide a safe place where children can learn about the world, how relationships work, and how to work together. Youth are increasingly challenged with social isolation, peer pressure, and educational challenges. When youth and their families struggle or enter the juvenile justice or child welfare systems, it is not easy to find help that actually helps, especially in disadvantaged communities in which it is hard to find help that matches the cultural, economic, and ethnic diversity of the family. Put simply, when families seek services, they face the challenge of finding effective services. Moreover, when they find the services provided by clinicians who want to help, it is important that these clinicians are adequately prepared to implement the most effective treatment approaches. Early psychological treatment models focused on treating the individual.

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Functional Family Therapy: A Comprehensive, Evidence-Based Treatment for Diverse Communities, by T. L. Sexton, A. van Dam, and M. Anderson

They centered on creating the necessary conditions for good relationships that, it was hoped, would facilitate clients changing and meeting their goals (Rogers & Truax, 1967). Early models of treatment also focused on using these core relationship skills to help get in touch with emotional struggles, challenge disruptive thinking patterns, or reinforce behavior changes. The early models mental health professionals learned in school focused on discovering the causes, or drivers, of individual behavior and overcoming them. Therapists trying to learn treatment models were often told that it did not matter which model we used but instead to find one that fit our style and was comfortable for us so we could be authentic in its delivery. Thinking back years later, it is curious that the question was never "What fits the client best?"

Family therapy began when innovative family clinical practitioners concentrated on the patterns and structures of families as the unit of clinical change (Lebow & Sexton, 2016; Sexton & Lebow, 2016). Focusing on the process of how families function together created a new paradigm that brought dramatically different ways of thinking about clients, their problems, and how to help them change (Sexton & Stanton, 2016). The paradigm shift was revolutionary because it focused on the processes of how families worked rather than the internal motivation of any individual. Family therapy was unique because it centered on the process of how families worked and less on why they worked. These early clinical ideas became the basis for the next generation of family therapy models.

Unfortunately, in community-based practice, these potentially powerful models were often initially seen as an adjunct to more critical individual treatment approaches (Sexton & Lebow, 2016). Even early on, family therapy embraced science. Many early models also evaluated the legitimacy of family therapy in general and the efficacy of treatment models and clinical change mechanisms more specifically. Science was used to evaluate what worked, how it worked, and what promoted positive client outcomes. Today, family therapy models have been demonstrated to successfully help families with many of their most serious problems (Datchi & Sexton, 2016; Sexton & Datchi, 2014; Sexton et al., 2013). Systematic family therapy models are no longer the add-on. Instead, they are now the primary treatment models for various problems across the service delivery systems in which families receive help.

Functional family therapy (FFT) has a long history as a treatment model for adolescent conduct problems, drug use, and mental health concerns (Gurman & Kniskern, 1981; Parsons & Alexander, 1973; Sexton, 2010; Sexton & Datchi, 2014). FFT was one of what are often called the "second generation" family therapy models (Gurman & Kniskern, 1981). As a theoretical model, FFT is

among family therapy models built on the core principles of systemic thinking and the early family therapy theoretical models, including structural family therapy (Minuchin, 1974), strategic family therapy (Madanes, 2014), the social constructivist approaches (Hoffman, 1990), and the interactional ideas of the early Mental Research Institute approach (Weakland et al., 1974).

FFT is built on the same core systemic ideas as these other early and contemporary family therapy models, but it stands out because of its unique perspective. Unlike other models that view families as having a predetermined "healthy" way of functioning, in FFT healthy families are those that meet the needs of their members while fitting into the larger context in which they operate (Sexton & Alexander, 2003). Based on the core principles presented in Chapter 2 of this volume, FFT perceives families as patterns of behavior that hold unique meanings, given by each family member to the behaviors in those patterns. Unlike other systemic models with a separate assessment phase, FFT assesses patterns, meanings, and the ways in which families are attached as an ongoing process central to each treatment phase (Waldron & Turner, 2008). Unlike other intergenerational models such as Bowen (1993), FFT focuses on the current relational functioning of the family, considering historical influences as the basis for how each family member thinks and acts.

In contrast to the early strategic models, such as Haley (1976), FFT is a process of change rather than a list of techniques that match the unique family's functioning in treatment (Waldron & Turner, 2008). FFT also approaches family assessment differently. Finally, as currently practiced, FFT uses real-time family feedback to make session-by-session clinical decisions. This approach is unique to FFT and allows the therapist to adjust treatment in real time based on the needs and responses of the family.

