Functional Family Therapy Clinical Training Manual

Thomas L. Sexton, Ph.D.
James F. Alexander, Ph.D.

This manual is for use with certified Functional Family Therapy Training. This manual was funded in part by a grant from the Annie E. Casey Foundation.
Contents

About the Writers .........................................................................................v
Acknoldgements ......................................................................................vi

INTRODUCTION .........................................................................................1

SECTION I
The Foundations of Functional Family Therapy.........................11

SECTION II
Clinical Training Manual.................................................................27

SECTION III
Closing Thoughts..................................................................................110

References...............................................................................................113
About the Writers

**Thomas L. Sexton**, Ph.D., ABPP, is a Professor in the Department of Counseling and Educational Psychology at Indiana University where he is the Director of the Clinical Training Center, Director of the Center for Adolescent and Family Studies, and teaches in the APA accredited Counseling Psychology Program. Dr. Sexton has written in the areas of outcome research and its implications for clinical practice and training. His recent publications include major research articles in the *Handbook of Psychotherapy and Behavior Change*, the *Comprehensive Handbook of Psychotherapy*, the *Handbook of Family Therapy*, and numerous other publications. He is also a national expert on family-based treatment interventions for at-risk adolescents and regularly presents workshops nationally and internationally. Along with Jim Alexander, he is the author of the most recent theoretical presentations and developments in Functional Family Therapy. He is one of two national Functional Family Therapy trainers, supervises the FFT externship program, and directs the national and international FFT implementation and dissemination projects. He is a licensed Psychologist, member of the American Psychological Association (APA), the American Counseling Association (ACA), an Approved Supervisor in the American Association of Marriage and Family Therapy (AAMFT), Vice President of Scientific Affairs for Division 43 (Family Psychology) of the American Psychological Association, and a Diplomate in Family Psychology (ABPP).

**James F. Alexander**, Ph.D. is a professor at the University of Utah and a progenitor of Functional Family Therapy (FFT). He is past Director of Clinical Training at the University of Utah and has received numerous honors (Distinguished Contributions to Family Therapy Research, American Family Therapy Academy; Family Psychologist of the Year, Division 43 of the American Psychological Association; Good Housekeeping List of Top U.S. Mental Health Experts; Superior Teaching Award, University of Utah, College of Social & Behavioral Science; APA Division 43 Presidential Citation for Lifetime Contribution to Family Therapy Research; "Scientist Exemplar" award, American Association for Marriage & Family Therapy Research Conference; Superior Research Award, College of Social and Behavioral Science,
University of Utah; “Distinguished Alumnus” California State University Long Beach; Cumulative Contribution to Family Therapy Research Award, AAMFT). Dr. Alexander has provided over 350 national and international clinical training workshops and conference presentations, has received over 20 clinical research and training grants, almost 100 publications (chapters, books, journal articles) and is past President of Division 43 of the APA. In addition to developing the core elements of FFT, Dr. Alexander has assisted Dr. Thomas L. Sexton in developing the state-of-the-art FFT national dissemination protocol (FFT SDS: Service Delivery System).
Acknowledgements

The authors would like to thank the Annie E. Casey foundation for their generosity which made publication of this manual possible. We would also like to thank the thousands of families we've worked with over the years who share their personal struggles with us week in and week out. It is our privilege to learn from them and continuously improve the delivery of our services to at-risk youth and their families. We are also indebted to the team of therapists, supervisors, and mental health facilities who provide Functional Family Therapy at sites across the country. Their dedication to faithfully delivering this model of therapy has contributed to a rich database of information that allows us to study our work with families and fine tune our training of future FFT therapists. Our thanks to Jan Sorby at Sorby Design for her help with the layout and graphics for this manual. The authors also wish to thank Lynn Gilman for her dedicated editorial assistance throughout this project. Finally we must thank our own families who provide love and support and tolerate the diversion of our attention to this important work.
Introduction
This manual represents the clinical model aspect of the FFT Service Delivery System (FFT-SDS). The FFT-SDS is a comprehensive service delivery system for use in helping at risk youth and their families. The system includes an evidence-based family intervention (Functional Family Therapy), a comprehensive client assessment system, an integrated quality assurance protocol, and a systematic training and dissemination process. The components of the FFT Service Delivery System provide therapists, agencies, and communities all the tools necessary for providing a comprehensive treatment program for youth in mental health, juvenile justice, and child welfare systems. Other aspects of the system are detailed in the accompanying supervision and implementation manuals.

This manual, which describes the clinical model, is designed for two groups of readers. For some readers it will provide an introduction to, and overview of, Functional Family Therapy (FFT). We believe that administrators, clinicians, supervisors, and other decision-makers reading it will find sufficient detail to make an informed decision about whether or not FFT fits your personal, agency (or practice), and client needs.

The majority of readers represent our (future) partners in FFT. For you, this manual represents a platform upon which you can develop your competence as an FFT therapist. Becoming a competent FFT therapist is a developmental process, which is accomplished by first going through the information presented in the manual, then undertaking formal FFT training, undergoing
supervised practice, and receiving feedback by FFT trainers as part of FFT Site Certification.

A preliminary word of caution: Like most if not all manuals, this manual is not designed, nor should it be used, as a “stand alone” means to become an independent practitioner of FFT. In a sense, no treatment manual can represent all the components of a successful and sophisticated change process, any more than a pilot’s manual can train someone how to fly an airplane. FFT is a sophisticated and demanding approach to intervention, and is provided often in difficult circumstances such as disrupted homes. Thus FFT training is also a sophisticated and complex process, and none of us would ever want to shortchange the clients, or underestimate the clinical demands, by minimizing the complexity of the training process.

As you study the manual, please note that FFT is demanding of therapist energy and passion; competent delivery of FFT involves commitment and focus. However, the returns you will receive for this investment are great. FFT is low cost to deliver, yet the outcomes are very positive and the benefit-to-cost ratio is very high. FFT therapists witness great behavioral and emotional changes in the youth and families we serve. Furthermore, the outcomes we see are long lasting, and will impact positively myriad others who will intersect with our clients’ lives for years to come.

In designing the manual, we understand that some therapists operate “from the heart,” while others work more from a model or conceptual framework, and others prefer to base their interventions on intuition or “doing what it takes.” Thus we understand that clinical training involves a variety of perspectives and avenues for learning. However, as an introduction to FFT this manual will be primarily conceptual (vs. experiential). Understanding the principles, techniques, and philosophy of FFT is a necessary—necessary but not sufficient—condition for highly effective intervention. Becoming a competent FFT therapist thus represents a process, not an event, and it involves multiple contexts for learning. This manual signifies a first major step, and we ask that you read and interact with the manual in the same way that a potential pilot prepares to learn to fly; study the materials thoroughly, be clear about each major element presented in the manual, and determine (for later interaction with your FFT trainers) which elements you find enlightening, confusing, and/or inconsistent with what you want to become as a therapist. As noted, understanding is not a sufficient condition to become a
competent FFT therapist, but it is essential as a first step, and helping you negotiate this step successfully is the primary goal of this manual.

While the manual describes technique in detail, we must remember that techniques exist to serve the foundational goals of FFT; they are not ends in-and-of themselves. The manual also will discuss intervention concepts. These concepts are presented primarily to provide the guideposts that we follow to attain our goals, all of which center on providing highly effective treatment to diverse populations in need. Finally, we will discuss data and philosophy, but once again not as acontextual academic topics. Instead, data (accountability, quality improvement and therapist development) and philosophy (strength based, respectful, alliance based, stage-change model) underlie the focus and the passion that carries us through the tough times. They help us sort through the challenges and barriers we encounter when we deal with difficult youth and their families, and they help us create the joy and dignity that emerges when we share FFT successfully with troubled youth and families.

As you read the manual we also ask that you remember that FFT is not designed to further a particular version of the “healthy family” or a particular lifestyle ideology. Instead FFT is designed to be provided by therapists of all races and ethnicity, all spiritual systems, and gender/sexual preferences. In turn FFT is designed to respect and help at-risk dysfunctional youth and families who also represent the same diversity, as well as the entire range of family forms. Our defining feature is not an insistence on one view; instead our defining feature is our dedication to helping people who typically are unhappy if not hopeless, who are under great stress, who often are underserved and yet “treatment resistant,” and who have limited resources yet are in great need.

In sum, as you read this manual we ask that you consider your motives for undertaking FFT. We ask this because FFT will challenge some of your assumptions, and we will at times propose intervention strategies that are inconsistent with other, often more clinically popular, intervention models. Thus adopting FFT is not a means to join the mainstream of clinical interventions. Instead it is a decision to adopt a set of principles which include:
• Rigorously and independently empirically studied and validated: It works, and does so in diverse contexts with diverse populations
• Multicultural experience and a core belief in respect and working within the culture
• Accountability; every session and every family is tracked in order to help therapists and supervisors provide the most responsive and effective intervention
• Alliance based with an emphasis on alliance with all family members
• Creative ("doing what it takes") but in the context of carefully articulated structure and principles
• Relentless - FFT therapists simply do not give up

Finally, FFT is “family based” in all aspects: Should you choose to become an FFT therapist, we consider that you also join the “FFT family.” We enter into an ongoing partnership in which we provide resources for continuing feedback and quality improvement, for developing additional funding resources, and for demonstrating treatment effectiveness. With adherence and competent application you can join the team of FFT clinicians who provide effective service to the youth and families who are in such great need.

Welcome to FFT,
TLS
JFA

Organization: Using the manual

It will become obvious that this manual is much more than the usual compilation of written material. Instead, you will encounter text and you will encounter printed power-point slides that you will see again during subsequent training experiences. Also you will find references to additional information sources, and contact information. Finally, you will encounter sections of the manual that are more or less relevant for different readers:

• Therapists beginning FFT site-based certification are expected to read all three sections. As an FFT therapist you represent the

FFT program as it occurs during the actual clinical process, as well as contacts with multiple systems relevant to the family you are seeing. In addition, often you will also find yourselves explaining FFT to other professionals, decision-makers, and even lay persons. As a result, it will be helpful to understand not only the clinical model itself, but also the background and summarized scientific support for the model, and the extensive technical support information provided to all FFT therapists.

- Decision makers interested in adopting FFT may find the manual just as informative as do clinicians, but often the primary focus is on the breadth of application of the model, as well as the extensive empirical support that is necessary to meet the standards of “evidence-based models” mandated by many funders.
- Program administrators often are also interested in implementation issues and the availability of information to allow for quality improvement.

The manual is organized in three sections. Section I describes the background and empirical foundations of Functional Family Therapy. This section will help you understand the place of FFT in the new landscape of therapeutic approaches. Section II describes the specific clinical protocol used as the basis of delivering FFT. This section is the “nuts and bolts” and it is only useful when built upon the core principles (of section I). Finally, Section III describes the implementation of FFT from its delivery within the room with a family to the integration of other services and the use of the FFT-Clinical Services System (FFT-CSS).

Learning FFT: Primary objectives of clinical training

As you begin your journey of learning FFT we will ask that you adopt two primary objectives:

1) “THINKING THROUGH THE FFT LENS”

Many factors contribute to successful intervention with complex and sometimes desperate family situations. Learning to deal with such situations successfully through FFT is about learning how to develop the FFT clinical “lens.” This FFT lens focuses each therapist’s unique strengths on clinical decisions that help
change the complex behavioral and clinical struggles of the family. Families, like therapists, are unique at many levels, creating the same challenge for us as trainers as families do for therapists. That is, we cannot adopt a “cookie cutter” or “one size fits all” approach to therapy or training. At the same time, extensive clinical and research evidence tells us that training, just like intervention, must be orderly and follow certain principles and developmental sequences. The FFT lens provides a structure within which we can understand, and develop moment-by-moment clinical strategies to manage the complexities that emerge when an individual family, with its unique qualities, works with a therapist (similarly unique) in a treatment context (which may also be unique). By using a common lens that

Figure 1
appreciates and respects the complexities of these individual differences, yet examines them in the context of a common framework, FFT can be open and responsive to the range of family as well as therapist qualities. In turn, FFT then can develop clinically rich intervention strategies and techniques which can be adopted as appropriate for the range of clients, cultures, and problem situations we face. Yes, not all races and cultures are the same, any more than all youth who use drugs or engage in other risky behaviors do so for the same reason. FFT thus uses the lens to understand why this youth of this ethnicity is drug involved in this set of multisystemic (parent, community, school) factors and with this biological makeup. Only then can we individualize our intervention to be maximally effective. To facilitate this process, we will pursue our second major objective: Openness.

