**Program Background**

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 a set of core theoretical principles which represents the primary focus (family), and an overriding allegiance to positive outcome in a model that understands both positive and negative behavior as representations of family relational systems (functional**). Thus, Functional Family Therapy has adopted an integrative stance that stresses functionality of the family, the therapy, and the clinical model.

The developers and replicators of Functional Family Therapy have recognized that solutions require an integration of high quality science, tested theoretical principles, and extensive clinical experience in pursuit of specific 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; and
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.

Unlike other therapies, FFT was not developed on college students, neurotic individuals, or inpatient adults. Instead, FFT grew out of a need to serve a population of at-risk adolescents and families that were under served, had few resources, were difficult to treat, and were often perceived by helping professions to be treatment resistant. In many cases these families entered the "system" angry, resistant, and unmotivated to change. Essentially the "helping professions" did not know how to treat this population. **FFT developed out of the awareness that to be successful in treatment of this population we needed to be culturally competent, and understand why this group was so treatment resistant. Thus, FFT attempted to develop ways to engage these families in order to help them achieve obtainable change and become more adaptable and productive. Over the last 30 years, FFT has learned that it is important to do more than simply stopping bad behaviors.** We know that it is important to motivate families to change in a positive way by uncovering and developing the unique strengths of the family in ways that enhance the families' self-respect while providing specific ways to improve.

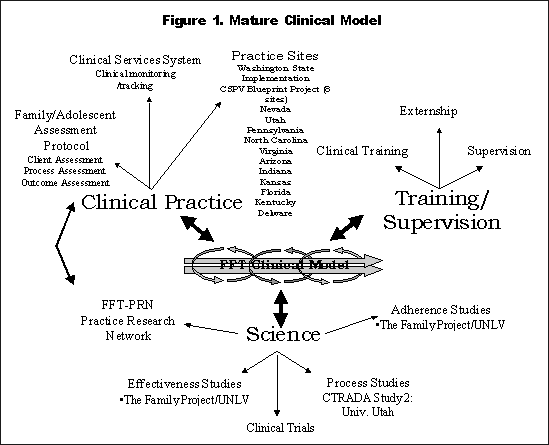
Since its inception in 1969, FFT has accomplished its primary goals by integrating the most promising theoretical perspectives, the empirical data available, and hours and hours of direct clinical experience with the troubled youth we wanted to help. FFT is designed to increase efficiency, decrease costs, and enhance our ability to provide service to more youth by:

1. Targeting risk and protective factors that we can, in fact, change and then programmatically changing them;
2. Engaging and motivating the families and youth so they participate more in the change process;
3. Entering each session and phase of intervention with a clear plan and by using proven techniques for implementation;
4. Constantly monitoring process and outcome so we don't fool ourselves or make excuses for failure; and
5. Believing in the families we see and then believing in ourselves.

At the time of the inception of Functional Family Therapy, the majr 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, manualizeable 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. In the late 1990's FFT further articulated the clinical change model adding a comprehensive system of client, process, and outcome assessment implemented through a computer-based client tracking and monitoring system (FFT-CSS).

Throughout its development FFT has insisted on step by step descriptions of the clinical change process as well as rigorous evaluation of both the process and outcomes of this work. FFT has also insisted on integrating high quality science (in regard to evaluation and research) with sound clinical judgement and experience and comprehensive theoretical principles. Thus, over the last 30 years FFT has been a dynamic and evolving clinical system that retains its core principles while adding clinical features that further enhance successful outcomes. In its most recent iteriation, FFT has developed a functional family assessment system to aid FFT therapists in targeting and implementing therapeutic change goals in a way that leads to accountability through process and outcome evaluation. Thus, FFT has matured into a clinical intervention model with systematic training, supervision, and process and outcome assessment components all directed at enhancing the delivery of FFT in local communities (see Figure 1).

Brief Description of Intervention   
Functional Family Therapy (FFT) is a well documented family prevention and intervention program which has been applied successfully to a wide range of problem youth and their families in various contexts. While commonly employed as an intervention program, FFT has demonstrated its effectiveness as a method for the prevention of many of the problems of at-risk adolescents and their families. Functional Family Therapy (FFT) is an empirically grounded intervention program that targets youth between the ages of 11 and 18, although younger siblings of referred adolescents are also treated. **FFT is a short-term intervention with, on average, 8 to 12 one-hour sessions for mild cases and up to 26 to 30 hours of direct service for more difficult situations**. In most programs sessions are spread over a three-month period of time. Target populations range from at-risk preadolescents to youth with very serious problems such as conduct disorder. The data from numerous outcome studies suggests that when applied as intended, FFT can reduce recidivism between 25% and 60%. Additional studies suggest that FFT is a cost-effective intervention that can, when appropriately implemented, reduce treatment costs well below that of traditional services and other family-based interventions.



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. Phase 1: 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, reducing the oppressive negativity within family and between family and community, and increasing respect for individual differences and values.
2. **Phase 2: 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.**
3. Phase 3: 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 the therapist.

Each of these phases involves both assessment and intervention components. Family assessment focuses on characteristics of the individual family members, family relational dynamics, and the multisystemic context in which the family operates. The family relational system is described in regard to interpersonal functions and their impact on promoting and maintaining problem behavior. Intervention is directed at accomplishing the goals of the relevant treatment phase. For example, in the engagement and motivation phase, assessment is focused on determining the degree to which the family or its members are negative and blaming. The corresponding intervention would target the reduction of negativity and blaming. In behavior change, assessment would focus on targeting the skills necessary for more adaptive family functioning. Intervention would be aimed at helping the family develop those skills in a way that matched their relational patterns. In generalization, the assessment focuses on the degree to which the family can apply the new behavior in broader contexts. Interventions would focus on helping generalize the family behavior change into such contexts.

As a clinical model, FFT has been conducted in varied clinical settings and as a home-based model. The fidelity of the FFT model is achieved by a specific training model and a sophisticated client assessment, tracking, and monitoring system that provides for specific clinical assessment and outcome accountability (FFT-CSS). The FFT Practice Research Network (FFT-PRN) allows clinical sites to participate in the development and dissemination of FFT model information.

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 multi-site 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.