In the 1990s through the 2000s, FFT was labeled as an evidence-based treatment (Sexton & Alexander, 2002a). Evidence-based means that the ideas of FFT have a scientific foundation and, when practiced as intended, the model produces positive outcomes with various youth and families. Over the years, the body of evidence supporting various treatment programs has grown significantly, with several programs labeled as evidence based. One such program is multisystemic therapy (MST), which employs an eclectic blend of treatments to address factors within the larger system that surrounds families (Henggeler et al., 1999). Multidimensional family therapy (MDFT; Liddle, 2016) and brief strategic family therapy (BSFT; Szapocznik & Hervis, 2020) are actual family therapy models based on the core principles of structural family therapy (Little, 1999). These programs have demonstrated efficacy in treating a wide range of mental health issues in children and adolescents. Among these models, FFT has been recognized as a premier evidence-based family intervention model for working with adolescents with problem

behaviors (Kazdin, 2013). Along with MST, FFT was at the center of the beginning of the evidence-based practice movement that revolutionized juvenile justice treatment in the late 1990s.

More recently, the Family First Prevention Services Act (FFPSA; 2018) recognized FFT as among a few evidence-based interventions, including BSFT, MST, parent–child interaction therapy (PCIT), generational parent management training - Oregon model (PMTO), and others, that improve the well-being of youth and adults, enhance family functioning, and overcome the challenges of delinquent behavior, substance use, and behavioral and emotional functioning of youth. With the FFPSA implementation, FFT is again poised to revolutionize interventions used in the child welfare arena.

Despite widespread use, to remain relevant in a changing world working with contemporary families, evidence-based models like FFT must continue to evolve and incorporate new ideas and research while maintaining their core mechanisms and theoretical principles. Over its 4 decades of evolution and development, FFT has matured to include a comprehensive theoretical lens, a systemically relationally-based change process map, and an appreciation and reliance on the clinical creativity of the therapist who translates the model from an idea into practice in the relational interactions with the client and family using honest, real-time client feedback and decision-making support.

From our experience implementing and practicing FFT in community-based settings, we know that it takes more than a model to replicate the positive outcomes of research findings in real-life community practice settings for several reasons. First, contemporary families are complex relational systems that face enormous challenges when interacting with the justice, mental health, and child welfare systems. Models need to adjust to the complexity of families as they change form and function over time. Second, most therapeutic models lose a significant number of potential positive effects demonstrated in research studies when implemented in the community, which means that more than just high-fidelity practice contributes to outcomes (Sexton, 2010). Finally, therapy is, at its core, a relational interaction between the therapist and the client. The therapist helps guide the family through the complex phases of change that result in new stability with improved functioning and resilience. The therapist needs a process-based lens to think about the family in ways that highlight the critical change processes. Session by session, the therapist needs the guidance of the family as they try to match the model to the family. Moreover, therapists need to plan and think through ways to reflect on what happened and to prepare for a purposeful next session.

WHY THIS BOOK?

In the last 40 years, FFT has been represented in all major professional handbooks and publications (e.g., *Handbook of Family Therapy*; *APA Handbook of Contemporary Family Psychology*, *Handbook of Clinical Psychotherapy*) and individual volumes describing the model (Alexander et al., 2013; Parsons & Alexander, 1973; Sexton, 2010). In this book, we aim to go beyond a theoretical description of the model and instead look at the evolution of FFT as it is practiced, implemented, and trained. In the pages that follow, we bring the theory and science of FFT and our practical experience working with FFT in diverse contexts to

- illustrate the evolution of FFT. In its evolution, FFT has blended structure and creativity into a systematic approach to working with some of the most challenging clinical cases. We use real-life clinical case studies in each chapter to illustrate the concepts practically.
- highlight how we have contextualized FFT to best fit the different community contexts in which it is practiced. Over the last decade, FFT has evolved to work in several unique settings. These adaptations are systematic contextualizations of the core FFT model designed to fit the unique features of the service delivery context in which it is used. These adaptations address the emerging needs of families in child welfare, youth and families in foster care, and adult offenders reuniting with families to support their rehabilitation.
- show how continuous quality improvement strategies promote the successful implementation of FFT in community settings with model fidelity.
- illustrate community-based implementation of FFT. The positive outcomes of any treatment model depend on how it is delivered. We practice FFT by integrating the model's foundational research with the ongoing real-time feedback (or evidence) from the family's session-by-session markers into clinical decision making. We focus on therapist clinical decision making and training to bring knowledge and the ability to translate that knowledge into practice. We offer a new approach to systematic clinical decision making that integrates client voice with clinician assessment to produce model-specific sessions and case plans.
- show how we have leveraged technology to improve practice, training, and implementation. Clinical decision making in FFT is built around leveraging technology through our unique Care4 web-based platform. FFT-Care4 is a comprehensive web-based system integrating clinical

decision making with session-by-session client feedback, translating the results into real-time feedback to help practitioners make the next clinical decision. This approach helps combine patient-centered evidence (or input) into a comprehensive method for planning and implementing FFT sessions in an easily digestible way that allows clinicians to adjust and adapt to best meet the needs of each unique family.