2) OPENNESS AND COMMITMENT TO LEARNING A NEW MODEL OF WORK

To benefit from and enjoy the process of becoming a competent FFT therapist requires openness to thinking differently about a number of central elements about the client, their problems, and therapy. To successfully learn requires openness to including the strengths of the therapists and their unique style and the model. For many, at first it feels uncomfortable not relying on your “tried and true” methods of thinking and acting. However, the good news is that there is a system provided to support your learning (the FFT SDS: Functional Family Therapy Service Delivery System), and over time the new FFT patterns become automatic and very rewarding. Your contribution to this process is your willingness to be open and honest about who you are, and your commitment to adopting a new way of practice in a way that works for who you are. Because the FFT model may be new to you does not mean you have to relearn all the conceptual and clinical bases of therapy. Instead, it means that you have to build upon what you know and create a new and integrated way of working “through the FFT lens.”
Functional Family Therapy Clinical Training Manual
The Foundations of Functional Family Therapy
Principles endure; expressions of those principles change. As we see in the constant struggles we have with such constitutional principles as “free speech” and the “right to bear arms,” changing circumstances require that we adapt to current circumstances yet retain our core principles. FFT is an intervention model that has existed for a long time, and it represents a core of enduring principles but at the same time a model which is evolving, dynamic, and contemporary. FFT continues to be open to new ideas, new research, and new (and often very underserved) populations in need. It will be up to you to decide whether or not you support the core principles, just as people in every country (including ours) must decide whether or not they support the core principles of that nation. Assuming we do, then each and every one of us can work to improve the ways we develop to live by those principles. In order for you to make an informed decision upon which to base your clinical work with families in need, this section of the manual will discuss briefly the core principles of the intervention you are learning, and provide a brief historical context for their development.

FFT cannot be adequately described by any single theoretical label (e.g. behavioral, multisystemic, interpersonal). Instead, FFT is a systematic clinical model that evolved along a path best described as a dynamic process of model integration (Alexander, Sexton & Robbins, 2002). Since its inception in 1969, FFT has held to the principle of integration, and its foundations are essential for a complete, mature, and enduringly effective intervention. For FFT these foundations include:
1) Clinical experience in meeting important clinical needs. What we do with people must evolve in part from being with these people in an intense and meaningful clinical process. For FFT this has been an essential component of its development. FFT grew out of a need to serve a population of at-risk adolescents and families, and we attended to this underserved population in a way that focused on understanding why they presented so many clinical challenges, and why traditional and even “mainstream” interventions had so little success in helping them. To address this problem with high risk youth and families the early contributors to FFT set out to develop a new set of philosophies and techniques that would lower their resistance, provide the type of interventions that would motivate them, reduce their negativity, and give them hope.

Because so many families characterized as having “high risk youth” experience so many challenges, FFT has been based on the premise that our job is to take responsibility for motivating families and accepting families “on their own terms” rather than applying a treatment goal which was based on someone else’s version of what a family “should be,” what a culture “should be,” what a particular spiritual belief or sexual orientation or economic system “should be.” And we needed to give every family member hope, and engage and motivate them, and we needed to do this very quickly and effectively.

Early clinical experience showed that it was helpful to provide a plan, or “roadmap,” for change that matched who the families were, and to provide the tools necessary to navigate the challenges and roadblocks the families faced in the change process. Clinical experience also suggested that long-term change needed to focus not only
on stopping the maladaptive behavior, but also on developing the unique strengths of the family in a culturally sensitive way, and enhancing their ability to make future changes. Finally, with this population it became clear that incorporating community resources to help support changes made by the family is essential.

2) The second foundation of FFT is integrated theory (multidisciplinary) and scholarship. As clinicians we benefit from, but can be limited by, what we can see and hear directly. Other disciplines (e.g., sociological thought, cultural anthropology, linguistics) and contexts (medical, juvenile justice, education, unique neighborhoods) also must provide central knowledge to our clinical work, just as basic scientists (e.g., biochemists) provide input into the improvement of medical service delivery by medical clinicians. None of us can do this alone!

The emphasis on understanding, defining, describing, and researching the process of intervention began early in the FFT evolution. This emphasis emerged because it became clear that theoretical development was necessary if this population were to be well served. With respect to dysfunctional youth at least, clinical interventions of the time provided no vehicle for understanding the relational elements of family functioning or clinical change, clinical accountability, model replication, or understanding the change process. In that early context it was critical that FFT develop a clinical “model” that could guide practice. Early comprehensive articulations of FFT (Alexander & Parsons, 1982; Barton and Alexander, 1981) relied heavily on the work of early communication theorists (e.g., Watzlawick, Beavin, & Jackson, 1977).

**OUTCOME STUDY**

Klein, Alexander, & Parsons (1977)

**Clients:**
Sibling study: multiple levels of prevention/intervention (Follow up to Alexander & Parsons, 1973 - see above)

**Outcome:**
This 2-3 year follow-up study found that siblings in the families that received FFT had only a 20% rate of court referral following FFT. Siblings of adolescents in the other treatment groups had significantly higher recidivism: No treatment 40%; Client centered family therapy 59%; Eclectic-dynamic family therapy 63%. At initial post treatment evaluation, families who received FFT were significantly improved in the process of their family interactions compared to those who received other treatments, and these family processes differentiated families who ultimately experienced a sibling referral from those who did not.
OUTCOME STUDY

Hansson (1998) Lund, Sweden randomized trial of FFT vs. Family Case Management combined with Individual Counseling

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

Outcome:
At 2-year follow-up, the FFT group (n = 45) had significantly less recidivism (48% vs. 82%) than the treatment as usual group (n = 50). Maternal improvements on symptom checklists evaluating depression, anxiety, and somatization in FFT group only.

OUTCOME STUDY


Clients:
“Status delinquents:” youth with offenses including runaway, truancy, sexual promiscuity, possession of alcohol, and ungovernability. Referred by probation workers.

Outcome:
Equivalent to those obtained by senior/graduate level therapists in earlier studies. Recidivism at one year was 26% for the FFT group, compared to a population base rate of 51%. Changes in the family processes, most notably decreases in family defensiveness, were seen with this sample just as they were with more senior therapists.

1967) and incorporated the notion that behavior serves to define and create interpersonal relationships and that behavior has meaning only in its relational context. At this time the model also relied on the use of specific behavioral technologies such as communication training (Parsons & Alexander, 1973). As the model evolved, cognitive theory, particularly attribution and information processing theories helped explain some of the mechanisms of meaning and emotion often manifested as blaming and negativity in family interactional patterns (Jones & Nisbett, 1972; Kelly, 1973; Taylor & Fiske, 1978). More recently, social constructionist ideas have informed FFT through a focus on meaning and its role in the constructed nature of problems, in interrupting family negativity, and in organizing therapeutic themes (Gergen, 1995; Friedlander & Heatherington, 1998).

3) Thirdly, FFT is founded on empirical evidence produced by process and outcome studies. Beliefs and theories are critical for dealing with challenging and complex clinical problems, but we also need feedback and accountability. What sort of therapists (race, training, qualities, etc.) are the most helpful with this particular type of family? We certainly all know of the various opinions that we encounter in the treatment community, but we also
are painfully aware of how many strongly held beliefs are associated not necessarily with positive outcomes but with “justifications” in the face of undesirable results. FFT is based on a core belief that we no longer can or should maintain interventions that do not help those clients we purport to serve. Instead, we need to know what works, when it works, how it works, and under what circumstances we need to adapt it so it will work within specific unique contexts.

As a result, FFT has always been informed by the findings of scientific inquiry. The early clinical trial studies (Alexander & Parsons, 1973; Klein, Alexander & Parsons, 1977) focused on questions of efficacy, with pragmatic outcome measures that had both clinical and social relevance (recidivism). These early studies established FFT as an effective approach with a variety of offending adolescents. Process studies attempted to identify the mechanisms by which FFT was successful. These studies informed clinical practice by indicating that family negativity significantly impacted engagement and motivation (Alexander et al, 1976) and that the gender of the therapist was differentially related to both the rate and quantity of speech by family members (Mas, Alexander, & Barton, 1985; Mas, Alexander, Turner, 1991; Newberry et al., 1991). These early process studies raised additional questions answered by a second wave of clinical trials focusing on the effectiveness of FFT in different settings with different populations (Barton, Alexander, Waldron, Turner, and Warburton, 1985; Lanz, 1982; Gordon, Arbuthnot, Gustafson, & McGreen, 1988; 1995; Hansson, 1998; Sexton et. al, 2000). More recent studies have focused on specific clinical techniques (e.g., Robbins et al., 1996), the role of balanced mechanisms by which FFT was successful. These studies informed clinical practice by indicating that family negativity significantly impacted engagement and motivation (Alexander et al, 1976) and that the gender of the therapist was differentially related to both the rate and quantity of speech by family members (Mas, Alexander, & Barton, 1985; Mas, Alexander, Turner, 1991; Newberry et al., 1991). These early process studies raised additional questions answered by a second wave of clinical trials focusing on the effectiveness of FFT in different settings with different populations (Barton, Alexander, Waldron, Turner, and Warburton, 1985; Lanz, 1982; Gordon, Arbuthnot, Gustafson, & McGreen, 1988; 1995; Hansson, 1998; Sexton et. al, 2000). More recent studies have focused on specific clinical techniques (e.g., Robbins et al., 1996), the role of balanced
alliance in program retention (Robbins et al., 2003), and therapist model adherence as a primary mediating variable in successful outcomes (Sexton, 2002). The outcome of these studies suggested that FFT was applicable across an even wider client population over diverse settings, with real therapists in local communities.

**FFT as an evidence-based, mature clinical model of practice: The changing landscape of mental health practice**

The integrative and systematic nature of the FFT clinical model along with its repeated demonstrations of successful outcomes with at-risk adolescents and their families has led to widespread community-based application in many settings with a wide range of clients. There are two reasons that FFT has emerged on the radar of local community providers. These may be the reasons that your agency decided to adopt FFT. First, is a push for accountability by funders, care providers, and communities. The second is the increase in the quality and quantity of relevant research to guide practice. There is much more research on aspects of the change process that can impact practice. It is no longer that one research finding will contradict another. Now there are clear trends that are well documented in many areas.

Like a handful of other models, FFT is a “Best Practices” program. Best practices are intervention programs that have a high probability of, when delivered well, producing positive results. These evidence-based practices have certain similarities. These criteria are the common elements that

---

**OUTCOME STUDY**

(1985 C): “Hard core”/ Seriously Offending Adolescents

**Clients:**

Conduct Disordered adolescents 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).

**Outcome:**

The FFT group (with an average of only 30 hours of FFT per family) had a 60% recidivism rate at 16 month follow-up compared to 93% of comparison youth released to alternative “reentry” programs (primarily group homes) and an 89% average annual institutional base rate. In addition, those from the FFT group who did re-offend did so with significantly less frequency and severity than re-offenders in the non-FFT group.
contribute to the successful outcomes they have demonstrated. Any systematic practice should include:

1. Systematic Clinical Intervention Programs—current best practices are not “interventions” or discrete “clinical tools” but instead are systematic programs of intervention that have principles and systematic practice protocols. These models have both an integrative and overarching theoretical perspective and a specific clinical protocol. Having a set of principles and a specific protocol allows the interventionist to be focused and systematic while at the same time clinically responsive to a diversity of clients. As a result, the interventionist can guide practice with specific clients and in specific community settings.

2. Strong scientific/research support in the areas of both outcome and process studies that have been conducted over time, in multiple settings, by multiple therapists, with diverse clients.

The impact of the shift to systematic/evidence-based programs is that the model is the primary source of clinical decision making.

Figure 2
With this shift in the primacy of a clinical model, the issues of model fidelity, adherence and competent adherence become important.

“Oh, this is just X therapy in a different package.” Best practice approaches, like FFT, are not the same as earlier models of family therapy. Instead, they represent a very new and different approach to clinical practice. At the same time, they are based on earlier models and founding constructs of psychology, marriage and family therapy, and psychological research. FFT is a “mature clinical model” that has emerged as one of the next generation of family based approaches. Thus, FFT may share elements of structural family therapy, while at the same time being fundamentally different in its core principles and protocols. In addition, FFT incorporates many of the current
OUTCOME STUDY

Juvenile offenses at 2 ½ 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 treatment. Rural poor clients.