These areas of evolution and development in the FFT model bring together the best of the science, theory, and clinical practice when implemented in community settings, allowing each to be constantly tested with complex families in complicated scenes with a wide range of problems. These adaptations make FFT far from just a theoretical guide but a practical, comprehensive, clinical approach for helping families in natural community settings.

As a reader, you may approach the book in two ways: first, with curiosity about this way of thinking and working. The book contains many ideas that you can take and apply to your clinical work, as well as several techniques and tools you can use to help your clients. The second may be for readers seeking a primary model to guide their everyday practice. These readers may be interested in adopting a comprehensive model of practice that integrates a way of conceptualizing families, problems, and treatment and a systemic treatment model. For those readers, we also describe how to practice FFT systematically, use ongoing family-based evidence to make clinical decisions, and receive systematic training that leads to certification in FFT. This book may inspire other readers to receive additional FFT training. All readers will find something helpful in this book. FFT is a complete model that includes a way of thinking, delivering services, planning purposeful sessions, and integrating the client's voice in every treatment decision through measurement feedback.

THE CHALLENGES FACING CONTEMPORARY FAMILIES

Helping families change is one of clinicians' most complex therapeutic tasks (Sexton, 2016). What makes helping families even more difficult are the enormous challenges to children's social and emotional development that contemporary families face. These challenges come from various sources, including social media and technology, the general cost of living and housing affordability, access to quality education and community resources, and the availability of quality mental care. The data emerging regarding the challenges faced by contemporary families are disheartening. Based on 2020

data from the Substance Abuse and Mental Health Services Administration (SAMHSA; 2021),

- 60,000 youth enter the juvenile justice system every year.
- 615,000 youth were victims of child maltreatment. Of these, 72% were under the age of 10 years, 16% were victims of physical abuse, 9% were victims of sexual abuse, and 7% were victims of emotional abuse.
- The number of adolescents involved in the mental health system has grown significantly. Of these, 15.1% had a major depressive episode, 36.7% had persistent feelings of sadness or hopelessness, 4.1% had a substance use disorder, 3.2% had an illicit drug use disorder, 18.8% seriously considered attempting suicide, 15.7% made a suicide plan, 8.9% attempted suicide, and 2.5% made a suicide attempt requiring medical treatment.
- 520,000 youth are currently out of their homes in foster care. Of these, some 200,000 exit the system and do not go home. While the numbers have been decreasing, current research suggests that children in foster care showed higher levels of psychopathology than those from the community or matched/at-risk samples.
- Placement instability is related to behavior problems among youths in foster care, regardless of the type, severity, or frequency of children's maltreatment experiences.

While staggering, these data are even more troublesome because they are drastically disproportional. National data trends continue to show that Black and American Indian children are overrepresented among children entering foster care. In 2020, Black children made up 20% of foster care entries while making up only 14% of the total child population (Annie E. Casey Foundation, 2022). Families of color are more likely to experience adverse outcomes, more likely to experience multiple placements, less likely to be reunited with their birth families, more likely to experience group care, less likely to establish a permanent home, and more likely to experience poor social, behavioral, and educational outcomes. This disproportionality is also represented in juvenile justice: In 2017, youth of color accounted for 28% of the U.S. population but represented 67% of offenders in residential placement (Office of Juvenile Justice and Delinquency Prevention, n.d.). This disproportionality reinforces how vital it is to ensure services that have been demonstrated to be effective reach those families and communities impacted by systemic racism in hopes of preventing these trends from continuing.

Understanding how families work and how to help effectively is challenging. Typical approaches to understanding families begin with a "typical" or prototypic family structure or process. Unfortunately, the modern family defies simple categorization. Recent changes in family life are only the latest in a series of transformations in family roles, functions, and dynamics over time. For example, in the 1950s and 1060s, 73% of children in the United States lived within two-parent households (Aragão et al., 2023). Currently, two-parent heterosexual households are not the norm—the vast majority of families include single parents, blended families, cohabiting or remarried parents, same-sex couples, and partners without children, and less than half of families in the United States self-identify as two-parent households. Divorce and the resulting family disruption are as likely as not for families today. That means more reconstituted families with stepparents and youth from different families or origins. Economics has also placed significant challenges on families. Difficult economic conditions and increasing inequality have resulted in changes in family roles and other work arrangements for parents, causing changes in parenting and family structure at home.

In our work, we adopt a rather broad definition of families that crosses cultures and geographic boundaries. For FFT, the family is the current constant relational system in which a youth lives. The current family may be multigenerational families, single households, friends, and nonrelated relationships that become family because of estrangement or other circumstances with their family of origin. In FFT, our focus is not on the structures and features of families but on how families work or function. A relational family systems view on family functioning best captures how families across cultures function (Sexton & Stanton, 2016). This view allows the therapist to have a systemic idea of how families work so they can identify the core family process on which to apply therapeutic change mechanisms. This approach also allows treatment models to cross some of the barriers noted previously, including unique family forms and cultural expectations for family. This approach lets clinicians focus on how they are working to help families function within their structures, values, and traditions in a way that meets the goals of the context around them.

The challenge for communities and treatment providers is providing culturally appropriate and effective services and programs that fit the communities and clients to be served. For individual clinicians helping families, the challenge is understanding families beyond their presenting problem and applying a relational and systemic perspective to understanding youth problems more broadly and systemically. Take a few minutes and remember when you first started doing therapy. You had been to class, maybe even practiced, and role

played. With your first family, you faced multiple people with different agendas, high emotions, and a long history of struggles that are enacted right in front of you. What did you need to help them? What would have helped you manage the emotional, complex, and sometimes intense interactions between family members? What should you have looked for to understand how the family worked? Functional family therapy is a model that brings structure to clinicians to help them understand families, the problems they face, and a change process to help them.

THE HISTORY OF FFT: EVER EVOLVING AROUND UNWAVERING CORE THEORETICAL PRINCIPLES

FFT is unique as a theoretical model because it is dynamic and evolving (Sexton & Alexander, 2003). More than a series of intervention techniques, FFT is a way of thinking about clients, the problems they experience, and a systematic and comprehensive way of helping them change. As noted earlier, FFT takes three elements: a lens to help you focus, a map to follow that leads to effective change, and the therapist's creativity that helps match the model to the uniqueness of the family and allows for creative yet model-specific and guided solutions that successfully wrap the FFT model around the family (Sexton, 2010, 2016, 2017).

Bruce Parsons (1972) initially developed the FFT model for his doctoral dissertation. According to Parsons (personal communication, June 16, 2010), focusing on youth engagement in the juvenile justice system just "came to him." This early idea to think about change as a series of phases built on the systematic engagement of youth was the core idea that created FFT. In the 1970s and 1980s, FFT was pioneered and further developed by Jim Alexander. Under Jim's guidance, FFT was among the first models to research clinical model development by including one of the first treatment processes and randomized outcome studies as part of the early development process (Alexander & Parsons, 1973; Parsons & Alexander, 1973). This work resulted in an earlier version of the FFT clinical model that focused on a two-phase therapy process (engagement and client motivation) and education (specific behavioral interventions). Early descriptions of FFT relied on simplistic behavioral technologies such as communication training (Alexander & Parsons, 1973) and common systemic principles of family relationships.

The first significant articulation of the core principles of FFT was developed by Barton and Alexander (1981), and FFT was included as one of the second generation of family therapy models in the historical *Handbook of*

Family Therapy (Gurman & Kniskern, 1981). Unique in the work of Barton and Alexander (1981) was the introduction of relational functions as a theoretical description of the role of individual psychological processes in the systematic patterns and relationships among family members. The research focusing on the clinical process, particularly in regard to gender and relational negativity and blame, contributed to the further understanding the FFT clinical process. In 1988, Alexander developed the anatomy treatment model (ATM) that advanced the field forward by systematically linking treatment into phasic goals matched with specific therapist behaviors (Alexander, 1988). ATM focused on a five-stage treatment model that was very linear in its approach (engagement, assessment, motivation, behavior change, and generalization).

Over the last two and a half decades, Sexton and Alexander have been the primary model developers of FFT, coauthoring chapters, studies, and manuals (Alexander, Pugh, et al., 2000; Alexander & Sexton, 2002; Alexander, Robbins, & Sexton, 2000; Sexton & Alexander, 2002a, 2003, 2006). The Alexander and Sexton collaboration began in the late 1980s with the establishment of the first national FFT training center, research, and international certification training program (Alexander, Pugh, et al., 2000). That initial work resulted in the first rollout of FFT as a treatment program in the Washington State juvenile justice system during the beginning of the evidence-based practice movement. The core FFT training program and the first iteration of a computer-based decision-making tool (Client Services System, CSS) were developed in that early work.