Outcome:
Compared to juveniles who received regular probation services (n = 27, 67% recidivism rate), clients in the FFT group (n = 27) had an 11% recidivism rate at 2-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. 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.

The effectiveness of FFT: Does it work?

Functional Family Therapy is based on a long-term, systematic, and independently replicated series of outcome and process studies. The research overcomes many of the criticisms of traditional clinical research by investigating “real” youth (e.g., multi-problem, ethnically diverse, representing a wide range of SES) in “real” settings (e.g., home, community) by “real” therapists (practicing professionals) with diverse training backgrounds. These results have lead the Center for Substance Abuse Prevention (CSAP) and the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to identify FFT as a “model” program for both substance abuse and delinquency prevention (Alverado, Kendall, Beesley, & Lee-Cavaness, 2000). Similarly, the Center for the Study and Prevention of Violence (CSPV) designated FFT as one of the eleven (out of over 500 reviewed) “Blueprint” programs (Elliott, 1998). FFT is an evidence-based intervention model that meets any of the current benchmarks of empirically validated treatments (Sexton & Alexander, 2002).
FFT has demonstrated outcomes in many settings and with many and diverse clients. Specifically, these outcomes have focused on the three critical issues of the treatment of adolescents and families: (1) the range of behaviors associated with externalizing behavior disorders (e.g. violence, drug use/abuse); (2) the outcomes of FFT based research have identified FFT as effective in engaging and retaining youth with difficult problems in therapy and reducing dropout; (3) finally, FFT has demonstrated successful outcomes by showing itself to be cost effective. In the sections below we briefly review the scientific evidence for FFT in these three areas.

**1. Behavioral Outcomes.**

One of the primary outcomes for any program designed for use with externalizing behavior disorder youth is specific behavioral changes. The research demonstrating that FFT works has occurred across different settings, and different populations. The summary of these research findings are included in the side bars throughout this section of the manual. The results of published studies suggest that FFT is effective in reducing recidivism between 26% and 73% with status offending, moderate, and seriously delinquent youth as compared to both no treatment and juvenile court probation services (Alexander, et al, 2000). Of most interest is the range of community settings and client ethnicities that have composed these studies (a more complete list can be found in Alexander, et al, 2000). These positive outcomes of FFT remain relatively stable even at follow-up times as long as five years (Gordon, Arbuthnot, Gustafson, & McGreen, 1988) and the positive impact also affects siblings of the identified adolescent (Klein, Alexander, & Parsons, 1977). While these studies typically used recidivism as the...
OUTCOME STUDY


Clients:
Drug abusing adolescents. Caucasian and Hispanic families.

Outcomes:
Adolescents receiving FFT or Combined showed significant reductions in percent of days using marijuana from pretreatment to 4 months following initiation of treatment. These results provide support for the immediate benefit of family therapy for substance-abusing youth and are generally consistent with the family therapy outcome literature for adolescent substance abuse. Adolescent marijuana use in the group therapy condition was not significantly lower than baseline at the 4-month assessment, but it was significantly lower at the 7-month. The CBT condition was not significantly different from baseline at any of the follow-up measurement conditions \( t < 1.0 \). These findings provide tentative evidence that family therapy may produce more rapid changes than group therapy (i.e., at 4 months) but that group therapy may provide long-term benefits in reducing substance abuse.

---

OUTCOME STUDY

Barnoski (2002)/Sexton, Mease, Hollimon (2002). Results of a statewide implementation study of FFT vs. TAU (treatment as usual-probation services). Community effectiveness study with home based delivery of FFT with wide range of therapists and clients.

Clients:
Delinquents with various offenses including, drug/alcohol, violent behavior, and school problems. Half had experienced sexual/physical abuse, 20% gang involved, 85% drug/alcohol involved.

Outcome:
Compared to control group (random assignment), FFT group has 30% fewer felony crimes 18 months post treatment. Cost saving of $1,120,000. Outcomes were directly related to the competency of the therapist. Those therapists who competently delivered the model had significantly lower recidivism (50% reduction in recidivism compared to the control group, 22%). Those who did not competently delivery FFT had outcomes no better than the control group. The study demonstrated the importance of therapist competency in the delivery of FFT in community settings.

dependent measure, a recent community-based effectiveness study of violent and drug abusing youth in a large urban setting with a multiethnic
and multicultural population found that those adolescents in the FFT treatment condition not only had significantly lower recidivism rates but also committed significantly fewer crimes that were significantly less severe, even when pretreatment crime history was factored into the analysis (Sexton, Ostrom, Bonomo, & Alexander, 2000).


Engaging and motivating youth and families has traditionally been a significant barrier to providing effective services. Some estimates suggest that dropout rates with this population range from 50% to 75%. Any program must successfully engage families if it is to be successful. FFT has always been focused on engagement. A number of studies have identified the engagement rates of FFT as compared to other modes with externalizing behavior disorder problems. The outcome of these studies suggests that FFT is successful at one of the areas of critical need: engaging and motivating youth and families to take part in therapeutic services. Results of these studies suggest that FFT is successful in engaging between 78% (22% dropout rate, Sexton, et al., 2000) to 89% (11% dropout rate, Sexton et al, 2003) in settings where FFT was delivered in community contexts with community based therapists.

3. Cost Effectiveness.

FFT has also proven to be a cost-effective intervention. Sexton and Alexander (2000) found FFT to be significantly more effective in reducing recidivism and $5,000 per case less costly than an equivalent juvenile detention intervention, and $12,000 less expensive than residential treatment of a similar course. In the most comprehensive investigation of the economic outcomes of family-based interventions to date, the State of Washington found that FFT had among the highest cost savings when compared to other juvenile offender programs. The cost of implementing
the program was approximately $2,000 per family with a cost savings (taxpayer and crime victim cost) of $13,908 (Aos & Barnoski, 1998).

In the Washington project FFT ended up costing $2500 per case and produced at $7.50 dollar return for each program dollar expended. When done with high fidelity these outcomes resulted in a $16,250 per adolescent saving (as compared to traditional treatment). Across the state-wide program FFT saved over $1,121,000.
Clinical Training Manual
Functional Family Therapy is a “best practice” treatment of choice for working with adolescents and families of externalizing disordered adolescents. The question is what does an interventionist do to successfully practice FFT with high fidelity (e.g. model adherence and competence) such that they can increase the likelihood of replicating the successful results in their community setting.

FFT is initially easy to grasp, yet it holds ongoing interest to seasoned clinicians. It provides a systematic and formalized change plan to use with families yet within that change plan there is infinite flexibility to individually tailor the way in which the goals of FFT are accomplished. Successful application requires close attention and adherence to the ordered goals of the model that allows for within the room creativity and clinical “wizardry” on the part of the therapist. Thus, the structure and organization of FFT provides the necessary support for clinical creativity and adaptation to individual families.

Functional Family Therapy (FFT) is a “true” family based approach that focuses on the multiple domains of client experience (cognition, emotion, and behavior) across the multiple perspectives within a family system (individual, family, and contextual/multisystemic). In order to understand and intervene successfully across these domains FFT has remained grounded in a relational context. This has allowed FFT to embrace the inherent dialectic tension in family therapy, that is the tension between clinical practice, foundational theory (systems, developmental psychopathology,
epidemiology, the sociology of culture, etc.), and rigorous science. FFT has adopted both a client focus based in sound clinical experience (ideographic) while at the same time attending to the common research and theory and change mechanisms (nomothetic) underlying a range of good therapeutic intervention.

This portion of the manual is intended to, along with face-to-face interactive instruction, prepare you to begin working as an FFT therapist. In the sections below we review the theoretical principles and specific clinical protocol that comprise FFT. These components guide therapists in their delivery of FFT. In addition, these components are the “anchor” that helps theoretically and practically ground the therapist in FFT.

1. Core theoretical principles
   - Core principles are the philosophical and theoretical background of the model. As such they are the theory that is the foundation of clinical, service delivery, and organizational decisions that surround FFT.
   - Principles provide guidance for the therapists by serving as a lens or a way to focus their understanding of the client, broad treatment decision/case planning, and individual in the moment-to-moment clinical decisions that are made when working with families.

2. Systematic clinical map/protocol
   - The clinical protocol or “map” is the pathway for change with a family. It involves three phases, conducted sequentially, with specific goals and requisite therapist behaviors in each.
   - The protocol and its goals serve as a within room and within session “anchor” to the therapist helping them focus on the most important immediate therapeutic goals. Thus, the protocol helps keep therapists out of the ongoing sometimes emotional content the family brings into therapy.
   - The clinical protocol also provides for an overall treatment plan for the family that includes sequential areas of attention, with specific goals and objectives within each phase. As such, it gives FFT a systematic process plan for how to approach and proceed with families.
At its core FFT is about people: The youth and family members we see, other people we consider but may not treat directly, the people who will cross paths with our clients in the future, the therapists providing FFT, and the perspective we bring to all these people. Specifically, intervention involves an FFT therapist who understands and respects herself, the family members, and the FFT model. In this context, the FFT therapist uses specific clinical skills and interventions to accomplish model specific goals and objectives. The FFT manual he follows, and subsequent training activities he undergoes, integrates theory, research, and years of clinical experience with diverse populations. Together the training and experience provide specific direction to the processes that go on between the therapist and the client/family. However, FFT is not a series or compilation of intervention techniques, even though as a “manualized model” the training and application of FFT may seem internally contradictory. In particular, the clinical model is best captured by seemingly contradictory descriptors such as:

- Simple yet complex
- Systematic and formalized yet flexible and individualized
- Requires high adherence yet depends upon individual creativity and clinical wisdom
- Comprehensive and orderly, yet much more than a “paint by the numbers” manual or a curriculum based intervention model.

These apparent contradictions are resolved through a set of integrated theoretical principles and a specific clinical “map” that is applied by individual therapists who have unique strengths that they bring to the model. They do so in a way that retains the essence of FFT, while at the same time making the practice of FFT uniquely their own.

Also seemingly contradictory, FFT is initially easy to grasp yet it holds the interest of seasoned clinicians. It provides a systematic and formalized change plan to use with families, yet within that change plan there is flexibility to individually tailor the way in which the goals of FFT are accomplished. Successful application requires close attention and adherence to the ordered goals of the model, and
embracing the core principles and philosophies that have constituted the bases of FFT through the years

**The core theoretical principles of FFT**

While not always apparent in immediate therapist actions, the core FFT principles form the background of all the FFT therapist’s clinical actions. These core theoretical principles represent the foundation for case planning, session planning, and specific strategies for how the therapist approaches the family. While the core principles have evolved out of the founding constructs of family therapy and early family therapy models, they are more than an eclectic collection of ideas. Instead they represent a systematic and integrated approach of how to understand clients, the problems that clients experience, and the process of therapy.

**Core Principle 1: Understanding clients—an attitude as much as a compilation of information**

Referrals come to FFT by way of an adolescent’s dysfunctional behaviors such as drug use/abuse, violence, and/or other externalizing behaviors. Often accompanying these referrals is significant conflict within the family and between one or more family members and other community systems (e.g., schools). It is easy to see such specific negative behaviors, but for FFT it is clear that successful intervention must address more than the problem behaviors of individual family members or even those of the family as a whole. Instead we must find ways to uncover and develop strengths not only within the families but also in relationships within the families and with the multiple systems linked to the family. Families are multisystemic units composed of individuals in a unique and organized family relational system, an ecosystemic or community environment, and a broad cultural context - all of which bear on the clinical processes presented to the therapist. Some of these multisystemic processes represent a direct influence, others are indirect. Regardless, it is critical for the therapist to understand the family in a broad context. It also is important to realize that some aspects of the multisystemic environment and processes are changeable, while many more (e.g., neighborhood gangs, poverty, culture) are not changeable by the individual therapist. Those that are unchangeable
require the therapist to recognize and work with and/or around them in ways that promote positive change in the family, and minimize the influence of negative influences that interfere with positive change. In turn, the processes that can be changed are prioritized within the treatment plan and systematically addressed to initiate and maintain positive change. Figure 5 represents the multisystemic map that is in the perspective of the FFT therapist as they prepare to engage a newly referred family.

Families are organized in that each is a functioning unit that operates in highly systematic ways. Thus we really don’t think in terms of “dysfunctional” families; instead we see families that function in predictable and organized ways (i.e., they are all “functional”), but for many the organization and functioning is chaotic or otherwise associated with undesired outcomes.