During this time, Sexton and Alexander evolved FFT along two parallel paths. First, they reenvisioned the clinical model to include three phases, initially labeled the phase task analysis (Sexton & Alexander, 2000). This model was based on the concept that the clinical process was guided by systematic and consistent treatment and assessment goals representing successful change while drawing on the constant and complex circular relational process between the therapist and family. Thus, successful FFT was described as a circular, relational, process-based model that moves through specific and predictable phases in which treatment outcomes build on one another, resulting in positive behavior change. Second, the early development of methods to systematically train therapists and implement FFT in community settings included our first attempts at community-based implementation and fidelity measurement (Alexander, Pugh, et al., 2000).

In 2007, Sexton and Alexander ended their partnership. Since then, Sexton has continued to publish chapters articulating the clinical evolution of FFT in the seminal works of the profession (*APA Handbook of Contemporary Family Psychology*, *Handbook of Family Therapy*). In addition, both Sexton (2010)

and Alexander (Alexander et al., 2013) published books on the FFT model. Currently, two certified training organizations (FFT Associates, https://functionalfamilytherapy.com; FFT Inc., https://www.fftllc.com) use the same clinical model but differ extensively in training, implementation, and the use of data in clinical decision making.

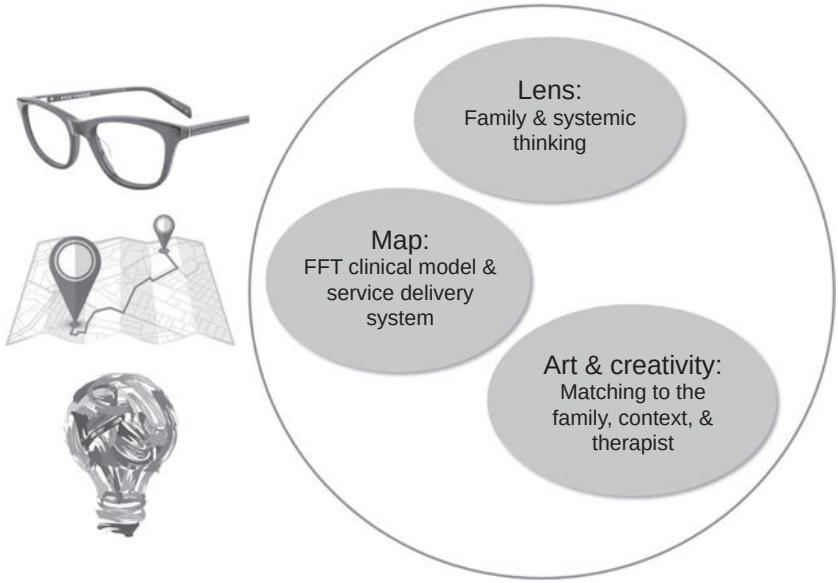
Unwavering Principles Guiding the Evolution of FFT

The evolution of a psychological model like FFT involves systematically refining and evolving the model over time based on empirical evidence, conceptual reasoning, and practical considerations (Popper, 1959). While FFT has evolved, it has done so around several guiding principles that aim to retain its core identity while allowing it to grow and evolve into the contemporary world (Sexton, 2010). Figure 1.1 shows the core components of FFT.

Theoretical Coherence

FFT has always been grounded in the systemic principles of family psychology. A lens is a valuable metaphor for understanding the core concept and foundation of how we think families function and how successful therapy

FIGURE 1.1. The Core Components of FFT: Lens, Map, and Art



Note. FFT = functional family therapy.

works. FFT's core lens uses a systemic view of family functioning, systemically based principles of therapeutic change, and implementation strategies to help build purposeful treatment with good outcomes. The lens describes the system of patterns and individual meanings that form the functioning of a family and becomes a way to help organize the overwhelming information therapists get bombarded with when working with families. The lens of FFT has evolved to fit the challenges of contemporary families.

Follow the Scientific Evidence

Foundational evidence is the scientific foundation of a model that makes clinicians confident that what they are doing is reliable and works. FFT has years of evidence showing positive outcomes, including improved communication, reduced conflict, reduction in child removals, improved family functioning, decreased substance use, and decreased mental health symptoms and behavioral problems (Alexander, Pugh, et al., 2000; Sexton, 2010, 2016, 2019a). As evidenced in family therapy and FFT, we continue evolving our ideas based on emerging science.

Practical Utility

For us, FFT is only as useful as it can be implemented in community settings with contemporary families. A map is a useful metaphor to describe the clinical protocol of FFT in a way that can be followed by therapists so it guides treatment. Each stage has goals and intervention strategies specifically designed to address these goals. FFT phase goals are proximal processes or intermediate steps to lasting family change. When used by therapists, the protocol becomes somewhat like a change map, leading them from the most critical initial stages to the final steps of helping maintain changes. When experienced by the family, it is a seamless process and conversation that is highly personal, specific, and relevant to their most concerning issues while engaging all family members.

Purposeful Clinical Decisions

Purposefulness by the therapist is required to successfully navigate the map of a model and replicate the evidence-based change mechanisms. Clinical decision-making tools and a measurement feedback approach help make each session purposeful and effective (see Chapters 9 and 10). Like the clinical model, these tools constantly evolve as we learn more effective ways to guide therapists doing FFT.

Creativity

FFT is creative and artful when the clinician translates the model to the unique nature of the family, thus fitting the model around the family rather

than having the family fit in the box of the model. The FFT model is the knowledge and procedural structure that forms the scaffolding of a therapist's expert judgment. This scaffolding includes the system within which cases are conceptualized and the foundation of how in-the-room decisions are made. The model offers a way to integrate case conceptualizations, core skills, and contingent yet model-specific clinical decisions. It organizes the vast array of information gained from clinical experience into meaningful and usable principles that have clinical utility. It allows the therapist to know the goal, the most reliable and valid ways of accomplishing it, and a way to judge whether adaptation or variation needs to occur. Ultimately, the FFT model helps navigate the complex, emotional, and challenging tasks in successful therapy. In this way, FFT is both structured and client centered.

An Evolving Model and an Evidence-Informed Service Delivery System

In the last two decades, our team (Sexton, 2010, 2019b) focused on the theoretical evolution of FFT by bringing to the model clinical specificity that applies to community-based practice. For example, in the engagement and motivation phase, we have further developed the ideas of relational reframing and incorporated relational themes to make reframing easier and more effective in changing core meaning among family members (see Chapter 3). In the behavior-change phase, we have further articulated the skills and how the skills are implemented (Chapter 4). Rather than teaching skills, we focus on helping guide families by demonstrating skills in sessions. We also expanded the core concept of maintaining change in the generalization phase to include specific relapse-prevention strategies (Chapter 5).

The contexts in which FFT is used have also expanded. To be successful with contemporary families, FFT must fit into the service delivery contexts of child welfare, mental health, youth services, and foster care. However, it has to fit in a way that allows for positive outcomes. Several early research studies suggested that FFT was more effective when practiced in community-based settings with high fidelity. Sexton and Turner (2010), Graham et al. (2014), and Hartnett et al. (2016) found that positive outcomes of FFT in community-based settings were the result of an interaction between the model and the fidelity of the model as implemented by an individual therapist. Thus began an effort to understand what it takes to implement an evidence-based model like FFT in a community setting. These efforts have resulted in a comprehensive implementation approach that now includes a specific clinical protocol, a reliable and valid measurement system, and decision-making tools to help improve outcomes. Today, continuous process assessment and systematic evidence-based treatment planning bring clients' voices into clinical decision

making through feedback, a central principle in FFT practice. This approach also allows for ongoing research and model development.

Scientific Foundations

As noted earlier, research and evaluation have always been vital to the evolution of FFT. The cumulative evidence over 40 years demonstrates that when implemented correctly, FFT can result in positive outcomes in many settings and with thousands of diverse clients (Alexander, Pugh, et al., 2000; Sexton, 2010, 2019b). The research supporting FFT is community based, of high methodological quality, and with "real" youth (e.g., multiproblem, ethnically diverse, comprehensive socioeconomic status) in real settings (e.g., home, community) implemented by community-based professionals with diverse training backgrounds. These studies led the Center for Substance Abuse Prevention and the Office of Juvenile Justice and Delinquency Prevention to identify FFT as a model program for both substance abuse and delinquency prevention (Sexton & Alexander, 2000). Similarly, the Center for the Study and Prevention of Violence (CSPV) designated FFT as one of the 11 (out of over 1,000 reviewed) "Blueprint" programs (D. S. Elliott, 1998). The Families First Prevention Clearing House reviewed FFT and found it well established in four different areas (see the next section). Such designations are based on the fact that FFT has demonstrated outcomes in many settings and with many diverse clients. The information presented in this chapter is not intended to be a systematic review of the research on FFT. Instead, this selected list attempts to establish the breadth and longevity of the research evidence.