We also view clients, our families, as having strengths. In fact, we give more than just the “lip service” to the concept of “strength
based.” A useful metaphor is that of the “half full or the half empty” glass. Many traditional mental health approaches focus on the symptoms, diagnoses, or behaviors for which the client has been referred. Such approaches have been criticized for seeing the family as half empty (examples include the labels such as “single parent” and “ADHD” which are considered to be limiting factors). However, while important, a focus on symptoms and maladaptive processes can lead therapists to forget the “half full” aspect of strengths and resources. Admittedly, some if not many of the strengths are not realized, so we must go beyond the obvious content of what constitutes the referral to FFT. In fact, we in FFT work to see the glass as neither half empty or full; instead we simply work to see what is in the glass, even if the strengths are more difficult to see on the surface. Thus, the first important step in understanding problems is to keep all aspects of our clients in the foreground, rather than allowing their problematic behaviors and maladaptive family functioning to emerge as our primary focus. As a simplistic but telling example, consider the customary referral process. Usually described are problem behaviors (e.g., juvenile offenses, referral concerns) and sometimes, associated DSM diagnoses; rarely if ever do we get referrals that also have a specific line item for individual and family strengths/protective factors!

**Implications for you at this time.** In sum, the first core principle entails: (1) seeing youth and families, and their links to multiple systems, rather than individual problem behaviors, as our “foreground” focus; and (2) seeing these relationships from a balanced (strength as well as risk factor) perspective.

At this point in the manual it is not of central importance that you understand the complex conceptual bases for this philosophy, nor that you agree wholeheartedly with them. It is only necessary that you understand that such a philosophy is central to FFT, and that the successful application of FFT will depend on your sharing that philosophy by the time you finish training and begin seeing families.

If you find yourself experiencing a “yes, but” reaction to this core principle, we ask that you revisit the issue as you encounter the specific techniques (described later) that embody this principle.
Core Principle 2: Understanding client problems systemically

Over its 35 years FFT has developed a well articulated, theoretically integrated, set of multisystemic principles that guide our understanding of the presenting clinical problems of adolescents. As noted above, disruptive behaviors and conduct problems are the most common reasons that adolescents are referred to mental health care (Kazdin, 1991). Similarly, the most common referrals to Functional Family Therapy are for adolescents demonstrating the wide range of behaviors included under the heading of Disruptive Behavior Disorders (Costello & Angold, 1993) and often meet criteria for DSM-IV classification as Oppositional Defiant and Conduct Disorders. Unfortunately, the DSM-IV type classification represents a rather narrowly defined set of behaviors that misses clinically rich constructs regarding etiology, course, prognosis, and treatment that are necessary to understand the adolescent’s problems (Alexander & Pugh, 1998).

Like others (Kazdin, Siegel, and Bass, 1992), we suggest that these behavior patterns of adolescents referred to FFT represent a “package” that includes biological, relational, family, socioeconomic, and environmental factors. Thus, regardless of whether the behavior of the adolescent is diagnosable or whether it fits the developmental trajectory of early or late onset (Loeber, 1991), we attend to the role of the family, parents, peers, school, and environment in understanding the adolescents referred to us.

As a multisystemic model FFT acknowledges the clinical importance of serious problems at the level of individual functioning as well as the interactions between the youth, family, school, peer, justice, and neighborhood systems (Liddle, 1995; Szapocznik et al., 1997). However, FFT views these influences as ones that are mediated by the family relational system. This perspective is based on the extensive evidence that the problems of these youth are best understood by looking at their individual behavior in terms of it being nested within the family, which is in turn part of a broad community system (Hawkins, Catalano, & Miller, 1992; Robbins, Mayorga, & Szapocznik, 2003; Szapocznik & Kurtines, 1989). The construct of family risk and protective patterns is a particularly useful way of looking at adolescents with externalizing behavior disorders. Adolescents represent complex clinical profiles of behavior problems including drug use and abuse, antisocial conduct disorder behavior, as well as many other mental health problems. Using risk and protective factors as
an approach to understanding “clinical” problems is useful because it describes patterns of alterable behavior rather than labeling the youth or family with characteristics that become stable and enduring.

In addition, this way of thinking about problems is useful because it describes a probability (the likelihood of problems) rather than causal relationships. Further, it suggests that it is not the “problem” behavior that is the source of family difficulty but the way in which it is managed within the family relational system. Thus FFT focuses on the relational patterns that are represented by, and mediate, problematic adolescent behaviors, this in turn increases the likelihood that long term change is initiated and maintained because the patterns that represent the “active ingredients” of alterable risk and protective factors are targeted (i.e., risk decreased, protective factors strengthened). As a result, long term change not dependent upon continuing input from the therapist, but instead is maintained from within the family and through positive relationships with community (i.e., multisystemic) resources.

This represents the “Family First” (Sexton & Alexander, 2002) focus of FFT. The Family First principle is reflected in two major ways: (1) it targets points of change, i.e., the primary therapeutic mechanism for changing both specific problem behaviors of youth and the family relational patterns that support those behaviors; and (2) it identifies the immediate focus of intervention, i.e., the family rather than individual youth or extra-familial relationships. Thus the youth and multiple system processes (ranging from behavioral deficits and maladaptive cognitive processes to gang membership and poor relationship with school) are targeted in the context of having launched change first within the family. In order to accomplish this sequence of therapeutic foci, FFT views specific presenting clinical problems (clinical syndromes) as relational problems—as specific behaviors embedded within enduring patterns of behaviors—that are the foundation for stable and enduring relational “functions” within family relationships (Alexander & Sexton, 2002, Sexton & Alexander, 2002).

The ultimate functionality of family behavioral patterns is of course contextual, depending upon the unique elements of the family history, individual temperaments, and environmental situations. The FFT therapist focuses on relational patterns between family members and these patterns are identified as to how they “function” in the unique context of the family. Thus, we view the serious clinical
problems as only the “tip of the iceberg” so to speak. Below the obvious problem/clinical behaviors of a referred youth, lies a central family relational pattern and the functional outcomes of this pattern that bind the family into enduring and problematic cycles.

Families enter therapy with self-defeating cycles and harmful emotional reactions, which result in emotionally destructive and often volatile relationships. Many outside the family (e.g., therapists, juvenile justice and education personnel, developmental researchers, and clinical researchers) generally know what changes family members should make to improve the risk/protective balance and thereby successfully solve the youth problems. However, such change, involving seemingly simple and obvious changes, has been remarkably difficult and notoriously unsuccessful for the vast majority of treatment approaches. FFT believes that this is because the problems of at-risk adolescents and their families are relational rather than simply
behavioral, conceptual, the result of insufficient information or education, or the lack of consequences. Such factors are often found in clinical referrals, but addressing them as the direct (necessary and sufficient) foci of intervention simply does not work. Instead, working with families of problem youth requires that the therapist find the meaning of individual adolescent and parent behaviors in each family relational system so that reliable and valid clinical interventions can be developed that fit the unique nature of each family.

Conceptually FFT has approached this family-systemic framework by adopting a circular model of causes and effects in which the relational processes of the family are the primary unit of analysis. The goal is to derive meaning through the identification of sequential behavioral patterns and the regularities in those patterns (Barton & Alexander, 1981). From this identification the meaning of individual behaviors (e.g. drug abuse, delinquency, acting out behaviors etc.) is derived from an examination of the way these behaviors are inexorably tied to the relational process in which they are embedded.

In adopting this stance FFT shares a motivational substrate with most major theories of human behavior ranging from sociobiological to psychodynamic and behavioral. That is, behavior doesn’t simply happen, nor does it emerge from a genetic code, which operates independently from the environment. Instead behavior, whether “adaptive” or “maladaptive,” is goal directed. Youth and family members - at least the vast majority of youth and family members referred to FFT, direct their actions toward receiving a particular end or outcome, and these outcomes are either directly relational (e.g., attention, nurturance, distance, subservience) or they are attained relationally. Those actions in turn are mediated by the actions of others. From this perspective, behaviors become the “vehicle” for both creating and obtaining certain specific outcomes from interpersonal encounters. FFT uses the term functional outcomes to describe these patterns and their effects.

The focus on the functional outcomes of relational patterns rather than individual behaviors has helped FFT develop an ideographic and relationally focused approach to understanding families. Regardless of their form, the common, repetitive, and highly entrenched behavioral sequences apparent in families lead to consistent relational outcomes that can only be understood from an ideographic perspective.
FFT characterizes functional outcomes along two different dimensions: relatedness (closeness-distance) and hierarchy (one-up vs. one-down). Based upon the early theoretical concept of equifinality proposed by the early communication and systemic theorists (Watzlawick et al., 1974) and clinical experience, FFT learned that very different family relational patterns (e.g., anger and fighting vs. warmth and cooperation) produce the same functional outcomes (such as a high degree of interconnectedness). In contrast, very similar interactional sequences (warm communication and intimacy behaviors) can produce entirely different relational outcomes (e.g., they will enhance contact in one relationship, and can increase distance in another relationship). Thus, from this perspective, these dimensions represent the functional outcomes of patterned behavioral sequences, not specific behaviors in-and-of themselves.

Functional outcomes can be difficult to identify since they must be inferred by an observer from what is produced by the interaction process of the family. In other words, functional outcomes must be understood as an “end result” of varying and often arbitrarily punctuated relational sequences. It is important to note that FFT views these outcomes as the state of the relationship when the “dust settles.” In order to get a sense of this state the therapist must understand how the behaviors characterize the family over time and across situations.

Understanding functional outcomes can be further complicated by the fact that family members often misrepresent, and can even be unaware of the instrumental purpose of their own behavior. The complexity and temporal span of relational patterns that produce functional outcomes often lead family members to make other, mostly external, attributions for the cause, purpose and explanation of their own and others’ actions. The functional outcomes in the relationships between adolescents and parents are also complicated because they are subject to the developmental trajectory of the adolescent. A once stable hierarchal relationship between a parent and child is likely to change in adolescence, and it is the negotiation of this change that is a difficult transition for parents and adolescents. FFT views the family as a relational web of interrelated behavioral patterns, individual expectations and motivations (often influenced heavily by sources outside the family), and intertwined emotional systems in which the behavior patterns of each individual family
member serves (i.e., “functions”) to promote or limit certain behaviors in other members.

It is this relational system that is the primary entry point for therapeutic intervention. Like most other models of clinical change, FFT attempts to understand and systematically address, in the various stages of change, the factors that “drive” or “motivate and reinforce” behavior. Again, FFT is no different than most (if not all) change models; behavior happens for a reason. Where models differ is with respect to what those reasons are, and how to address them.

FFT assumes that all individuals develop on the basis of a combination of initial capacities, or diatheses (e.g., level of intelligence, emotionality, physical ability), which then interact with experience (learning histories, culture, “role models”) as well as various environmentally generated physiological and neurological processes, in an emergent process involving cognitive, emotional, and behavioral domains. By adolescence, these domains represent cognitive and emotional processes of appraisal and reaction, which are coupled with behavioral response tendencies. In turn, these tendencies interact with the environment (parents, other members of the youth’s microsystem) on a moment-by-moment basis in which each participant influences (constrains, reinforces, punishes, etc.) the other.

Families are the first and perhaps the most powerful learning context for children. Among the primary domains of this learning are the meaning of relationships and strategies for developing and maintaining them. After their initial development in the context of the family, the patterns are then carried into new contexts such as schools and peer relationships, and often even into adulthood. Unfortunately, for many of the youth referred to FFT the only interpersonal strategies that their environment (especially family) support are “dysfunctional” in other contexts: Some families model and reinforce gaining a sense of control via drugs or violence, some allow youth to attain attention only via coercion, and some youth are only able to achieve a sense of belonging by gang membership. The patterns carried to the world end up in “problem behaviors” that come to be labeled according to various clinical syndromes (e.g. oppositional defiant disorder, conduct disorder, drug/use and abuse). According to diverse theoretical perspectives (e.g., as diverse as Freud, Sullivan, Skinner, and Bandura, and even Biblical [i.e., “as the twig is bent ...”]), these strategies, even when they can be modified as a basis of experience, become stable and difficult to change.
Explaining the phenomena in a different way, early interaction-focused theorists (Walzlawick, et al., 1974) suggested that the patterns of relational interaction become stable and enduring and even come to define the relationship between people.