The initial study of FFT was conducted by Alexander and Parsons (1973) and Parsons and Alexander (1973). At 18-month follow-up, the reoffense rate for youth treated with FFT was 50% lower than the rate for other treatment groups (26% for FFT, 50% for no-treatment controls, 47% for client-centered family group therapy controls, and 73% for eclectic psychodynamic family therapy). The study also established that FFT positively impacted family communication patterns. Klein et al. (1977) published a follow-up study and found that siblings in the families that received FFT (in Parsons & Alexander, 1973) were significantly less likely to enter the system themselves. These findings suggest that FFT significantly impacted siblings who were not even the primary focus of attention in therapy. Gordon et al. (1988, 1995), using a model of FFT that emphasized problem-solving and specific behavior-change skills, found that participants in FFT had much lower rearrest rates at both 24 months and 5 years posttreatment. Compared to juveniles who received regular probation services (67% recidivism rate), those in the FFT group had an 11% recidivism rate at a 2-year follow-up.

The most extensive study of FFT was conducted in Washington State, and it was the first to study FFT in a large community-based setting with more than 2,000 participants (Sexton & Turner, 2010). Compared to a no-treatment control, participants in FFT had a 31% reduction in criminal behavior and a 43% reduction in violent recidivism. However, the positive effect of FFT was not uniform. Whereas therapists who delivered FFT with high fidelity (i.e., how it was designed) had the outcomes noted previously, those who did not provide the model with high fidelity had results that were worse than the results for youth who received no therapy at all but instead were merely supervised by their probation officer (Sexton & Turner, 2010). This finding suggests that quality assurance and implementation plans are critical in successful community implementation.

More recently, Gottfredson et al. (2018) studied FFT in community settings, providing services through the Affordable Care Act Medicaid programs and services. The study also provided a rigorous test of FFT accommodated for a contemporary urban population. Compared to those in other treatment, youth who participated in FFT showed significantly fewer drug charges, were less likely to be adjudicated, and had fewer property charges; FFT was effective in engaging and retaining both low- and high-risk youth in treatment. From baseline to 18 months posttreatment, youth at high risk for gang membership who participated in FFT had lower prevalence of arrest; had fewer felony, crimes against person, and property charges; and had a lower rate of being adjudicated as delinquent. Youth who receive FFT are less likely to receive alternative, more costly public services (such as residential placement), which results in an estimated reduction in service costs of $2,000 per youth served while receiving treatment.

International studies found similar positive outcomes of FFT. The first (Graham et al., 2014), in Ireland, was a retrospective study of FFT's effectiveness, suggesting that adolescent behavior problems improved in cases treated with FFT. The most significant improvement occurred in families treated by therapists who successfully implemented FFT. The 98 treatment completers showed a substantial improvement in conduct problems, hyperactivity, emotional symptoms, and prosocial behavior. After an average of 17 weeks of FFT, approximately 40% of cases were clinically recovered and scored below the clinical cutoff. Various areas of mental health and the best outcomes occurred when families received treatment from therapists who conducted FFT with high fidelity. In a second randomized trial (Hartnett et al., 2016), the dropout rate was only 7%. The families who participated in FFT reported significantly more improvement in adolescent conduct problems and family adjustment, and revisions shown immediately after treatment were sustained at a 3-month follow-up.

In Denmark, Vardanian et al. (2020) found improvements in youth behavior, family functioning, and school-related outcomes (e.g., school and truancy). FFT led to a significant reduction in youth reports of both internalizing and externalizing for females and of externalizing for males. FFT resulted in a significant reduction in parent reports on both externalizing and internalizing for females and males. FFT led to a significant reduction in parent and youth reports of family conflict. In studying the effectiveness of FFT in the juvenile justice system in Singapore, Gan et al. (2021) found improvements in mental well-being over time for adolescents in the FFT group. For youth at or above the clinical range at the baseline assessment, families in FFT showed significantly more family functioning improvement (clinical recovery) than families in the comparison group. Youth in FFT were significantly more likely to complete probation than youth in treatment as usual, with 84% treatment completion rate for youth in FFT.

Meta-analytic studies and systematic reviews have also found FFT effective to address several clinical problems. Waldron and Turner (2008) found FFT to be a model with enough evidence to be classified as well established as a treatment for youth substance use. Hartnett et al. (2017) systematically reviewed published and unpublished English language articles, identifying 14 studies containing 18 comparisons between FFT and other treatment conditions for adolescent disruptive behavior and substance use disorders. In 11 of these comparisons, assignment to conditions was random, while nonrandom assignment occurred in 7 studies. FFT was found to be effective in systematic reviews across various studies and contexts (Sexton, Alexander, & Mease, 2004; Sexton et al., 2013).

The cost saving of FFT in community-based systems has also been studied. Barnoski and Aos (2004) found that FFT saved the Washington State system $16,250 per youth in court and crime victim costs, not to mention the incalculable emotional pain suffered by family members. This same algorithm suggests that for every $1 invested in delivering FFT, there is a $14.67 return on investment in system cost savings. Recent studies and projections identify similar cost savings and other significant social benefits (Chapin Hall, 2024; Taxy et al., 2012). In studying the cost-effectiveness of FFT and MST models, Stout and Holleran's (2013) estimates of cost saving suggest projected annual savings of $1.33 million for FFT and $2.16 million for MST. They estimated total savings of $17.33 for FFT and $18.16 for MST for every dollar invested in treatment.

Another way of considering the scientific evidence for FFT is to look at the clearinghouse reviews of evidence that the FFPSA is now conducting. The FFPSA established the Title IV-E Prevention Services Clearinghouse, which

reviews and rates various mental health, substance abuse prevention and treatment services, and in-home parent skill-based programs to determine their level of evidence-based effectiveness. The Clearinghouse has a high standard of evidence:

- It must have at least two rigorous randomized controlled trials or quasi-experimental research studies with a nontreatment group.
- The trials must demonstrate a sustained effect at least one year beyond the end of treatment. The effect must positively favor the treatment group.
- The study must be published in a peer-reviewed journal, and the research must have been conducted reliably with an independent replication by another research team.
- The program must have a manual or a protocol that describes the service delivery clearly so that it can be replicated.
- The program should be able to achieve its intended outcomes or effects consistently.
- The trials must be conducted with a sample representative of the target population.
- Statistical significance must be maintained in the findings.

Based on these criteria, the Clearinghouse uses a systematic review process to rate programs and services as *well-supported*, *supported*, *promising*, or *does not currently meet criteria*. In their review of FFT, the Clearinghouse rated the model as among only a few well-supported models (only three that were family based) in youth and adult mental health, youth substance use, and family conflict.

IMPLEMENTING FFT IN THE REAL WORLD

Implementing FFT in diverse community settings is the work we do every day. Implementing a model like FFT is far more complicated than reading a book or taking a class. In real-life clinical settings, clinicians must translate the model with fidelity while constantly evaluating whether a client is improving, remaining stable, or deteriorating. The FFT model provides the structure of what to do, but the therapist uniquely translates the model, based on their creativity and clinical wisdom, uniquely for each family. As the family tells their story, the therapist must respond in a personal yet therapeutic way, taking every opportunity to react purposefully to meet the phase-based relational goals of the model and to help move therapy forward. In the therapy room, FFT is a conversation, an ongoing discussion in which family members

describe their struggles, experience their related emotions, and work to change their situation. The therapist's job is to turn these discussions into a mechanism for positive change. The therapist's creativity helps translate the presented concerns of the problem by the family into the FFT model in a specific and appropriate way.

The FFT model is designed to aid in that creativity. FFT is the structure within which the expert develops systematic and complex case conceptualizations by providing a reliable and clinically relevant way to understand clients, problems, and context. The FFT model forms the scaffolding of a therapist's expert judgment. The model offers a way to integrate case conceptualizations, core skills, and contingent yet model-specific clinical decisions. It organizes the vast array of information gained from clinical experience into meaningful and usable principles that have clinical utility.

WHAT'S NEXT?

Working with families effectively is difficult. Youths and their parents bring their private world to a stranger in hopes of finding solutions to insurmountable problems. The therapist must deal with their desires and hopes for the families and the growing and complex research on adolescent issues, evidence-based treatments, and good treatment. Ultimately, all this information must be combined into a relational, personal, and powerful way of working with troubled youths and their families. Success takes much more than broad principles and a good heart. FFT is a model that can help the therapist by providing an anchor in the storm of emotion and a map to guide what to do next. For the family, FFT delivers a respectful, empowering, and client-centered approach based on the best the field offers to help them with the unique, powerful, emotional, and essential struggles they face every day.

Chapter 2 describes the conceptual and theoretical core of FFT. This is the lens we use to understand families, their problems, and ways to help them change successfully. We address how FFT works, why FFT works, and the change process in FFT. In the remaining chapters in Part I, we review each phase of FFT change in detail. The interlocking and developmental approach of these phases makes a change process rather than a series of independent tools or interventions.