In the language of FFT, these stable patterns of interaction between the youth and family are signified by the internal “experiences,” (though they are not always conscious) of the individual in those relationships. The internal representation of these patterns, and their dynamic (motivational) properties, are referred to as relational functions (Alexander & Parsons 1982, Alexander et al., 2000; Alexander & Sexton, 2002). From the perspective of an individual, the relationship patterns of which they are a part “drift” into the background. It is the “experience” and behavioral outcomes of these stable patterns (e.g. how they feel, what they mean, and the symbolic interpretation) that is most predominate, or in the foreground. A useful metaphor may be the old saying by Bateson, “it is only the fish who don’t know it is water in which they swim.” Thought of in this way, family members don’t see the relational patterns that bind them to others—but we have internal representations and “experiences” of these patterns.

Thus, from this perspective, relational functions represent the outcomes of patterned behavioral sequences, not specific behaviors in-and-of themselves. Family systems and many interpersonal theorists have identified two main dimensions of relational functions (or “relational space”) within the family: Relational connection (or “interdependency”) and relationship hierarchy (Alexander & Parsons 1982, Alexander et al., 2000; Waltzaleck, Weakland & Fisch, 1974; Claiborn & Lichtenberg, 1989).

RELATIONAL CONNECTION (or interdependency) refers to the characteristic pattern that describes a relationship in terms of the degree to which high rates of mutual and emotionally vulnerable contact are necessary to maintain the relationship. High degrees of relatedness (relational interdependency) are experienced not only as a sense of interconnectedness, but psychological intensity in regard to enhancing the frequency of contact in the relationship. Low degrees of relatedness are characterized by autonomy seeking or maintaining, creating distance or independence, and a low degree of psychological intensity with respect to maintaining prolonged interdependent contact. Note that low degrees of relatedness are not
necessarily associated with “not loving” someone: One can “love” someone very much but not require a high rate of contact and ongoing “in vivo” communication to maintain the relationship. Conversely one can “hate” another upon which there is considerable dependency—the interrelatedness is high and intense, but not positive in tone.

In addition, from the FFT perspective high and low degrees of relatedness are not different ends of a continuum. Instead they represent two dimensions both of which are evident to some degree in the experience of a relationship. Midpointing is an experience of a relationship represented by both high connectedness (interdependence) and distance (independence). This balance can be one which manifests as a positive relational pattern, allowing and facilitating independence while remaining highly and positively emotionally linked, or can be maladaptive, as we see often in such phenomena as “borderline” or “ambivalent” parenting patterns.

**RELATIONAL HIERARCHY** is a measure of relational control and influence based on structure (e.g., formal roles) and resources, and it is independent of relational connection. Relational hierarchy also ranges from high (so-called “one-up”) to low, with relational symmetry being an experience of balanced structure and shared resources in the relationship. One-up and one-down relationships (“complementary” according to Haley 1964) are ones in which one member of a relationship possesses resources (economic, physical power, positional or role power supported by external systems) that are less available to the other member(s) in the relationship.

---

**Figure 7**

Relationship Patterns...
“the space between”

- Relationships become organized around repetitive behavioral sequences that come to “define” the relationship
- Stable over time...
- Rules...roles...that define the ways of typically being together
- Functional outcomes of these patterns are “functions”

- Problem Patterns

- Relationship organized around problems...
  - Repetitive “problem” sequences that come to “define” the relationship stable over time...
  - Window into “functions”
According to FFT, relational hierarchy, as a means of control in relationships, represents a more primitive and utilitarian approach to interpersonal influence; one that is characteristic of large segments of the animal kingdom (e.g., “the alpha male” insures continuity of the species). In contrast, relational connection tends to represent a more mutually enhancing approach to control in relationships, i.e. when people influence each other through affection and/or “commitment to the relationship” rather than through hierarchical power. While relational connection is seen occasionally in the animal kingdom, affection or commitment-based connectedness does not characterize the majority of relationships in species other than human.

As you will see as your journey through FFT training continues, identifying relational functions is more than a trivial matter; as noted above the same behavior pattern can produce dramatically different outcomes (functions) in two different relationships. In fact, it is often the fact that a pattern in one relationship (e.g., heavy dependency on mother) is a source of great problems in another (teacher in an overcrowded classroom). As a result FFT does not characterize any particular pattern (function) as inherently problematic, rather the means by which the function is served (acting out in the home in order to gain attention) can be. Stated simplistically, FFT works to change the attentional strategy of within-home disruption to one of performing well in order to produce the same outcome, i.e., attention from parent. Of course, such a change also requires the parent to change, and this change must also attain positive functional outcomes for the parent. Again, this is the basis for the FFT insistence on “Family First,” rather than targeting a particular pattern of one individual. Positive change, in order to be maintained, must meet the functional outcomes that work for everyone. Consequently, the FFT therapist does not attempt to change the core relational experiences of the family members any more than they would consider changing such major factors as culture, parental gender identity, or spiritual beliefs. In fact, FFT argues that different cultures, family configurations, and learning histories produce and value a wide range of relational patterns, and each of these patterns can produce both positive and negative behavioral expressions.

FFT does, however, insist on changing the means by which they are attained (drugs, violence, coercion, gang membership); that is, FFT changes the expression of these components when they damage
others. For example, parents who control via violence learn to control via nurturance and guidance. A so-called “one-up” pattern of parenting is unacceptable if it involves physical and emotional abuse, but it is generally applauded when it involves authoritative parenting, child-sensitive resource allocation, and nurturing. In other words, FFT does not attempt to change the hierarchy of abusive parents, only the patterns of behavior that serves the relational function (“one-up”). In a similar manner, FFT does not attempt to force an “enmeshed” parent to change the relational function of contact/closeness; instead FFT helps that parent replace “enabling” behaviors with appropriate nurturance which is contingent upon pro-social (not dysfunctional) youth behavior.

FFT also prioritizes the order in which these dimensions of relational function are addressed. Unfortunately, hierarchy, i.e., “control” based on a position of authority, has emerged as the predominant focus in many treatment programs dealing with youth
behavior disorders. The field often seems to presume that these youth must be “controlled” by institutions and parents, primarily through clear expectations, behavioral management, and consequences. While FFT agrees that this dimension of relational functioning is important, as an empowerment model FFT places the first treatment emphasis on relationship connection/interdependence rather than relationship hierarchy as a means to influence behavior. For example, FFT would rather empower a youth to not use drugs because s/he wouldn’t want to hurt her/his mother (i.e., damage the relationship), vs. because s/he fears mother would “hurt” (punish, consequence) her if s/he did use. Similarly, FFT would aim for a spouse or parent to stop physical violence because the spouse or parent wouldn’t “want” to hurt the other. In other words, for FFT both relational connection and hierarchy are important treatment foci, but enhancing positive relational patterns represents the first priority. As noted below, this is the basis upon which the first phase of FFT, Engagement & Motivation, emphasizes the affective component of family relationships (reducing blame and negativity, creating hope and positive alliance) as the necessary first step in the change process.

At the risk of being redundant, we will provide additional discussion of the phenomenon of relational assessment because of its importance, i.e., the absolute necessity of it being done well in order for treatment to be successful. As noted above, relational functions can be difficult to identify since they must be inferred by an observer from what is produced by the interaction process of the family rather than being phenomena that can be observed directly. In other words, functional outcomes must be understood as an end result (an outcome) of varying and often arbitrarily punctuated relational sequences. It is important to note that FFT views these outcomes as the state of the relationship “when the dust settles.” In order to get a sense of this state the therapist must understand how the behaviors characterize the family over time and across situations.

The focus on the outcomes of relational patterns and relational functions rather than individual behaviors has helped FFT develop an ideographic and relationally focused approach to understanding families. Regardless of their form, the common, repetitive, and highly entrenched behavioral sequences apparent in families lead to consistent relational outcomes (functions) that can only be understood from an ideographic perspective. Relationship functions are
reflected in patterns of behavior that maintain, albeit often in painful ways, the relationships between family members. A so-called “enabling parent” does so not out of “stupidity,” but because this represents the relational function of maintaining a level of contact (“connectedness”) with the drug-involved youth. In the same manner, a “rejecting parent” does so in order to maintain a high level of separation (“autonomy”) from a youth, while the youth at the same time may be acting out in order to maintain more connection with that parent. In other words, so-called maladaptive behavior patterns represent people meeting their relational functions in ways that their learning histories, their capacities, and their environment will allow, but doing so in ways that are maladaptive and often destructive to others. This is the reason that FFT targets change for both the individual youth and the particular environment (first the family, then others) in which the youth is embedded. Positive changes in a youth’s cognitive appraisal, emotional, and behavioral patterns will only be maintained if the youth’s environment supports those changes; and in turn, positive changes in parenting will only be maintained if others, including the youth support the changes.

Figure 9

Relational “Functions”

“Space between” people can best be explained by:

“When X relates to Y, the typical relational pattern (behavioral sequence within the relationship) is characterized by degrees of:

- RELATEDNESS
  contact vs. distance (psychological intensity)

- HIERARCHY
  relational control/influence

Goal...understand and use relational functions...
Attempting to change these basic motivational components of human behavior in just a few sessions is clinically impossible and ethically inappropriate
IMPLICATIONS FOR ACTION: WHAT TO DO WHEN YOU UNDERSTAND THE FAMILY RELATIONALLY?

Therapists must turn understanding of relational functions into action. In general, it is important to remember that understanding these functions is only useful if it helps promote therapeutic change. For the FFT therapist considering relational functions, behavior change plans are developed that keep in mind certain specific conditions:

- discrepant functions are accommodated
- all functions are accepted as legitimate
- functions are not the target of change; instead change is focused on the behavior, affect, and cognitive/attributions related to the expression of the functions. Thus the goal of behavior change is to provide positive alternative ways of expression
• use a “match-to-sample” approach to behavior change intervention which is culturally sensitive and appropriate.

**Core Principle 3: Understanding therapy and the role of the therapist as fundamentally a relational process.**

FFT views therapy as a purposeful, phasic process. From the FFT therapist’s perspective therapy involves following a systematic model that provides a pathway to change with the highest probability of success, while simultaneously responding to the immediate needs/feelings/reactions of the family in the moment. Thus successful therapy involves being both systematic and purposeful, while at the same time also being clinically responsive. From the FFT perspective these two therapeutic stances cannot be separated: purposeful while responsive. Understanding the relationship between these two essential therapeutic stances is based on FFT’s belief that therapy is a process in which two experts engage in a collaborative, alliance.
based relationship aimed at alleviating the critical risk factors that increase the likelihood (i.e. facilitate and maintain) symptomatic behavior.

The therapist is the expert on the change process. You are the professional in regard to the process event, the critical within-therapy events that must take place for successful change to occur. The change process is your domain; you are the expert in this regard. As a result you purposefully influence and direct the process of therapy in particular directions.

At the same time, the family and its members are the experts in their life, their individual emotions, their biases, and their journey. Successful therapy involves empowering the family to become unstuck and to pursue their goals and values in ways that do not increase the risk of future problems. In order to facilitate this process you are purposeful and clinically responsive.

Thus we have two experts, with different tasks, who must both do their part for therapy to be successful. This requires a partnership—a cooperation—an alliance based relationship and alliance based motivation to overcome successfully the difficult problems family members face.

ALLIANCE-BASED MOTIVATION. Motivation is a frequently studied construct that represents a central feature in most theoretical approaches to therapy. The dictionary definition of motivation is an “incentive to action.” In the context of therapy, motivation often is viewed as a static construct; a condition (incentive) that exists within clients that moves them to change. In fact, a number of change models suggest that the focus of early assessment should be on assessing clients readiness or stage of change; this often leads community practitioners to choose or at least prefer clients who are “ready” for change. However, in the 30-year history of FFT the majority of our families contain one or more members who are not motivated to change; in fact, many at first present as unwilling to even begin the change process, and some are intensely motivated to maintain the negative situation. As a result, FFT has developed strategies and techniques to create the motivation to change, leading to high success rates even in populations characterized as “resistant to change.”

Accomplishing this has required that FFT follow an “empowerment” rather than a “management” philosophy and strategy of change (Alexander & Sexton, 2002; Sexton & Alexander, 2002).
According to FFT a change process which is maintained is one in which the therapist is successful in developing an atmosphere of hope, expectation of change, a sense of responsibility (internal locus of control), and a positive sense of alliance which is shared by the family. This sense of alliance is not only between each family member and the therapist, but among family members as well. When they come to us family members often have very little sense of alliance with one another, or there are maladaptive subsystem alliances that maintain the maladaptive family patterns. Thus our first goal in FFT is to begin to develop positive within-family alliances, which then become the platform for long-term change and the difficult steps that are necessary to produce such change.

To be clear, it is perhaps misleading to suggest that our youth and families are “not motivated.” FFT views most clients coming to therapy as motivated to some sort of action. Unfortunately, they are motivated to maintain or engage in actions that do not produce successful resolution of the presenting concern. From the FFT perspective, therapeutic motivation occurs when the incentive to action results in new and adaptive patterns. Thus FFT defines therapeutic motivation (an incentive to change or to act) as the primary initial therapeutic goal. In turn, attaining this goal is based principally on alliance, a relational process, which emerges from specific therapeutic and clinically responsive strategies of the FFT therapist. As such motivation has an intrapersonal (within the client), a family interpersonal (between family members), and a therapeutic (between therapist and each family member) component. When activated in a therapeutic way, each of these components contributes to producing an incentive to action, a push to change that is critical for successful family therapy.

The centrality of alliance is not unique to FFT. Alliance is a well-defined construct in psychotherapy literature, and is usually defined as agreement on the tasks and goals within the context of an emotional bond.

- The *within family alliance* is demonstrated by family members overcoming their negativity and working together to the same end, with agreement on how to get there within the context of an emotional bond.
- The *family-therapist alliance* is a similar process of working together involving family members and the therapist. It is
increasingly clear from therapy process research that alliance is critical and additionally, in the family therapy context this alliance needs to be balanced. Balanced alliance occurs when the therapist develops roughly similar levels of working alliance with parent(s) and youth, even when one or more enter the therapy process with exceptionally aversive behavioral patterns (Robbins, Turner, & Alexander, in press).

The centrality of motivation is not unique to FFT, however it is viewed quite differently than in other approaches. Intrapersonal (within client) motivation includes a cognitive component which is related to the way in which clients understand the problem, and an affective or emotional component which is related to the way in which a person feels about the problem or concerns. At the point that families enter therapy, the cognitive and affective/emotional components of their attributions about the “problem,” and each other, generally reflect considerable blame and negativity. Successful motivation (for positive action) occurs when the therapist helps family members to view the “presenting concern” as one to which all members contribute but for which none are to be blamed. In addition, motivation is enhanced when the FFT therapist, through interpersonal processes such as reframing, helps all family members experience reductions in negativity and blaming, and instead provides reasons to feel hope and an expectation of potential success. These intervention processes, and related strategies such as sequencing and non-blaming, are described in a later section of this manual.

**THE ROLE OF RESPECT AND UNDERSTANDING.** It is difficult if not impossible for most of us to “respect” someone who attacks someone else with a fist or gun. It is difficult to respect a parent who continues to use drugs when such drug use has been implicated in their child’s behavioral problems. It is difficult to respect a youth who, in the first ten minutes of an intake session of the first session, blurts out: “Fuck you” (to mother), “Fuck you” (to grandmother with whom the youth and mother lives), and “Fuck you bitch...get outta my face” (to you, the therapist).

Such behaviors evoke, at least in most of us, negative emotional reactions, critical judgment, and what some might call counter transference. We are human beings with our own parents, children, and friends, some of whom have been injured emotionally and physically by the very same behaviors. Some of us, in fact, have been abused
ourselves, some of us have struggled with the residual self concept that emerged from a stern rejecting parent, some of us have worked in shelters or on crisis phone lines and experienced the consequences of the behavioral patterns we must work with in FFT.

In this context, the goal of providing hope and establishing a positive and balanced alliance is far from a trivial task. And yet, without it our hope of creating a positive change process which can and will be maintained is unlikely. Years of clinical experience and volumes of psychotherapy research support this core contention of FFT.

How does FFT meet this critical initial goal of intervention despite—or even with the help of—our own negative reactions? The answer lies within a subtle but essential restatement of the role of respect and understanding. Specifically, FFT argues that developing a positive and balanced alliance requires relentless effort to understand and respect the youth and families on their own terms. It is the

---

**Figure 12**

Relationally-based/Alliance Based

- Relational “bond”
  - relational “liking”
  - support
  - connection
  - credibility
- Agreed upon means...tasks
  - agreed upon roles
  - common process
- Common Goals
  - going in the same direction
effort - the process of relentlessly working - that is essential. As your training unfolds, you will find that your willingness to try to understand, in a non-blaming way, the complex variables that bring people to the point of problematic and even destructive behavior is critical to facilitating positive change. Without it, the likelihood of positive change is decreased dramatically.

**OBtainable Change Goals.** One of the great strengths of FFT is that in the multi-problem families with whom we work we are committed to finding ways to make changes that become meaningful for the family. FFT accomplishes this by focusing on significant yet obtainable behavioral changes that will have a lasting impact on the family. In that regard, FFT seeks to pursue outcomes that “fit” the values, capability, and style of the family; we do this rather than attempting to mold families into someone’s version of “healthy” or to reconstruct the “personality” of the family or individuals therein.

In order to accomplish this goal we must individualize and tailor our specific behavior change targets for each family, for the resources they have, for the values that they hold, and for the circumstances in which they live. The specific and obtainable behavior changes we attain in this manner have a major impact on family functioning because they are targeted to alter the underlying risk and protective patterns that support and maintain other problematic behaviors. Thus, what can seem to be small behavior changes in family process (positive monitoring, affirmation of pro-social steps rather than emotionally abusive criticisms) are ones that are lasting because they enhance the relevant protective factors and decrease the important risk factors in the family in treatment. In this way the obtainable changes that occur in these families not only have an immediate effect of changing a specific “problem” but also have an additional impact of actually empowering a family to continue applying changes to future circumstances. In this way what currently seems like a small change becomes, over time, a significant and lasting alteration in the functioning of the family that is reflected in major changes in the behavioral outcomes such as cessation of drug use and within family violence.

**Matching.** “Matching to” represents a final core philosophy regarding therapy and the FFT therapist. “Matching to” represents a way to negotiate the dialectic between the theoretical and clinical
goals of a model and the individual differences of specific clients. The matching to the phase principle guides FFT therapists to consider the phase of intervention they are in with the family, the goals of that phase, and how these determine how to respond and where to focus intervention or assessment activities. Matching to the client directs the therapist to achieve the phase goals in a way that fits with the clients’ relational needs, problem definition, or abilities of the family. Matching to the client allows FFT to respect, value, and work within the important cultural, racial, religious, and gender based values of the client. Matching to sample suggests that the therapist target outcomes that fit this particular client, in this situation, and which acknowledge the specific abilities, and unique values of this particular family. Matching to sample also helps therapists to avoid imposing their own value systems, social agenda, and interpersonal needs on the youth and family. Contingent clinical decisions are guided by the principle of matching therapeutic activities to the phase, the client, and the sample. Finally, the matching principle also allows therapists to view “resistance” as a situation that exists when the offered activity, intervention, or new belief does not feel to one or more family members as if it will be in their best interest.

**Clinical model protocol/map**

FFT is a phasic clinical change model consisting of three specific and distinct phases of clinical intervention:

- Engagement and Motivation (E/M)
- Behavior change (BC)
- Generalization (Gen)

Each phase has specific areas of assessment and therapeutic goals and specific therapist skills that, when used, increase the likelihood of successful outcomes with clients. The phases give the therapist a within session direction that maps the “proximal” or immediate goals and strategies of each session. In this way the phases are a “map” that indicate to the therapist where the change process is going.

Beyond establishing a set of goals, the FFT clinical protocol model also depicts the systematic and relational nature of therapy.
Therapy takes place over time, and evolves as a dynamic process. As such the phases of FFT are based on the following assumptions:

- FFT takes place within a transaction, a set of multilevel processes between family members and the therapist.
- The change process unfolds over time. Each phase involves clinically relevant and scientifically based interventions that are organized in a coherent manner and allow clinicians to maintain focus in the context of considerable family and individual disruption.
- Each phase has specific therapeutic goals unique to that phase, specific related change mechanisms that help accomplish those goals, and specific therapist interventions most likely to activate those change mechanisms.

As the primary clinical map for the FFT therapist, the phases set the agenda for the session and organize the therapist’s behavior in the session, acting as the “anchor” for therapists while they are in the room. In each family session, the family members bring in the “content” or details of their struggles, emotions, or perceptions. The therapist (as noted in the principles) focuses on the relational process embedded within this content, and responds to the actions of the family guided by the session specific, phase based goals of the clinical model. So, midst the emotion and the struggle among family members, the therapist is guided by the awareness of the goals of the phase in which s/he is operating. This means that the phases of the model must be well understood to the therapist as the primary “lens” through which they view the unfolding process of intervention.
While the phases discussed below are quite specific, direct and prescriptive (thus, it can look and feel like a prescribed curriculum), they cannot be pursued in a “paint by the numbers” fashion. Instead FFT is based on the idea that specific goals are pursued in clinically responsive ways, which are contingent upon the unique qualities of each family. Thus, FFT embraces two seemingly incompatible forces: being systematic and structured while being relational and clinically responsive. The clinical model is a “map” that details the specific goals and strategies of each phase of change. However, at the same time FFT clinicians use the powerful clinical processes that emerge when families bring in the issues that are most salient to them to accomplish these goals. When done in this way, the application of the phases and the accompanying strategies is done in ways that are unique to each family. A number of points are important when using a specific model as the basis of within session activities:

**Figure 14**

- Shares their story...what happened, who did it, what it means to me...how I feel about it
- FFT is a conversation...

- Listens to the personal nature of story
- Thinks about the change process...
  *how can I understand the problem?*
- Responds in a personal way that fits the phase of FFT
Every action of the therapist contains therapeutic potential. Thus, therapeutic “interventions” can include all of the activities of the therapist throughout each phase of therapy.

Assessment is an activity that takes place in each phase of the model. It is the focus of the assessment that changes across the phases.

Accomplishing within session goals (as defined in each phase) is not a linear, straightforward process. Instead, it is a relational process and thus, by definition, more circular in a way that sometimes may feel like “one step forward-one back.” While the phases appear “ordered” and “structured,” they unfold within the context of conversations between therapist and client. Many times these conversations even seem to “go in circles” and the therapist is always considering opportunities to meet the phase goals.

The next figure depicts the phases of the FFT clinical protocol. In the sections below we describe each phase in more detail.

Engagement/Motivation phase (E/M)

The Engagement and Motivation phase has four primary goals:

- building alliance between the therapist and EACH family member and between all family members
- reducing negativity and blame
- developing a shared family focus to the presenting problems
- building hope and an expectation for change

While both engagement and motivation are goals the therapist pursues within the first phase of conversation with the family, they are not the same phenomenon.

ENGAGEMENT is defined as involving the family in the immediate activities of the session such that they become interested in taking part in and accepting of therapy. Engagement comes from “small talk,” humor, interested questions, and working relentlessly to understand and respect family members. Engagement is both a goal (what the therapist tries to do) and an outcome (the family is “engaged”) and can be measured by the level of family specific involvement in the session. Remember, involvement does not have to
be “talking a lot” or “sharing.” Instead it is participation in the process in a way that fits the individual family member.

**MOTIVATION** is a state that family members develop through the initial phase in which they come to see hope that the problem can change, and a belief that the therapist and therapy can help promote those changes, that things can be different, and that they along with other members of the family are willing to undertake change. As noted above (core principles section) FFT seeks to develop alliance based motivation between the therapist and each family member and between family members themselves. The various aspects of this alliance based motivation represent internal client states that must be developed if families are going to be willing to return to therapy, participate in therapy, and accept and take part in appropriate behavior change interventions. They are developed over the course of E/M phase sessions by way of the therapist responding to “opportunities” that come up within the conversation with the family about the important issues in their life.
The engagement and motivation phase begins with the first contact between the therapist and family. The first contact may be on the phone or in person. In fact, it is preferable that the FFT therapist initiates contact with the family upon receiving a referral. Early phone contacts, even if just to make an appointment, are potential opportunities for pursuing the goals of the first phase of FFT. Whatever the first contact, in an active and engaging way FFT therapists immediately focus on the process goals of the E/M phase. These goals include: reducing between family member negativity and blame while developing a family focus for the problems presented by the family, helping the family experience a sense of support and hope that the problem can change, and developing a belief that the therapist and therapy can help promote those changes. The outcome is an alliance that develops wherein each family member believes that the therapist supports and understands his or her position, beliefs and values.

The engagement and motivation phase is successful when the family members begin to believe that while everyone in the family has a different and unique contribution to the primary concerns, everyone shares in the emotional struggle that is occurring. The family comes to trust in the therapist, and they come to know that regardless of what they may have done the therapist will protect and help them as much as anyone else. They become engaged in the process and come to believe that it will benefit them personally and the family as a whole and that the solution will require changes from each of them.

For engagement and motivation to occur, family members must experience a rapid change, during the initial sessions, in the interpersonal behavior between themselves and other family members. In particular, FFT therapists engage in a number of specific contingent responses to family negative and blaming interactions in order to accomplish reattribution of the causes, emotions, specific behavior, and intent of the negative behaviors of family members. S/he also must accomplish this in a way in which each member retains some responsibility for the family processes, but no blame. It is important to note: motivation results from the experience of the family over the entire session, not from any single thing said or done by a therapist.

Engagement and motivation also require that a mutual and family focused definition of the “problem” emerge. Having struggled with the behavior problems of their adolescent and/or parent for some
time, it is only natural that each family member comes to therapy with well-defined explanations for the problems they experience. These definitions may exist in emotional (“it hurts and I am angry”), behavioral (“stay away from me”, “you don’t deserve a break”) or cognitive terms (“you are just trying to hurt me”, “why does he/she intentionally do this?”). The cognitive sets, or problem definitions, that family members possess represent the meanings that contribute to the emotional intensity that is often behind the anger, blaming, and negativity seen in the interpersonal interactions between family members.

A family focused problem definition is one in which everyone in the family has some responsibility and thus, some part in the problem. However, no family member has blame for the state of affairs in the family. The difficult goal is the reduction of blame while retaining a sense of responsibility for one’s own actions.

A family focused problem definition has a number of important therapeutic functions. First, it contributes to the reduction of blaming and negative interactions among family members and thus produces hope and a sense of motivation. Second, it helps individual family members reattribute the intent and causes of behaviors from malevolent to benevolent, and thus alters the emotional attributions associated with problem behavior. Third, the family focused problem definition helps identify potential solutions that may have otherwise been difficult to identify. Finally, the family focused problem definition helps organize therapy and becomes the major theme that explains the problems of the family and thus organizes behavior change efforts. In fact, without this redefinition to include all family members, it is almost impossible to get everyone in the family involved in the behavior change phase.

**Assessment in the Engagement/Motivation Phase**

Assessment is an ongoing activity throughout the engagement and motivation phase in two primary areas. First, the therapist assesses the process issues of the phase and judges the progress of each of the phase goals in order to determine what interventions need to occur.

The therapist also begins to develop a multisystemic understanding of the individuals, family, and relational context of the family. To accomplish this the assessment is focused on identifying the problem
sequences that underlie the relational system of the family. Assessing these issues helps the therapist understand the family well enough to “match to” them and begin to plan for the behavior change phase. It is important to note that unlike some models, assessment at this phase is heavily based on observation rather than direct questioning or intervention.

It is also important to note that assessment of client risk factors is not the primary activity of the therapist. Instead, the therapist is reframing (which includes a strong focus on possible underlying strengths) and developing a relational focus to accomplish the primary goals of the phase (e.g. negativity/blame reduction, developing a family focus, etc.). Thus it is critical that the therapist not become a detective doing traditional assessment but instead stay open to observation while being therapeutic and pursuing the primary phase goals.

**Primary Therapist Activities in Engagement/Motivation**

**Reframing.** While probably the most common and universal therapeutic technique, reframing has a particularly important place in the engagement and motivation phase. Reframing has a role in each phase of FFT, but in engagement/motivation these goals are especially important. In engagement/motivation reframing helps family members find a way out of the defensive, blaming, and negative, emotionally spiraling behavior patterns that dominate the family. When events, emotions, and behavior are reframed an alternative route to emotional expression is created. In addition, an alternative cognitive and attributional set is created that helps redefine meaning events and thus reduce the negativity and redirects the emotionality surrounding them. In many ways reframing also creates confusion and thus provides some distance and protection from the automatic negative processing and relational patterns that have developed in families over time.

In E/M the FFT therapist reframes negative and blaming statements of a family member, the behavior of a family member, the implied intention and purpose of a family member’s behavior (as implied from another) in order to reduce blame and negativity while creating an alliance based family frame of reference for the concerns expressed by the family. From the FFT perspective, reframing has two distinct elements:
• **Validation.** The validation portion of reframing is a demonstration of understanding and support of what the client said, the emotion they expressed, or their position in an event within a family. This validation includes recognition of the negative (painful, destructive) impact of family members’ behaviors, but it is more than reflection, support and empathetic responding. In fact, the validation is a supportive statement because it describes, in very direct, straightforward non-blaming ways, the event, behavior, or emotion that occurred.

Alliance develops with the person to whom the therapist speaks because the therapist deals in straightforward yet supportive ways with the troubling events/behaviors/emotions. Alliance is built with other family members because they see the therapist talking directly about tough issues, but in a way that supports the family. The validation response supports and engages the client.

• **Reframe/reattribution.** Validation is followed by a reattribution, which presents an alternative theme or meaning to the event. The alternative meaning or theme must be plausible and believable to the client such that it fits them. For example, it is possible to reframe anger as the hurt that the individual feels in response to the trouble in the family. The reattribution is helpful because it changes the focus of the behavior from being directed to another person to inside the speaker. Thus, the blame inherent in anger is now redefined as hurt, which removes negative emotions while retaining meaning. There are three general directions that the reattribution aspect of reframing may take.

1) The first targets *changing the meaning* of a behavior, emotion, or event. Thus, the meaning moves from a negative and blaming meaning to one that describes the behavior, emotion, or event in other ways. This form of reframing helps reduce negativity by changing the presumed intent of the negative behavior. The most powerful reframes are those that impute possible noble, or at least “well intended,” motives to the apparently negative behavior.
These reframes will be elucidated during the FFT training you will undertake.

2) The second challenges the family by suggesting hope through focusing on a different potential direction for change. Challenge oriented reframes do not suggest solutions, but instead suggest a different direction and lend hope.

3) Finally, one can target a reframe toward linking family members together and thus creating a family focus to the emotion, behavior, and event.

CHECK/REEVALUATE the impact. In addition to the main elements of reframing (validation, reframing of intent) a reframing statement must be evaluated and its impact must be gauged. Thus the reframing process does not end with the delivery of a reattribution or reframe. Instead, the check and reevaluation steps are critical components that require the therapist to carefully listen to the response of the client. The therapist must listen for what fit and what did not, what was left out, what was/was not emphasized, what could be added to further match the reframing statement to the client. The check and reevaluation portion of reframing is what makes the process relational and co-constructed rather than one of discovering the “correct reframe.”

Whatever the family response, the therapist gains information that is put into a revised and more finely tuned validation and reframe that is next delivered. During this check or reevaluation the therapist may learn of an additional factor important to a family member, which will be highlighted in the next validation. Or it may be that the description in the reframe did not make sense to the client. Thus, in many ways there is no right reframe…but only the therapist’s best approximation to which the family adds information that is included in the next reframing opportunity. In this way reframing is a constructive rather than a discovery oriented process.

REFRAMING, THEMES, AND ORGANIZING THEMES

Reframing is a dynamic process that evolves over time and includes input from both the therapist and the family. Reframing relies on what we call themes. Themes describe problematic patterns of behavior, and/or relationships, in a way that suggests they may be motivated by positive (but very misguided) intent(s). Themes help
inform the reattributio...ns that promote the goals of the engagement and motivation phase:

- Suggests a non-blaming alternative explanation for “bad” behavior
- Suggests an alternative that focuses responsibility from the other/event to an understandable and non-malevolent aspect of an individual
- Reduces negative behavioral interchanges because they suggest an alternative explanation of behavior

Some possible themes that meet these criteria include:
> anger implies hurt
> anger implies loss
> defensive behavior implies emotional links
> nagging equals importance
> pain interferes with listening
> frightened by differences
> need to feel OK about self in context of problems
> protection
> giving up so much power to someone else

It is important to remember that these themes are only a beginning step in the reframing process. They can’t be delivered as interpretation but instead need to be one part of the process of reframing described above. These beginning themes must be presented in a way that fits the family, expanded in a way that makes them personal to the unique context and situation of the family, and developed well beyond these beginnings. Over time themes provide new “explanations” of problematic and painful patterns that provide:

- hope for the future and give family members a reason to “stick with” the difficult change processes which will ensue, and
- some sense of their “part” or “challenge”

When developed over the course of early sessions, themes come to organize new explanations of more than a single event, emotion, or behavior. Instead, negative aspects of the family history are seen
in terms of the “struggle” experienced by the entire family. When such a theme makes sense to family members, it becomes what we call an organizing theme because it will serve to be the center of future discussions and the basis for behavior change goals, and reemerge as a central feature of generalization. Organizing themes speak to each individual in the family and the family as a whole.

**REFRAMING AS A PROCESS**

It is important to remember that reframing is a relational process. As a process it goes on and moves forward fed by responses of the client and creativity of the therapist, and it must be based on the myriad cues (verbal, paraverbal, nonverbal) that emerge in the session. As a relational process it is about people and must be matched to what is important to the clients. Thus reframing is relationally contingent, and responsive.
Upon being presented with a reframing opportunity, the therapist first finds a way to validate the position, statement, emotion, or primary meaning of the speaker. FFT therapists support and sometimes initiate the reframing process with a *theme hint*. Theme hints represent comments, many of which are not even explained, which suggest that very problematic patterns of interaction may be “hiding” deep and very human emotions. Typical examples are found in sessions where a single parent and child begin to escalate their criticism and name-calling. In response, the FFT therapist might simply start shaking her head and say: “Wow - you two are sure working hard to hide your real feelings.” This theme hint implies that rather than the obvious anger and maladaptive behavior on both the Mom’s and Daughter’s parts, the therapist is instead interested in examining the underlying feelings (pain, abandonment) that in fact they may both share.

Reframing is a *process* that is conducted by the therapist by acknowledging the position of the client (validation) while at the same time reattributing the event to an alternative, yet plausible

---

**Figure 17**

- Respond thematically
  - Theme “hint”
  - Organizing theme
- Content of the problem
- Reframing...
- a relational process between
- But.....a NEW thematic explanation of event, problem, family, situation...that is
  - “real” for both therapist and client
  - mutually constructed...not forced
  - mutually accepted
explanation that fits the client while at the same time is not negative or blaming (reframe). However, it is also a process whereby the therapist and client are actually constructing a mutually agreed upon and jointly acceptable alternative explanation for an emotional set of events, or series of behaviors. Because it is jointly constructed it is “real” and relevant to both client and therapist. Over time the small individual reframes become thematic. As such they involve many family members, a series of events, and a complex, alternative explanation for the “problem” pattern(s) that are the basis for their referral. In this way, the reframing process helps organize and provide a therapeutic thread to the engagement and motivation phase. Initial themes and reframing become organizing themes, the outcome of which is a new problem definition that results in a reduction of negativity and blame, and an increase in a family (versus individual person) focus.

Outcomes of the Engagement/Motivation Phase

The engagement and motivation phase is successful when the family members begin to believe that while everyone in the family has a different and unique contribution to the primary concerns, everyone shares in the emotional struggle that is occurring. The family comes to trust in the therapist, they believe that the therapist has an understanding of their unique position, albeit that they may not agree, and the therapist has the ability to help. They come to know that regardless of what they may have done the therapist will protect and help them as much as anyone else; s/he is not there to “take sides” or “make one person change.” They become engaged in the process and come to believe that it will benefit them personally and the family as a whole and that the solution will require changes from each of them. In a sense they each will be more hopeful that a solution is possible and feel motivated to take the responsibility to try new behaviors and techniques in search of this solution.

What is next…

One of the useful things about having specific phase goals is that the therapist is able to judge the progress of sessions. In the engagement/motivation phase, the FFT therapist has been assessing the accomplishment of the reduction in negativity/blame, the
development of a family focus, and the building of alliance. The assessment has been through both direct observation and through reports from the family. As these changes occur the therapist begins to think about moving to the next phase of FFT. It is important to note that movement to any new phase is initiated by the therapist. The therapist, who has assessed and monitored the progress toward engagement and motivation goals, now changes his/her response to the family in a way that refocuses it on a different set of goals, the goals of behavior change. A new phase begins as the therapist starts to respond differently to the discussion in the room.

In the next phase of FFT, the therapist will focus on targeted changes in specific individual and family risk and protective factors. To do so, the therapist first needs to bring together their clinical observations regarding the relational functions of the family. In other words, we need to understand and work with what “drives” them (what they bring to us). This relational understanding will allow us to tailor our interventions so that the youth and family can and will
follow them, change in a positive direction, and be able to maintain those positive changes. Thus at this juncture we recommend that readers once again review the section on Relational Assessment (pps 33 - 47, this manual). Second, the therapist needs to target specific risk factors and develop individualized plans to build new behavioral competencies in these areas.

**Behavior Change phase (BC)**

The behavior change phase begins a purposeful refocusing of the therapeutic conversation by the therapist from reframing and redirecting to focusing on specific changes in targeted risk behaviors. The hope and involvement generated in the earlier phase provides the motivation and the family focused definition of the problem provides a rationale that makes the behavior change interventions logical and thus more likely to be carried out by the family. The relational understanding of the family gained in engagement and motivation provides a clear path to deliver the technologies of improved communication, problem solving, or parenting to the specific family.

The primary goal of the behavior change phase is to target and change specific risk behaviors of individuals and families. Changing risk behaviors involves targeting the behavioral skills of family members in order to increase their ability to competently perform the myriad of tasks (e.g. communication, parenting, supervision, problem-solving, conflict management) that contribute to successful family functioning. The apparent risk factors are reduced as family members develop more protective behaviors for use in these common family tasks.

The behavior change phase has four primary goals:

- Changing individual and family risk patterns…
- through activities both within and outside the therapy sessions.
- in a way that matches the unique relational functions of the family…
- and, is consistent with the obtainable change of this family, in this context, with these values

The activities in the behavior change phase cement the attributional changes made in the engagement and motivation phase by
adding behavioral changes to the common risk patterns of the family. This is accomplished by developing an individualized change plan that targets the risk and protective factors evident in the family and achieves goals using the unique relational pathways to change that fit the family. The emphasis in this phase is on building protective family skills that will improve the factors that put the family and adolescent at risk. The desired outcomes of this phase are the competent performance of the primary activities associated with risk factors: parenting, consequences (both rewards and punishments), communication processes between adolescent and parent and between adult figures in the youth’s life, negotiation of limits and rules, and problem solving and conflict management in a way that matches the relational capabilities of the particular family. These must be developmentally appropriate for all family members, and possible for this family with these abilities in this context.

The targets of a behavior change plan are somewhat common (e.g. negative and coercive as well as negligent parenting, youth non-compliance, communication, problem solving) in the population of at-risk adolescents. They are common targets because they represent the established risk factors for youth with externalizing behavior disorders and their families. The implementation, i.e., the strategies through which these changes are made, must be unique to each family relational system. Implementation of behavior change is unique because the paths to behavior change are based upon the unique relational functions and patterns of each family.

**Assessment in the Behavior Change Phase**

Assessment in the Behavior Change phase involves two domains of assessment. The first is an evaluation of the most important risk factors in the youth and family. This domain of assessment relies on pre-assessment instruments (e.g. OQ-45, YOQ, YOQ-SR etc.) as well as clinical observation. Identifying risk areas helps identify the targets of behavior change. The second domain is that of relational functions, which have been gathered through clinical observation throughout the engagement/motivation phase. Identifying relational functions helps determine the relational strategies through which changes in the targeted risk factors will occur, allowing the therapist to match the specifics of behavior change to the individual family.
RISK AND PROTECTIVE FACTOR ASSESSMENT

Understanding the role of risk and protective factor assessment in FFT is critical to the behavior change phase. It is the foundation upon which behavior change targets are selected. As noted above, we view individual behaviors and family relational patterns as embedded within a broad ecosystemic context and influenced by core neurological, biological, learning histories. Both the developmental psychopathology and the treatment literatures note the role of family and other social systems in child and adolescent behavior problems. In FFT we try to integrate these multiple assessment domains into a coherent model that helps focus the family therapist on those issues central to immediate treatment decisions. Risk factors are the primary focus of therapeutic attention because they represent domains that are modifiable areas of the client system. There is no doubt that...

Figure 19

Behavior Change Phase

Goals:
1. Help family develop competencies that may help change family “risk” patterns
2. Identify targets of change
3. Identify “pathways” of change that fit the family (“match to”)

Desired outcomes are improved...

- Parenting skills
  > Monitoring and supervision
  > Consequences/rewards/punishments
- Communication skills (parents & adolescent)
- Family conflict management
- Problem solving

These are common risk factors with at-risk adolescents
Pick competencies that are relevant to this family
these primary domains are influenced by more static and stable biological, learning, and core traits that provide context for individual and family behaviors. In addition, the ecosystemic context provides critical information to understanding the nature of the clinical problems primary in therapy.

There is also no doubt that the FFT therapist must have knowledge of the range of childhood and adolescent problems that present in one or more of a variety of situations (home, school, community), the relational and multi-axial assessment systems that will help them understand these presenting symptoms, and the available treatment options from which they might choose in order to successfully intervene. However, the primary clinical question is how do these contextual factors impact, and how are they impacted by, the individual and the family relational systems. Thus, it needs to be the FFT therapist who first identifies the clinically significant behaviors (see figure 19), assesses the common family patterns and the risk elements within those patterns, and identifies a treatment that addresses these risk elements in order to reduce the likelihood of clinically significant problem behavior in the future. In this way behavior change assessment can lead to identifying targets of change that “fit” the family.

RELATIONAL STRATEGIES AS A PATHWAY TO BEHAVIOR CHANGE TARGETS: “MATCHING TO…”

As noted repeatedly, the targets of a behavior change plan are the risk factors common in many families (e.g. communication, parenting, problem solving) in the population of at-risk adolescents, but the way in which those changes are made must be uniquely crafted to fit the relational functioning of the individual family in treatment. Thus, the goal is to increase competent performance of, for example, communication, but in a way that matches the relational functions of that particular parent and adolescent. In one family the implementation of communication change might take the form of close and connected negotiation of changes so both parents feel connected and a part of a collaborative relationship with one another. In another family, with a different relational profile, the same communication changes would look more disconnected and distanced with information exchanged via notes instead of conversation. Therefore, the goal of our behavioral intervention is not to change the relational functions of behaviors but instead it is the manifestation of these
outcomes. By focusing on the expression of functional outcomes not the outcomes themselves FFT individualizes the changes of behavior to fit the existing relational functioning of the family. Making behavioral technologies “fit” the family relational system allows the family therapist to take the path of least resistance.

The long history and success of FFT has been based on the fact that efficient change is only accomplished when the change plan is consistent with the problem definitions of the family and the relational functions of the family, when they fit with the individual strengths and weakness of individuals, when they provide positive and adaptive ways for family members to meet their functional needs, and when they are based on successful E/M. Therefore, the goal of our behavioral intervention is not to change the relational functions of behaviors, but instead it is the manifestation of these outcomes.

Figure 20

**Relatedness Assessment**

- She is nagging, worrying, and attempting to get help with parenting (contact)
- But, the result was he withdraws (distance).
- He avoids, responds, and withdraws (distance)

- By being away whenever dad was around...hitting her,
- By working late and being unresponsive and withdrawn

- Nagging, worrying, and attempting to set limits (contact)
- But, the result was Nicole leaving home (distance)

- Avoided home, used arguments to leave, referred to sex in a way that distanced Mom
Therapist Activities in Behavior Change

FFT therapists are equally as active in behavior change as they were in the earlier engagement and motivation phase. However, the focus of the therapist’s activities changes and the objective becomes accomplishing the goals of the behavior change phase. To move ahead the therapist must have a clear relational assessment and evaluation of existing risk and protective factors. This allows the therapist to put together an individual change plan that involves specifically identified targets and a relational strategy to accomplish those targets that matches to the unique relational system of the family. The organizing theme established in the engagement and motivation phase serves as the “rationale” for the change plan (e.g. it should be logically related).

FFT therapists take the events and issues that arise from the family and focus them toward behavior change. Just as in the engagement and motivation phase, the therapist systematically responds to the family issues by moving the conversation toward building competencies that mitigate risk factors in ways that match...
the family. This can happen both in session and as “homework” or activities that the family is asked to do before the next face-to-face contact with the therapist. In sessions, the therapist would, based upon the assessment process above, target, for example, communication. More specifically, they might target the clear presentation of single requests in behaviorally specific ways that is not coercive and negative. When the family begins to discuss the events or issues, the therapist focuses the discussion on enhancing communication. The therapist may coach, direct, refocus and practice these new skills during the session to then be practiced by the family. As homework the therapist would make sure that the objectives were clearly presented, specific, and accomplishable with a high expectation for successful completion by the family. Follow-up would occur in the next session.

The targeted changes are implemented both within sessions and through assigned family tasks accomplished between sessions, and continue to be based on the themes from the previous stage (E/M) which help provide the rationale for these new behaviors. As behavior change sessions unfold the therapist may model new skills, ask the family to practice a new behavior or interaction pattern, or provide guidance in the successful accomplishment of these new behaviors. S/he will often provide technical aids (e.g., “practice notes”), and through the use of therapeutic directives s/he may structure activities that the family practices. In fact, the implementation of these changes heavily draws upon many of the typical technical aids that help to increase the likelihood of success in changing behaviors. For example, communication might be enhanced through message boards or reminders.

**REFRAMING IN THE BEHAVIOR CHANGE PHASE**

While certainly central to engagement/motivation, reframing is also important in behavior change. In fact, reframing is a relational method to help focus the struggles and salient issues of the family toward the goals of behavior change, e.g. competency development. In this way reframing, following the same process as noted above, might help direct the family to shared, family focused action. Or it might link the behavior change target to the organizing theme to provide a rationale for the direction. Finally it may help reduce negativity and blame as it arises and thus keep the conversation of behavior change focused.
RELATIONAL ASSESSMENT IN BEHAVIOR CHANGE

Relational assessment is critically important in the behavior change phase of FFT. The goal of relational assessment is to identify the \textit{pathways} for change. In other words, the FFT therapist uses their understanding of the functional outcome of the central family behavior patterns (relational functions) to determine the way or \textit{pathway} to follow when attempting to change the identified family and individual risk factors. Thus, the FFT therapist may attempt to improve the communication competencies of the family but differently for each dyad because of different degrees of relatedness or hierarchy (see earlier section on relational functions). In this way, relational assessment becomes the corner stone of the behavior change phase.

It is important to remember the goals of relational assessment: to identify relational functions to use as \textit{pathways} to implement specific behavior changes. The goal is a change in the behavior, affect, and cognitive and attributional process related to the expression of these functions. Thus, the goal is alternative means of expressing the function.

To do so the FFT therapist must remember:

- discrepant functions between individuals are accommodated
- all functions are accepted as legitimate
- functions are NOT the target of change

COMMON BEHAVIOR CHANGE TARGETS

The activities within the behavior change phase of FFT cannot be viewed as techniques, isolated interventions, clinical “tools,” or as a set of curriculum-based activities (e.g. with “six easy steps”). Instead, FFT understands the common competencies that are behavior change targets as a set of principles that the therapist brings to bear on the unique relational organization of the family. For example, communication is not taught as specific steps as much as it is woven into problem solving and homework, directives. The principles of positive communication do guide the therapist in identifying potential areas of change and potential targets of change. Thus, FFT therapists rarely focus on “communication” but instead attempt to change a specific principle that is not evident in the family relational pattern (e.g. brevity, specificity, congruence). This is often accompanied by role-playing within a session.
In the sections below we discuss the major areas of behavior change. Consistent with the discussion above, we present the core principles that link to each area. These principles are intended to be used by the therapist to tailor and match a specific change plan to a specific family.

**PRINCIPLES OF POSITIVE COMMUNICATION.**
Communication training is a common focus within the behavior change phase of FFT. Our view is that all families communicate and in fact have well entrenched communication patterns. In behavior change the goal is to identify those aspects of existing communication patterns which can be altered and built upon to promote successful and effective communication patterns in families. In addition, communication is clearly the foundation of any other skills or competency in a family. Thus, parenting, problem solving, and conflict management all depend on and are enhanced by improved communications skills.

There are many communication programs available. In FFT, we have identified the basic principles of these approaches. Communication change should be based on these principles.

1. **Source responsibility** is important in communication because it helps develop individual ownership of requests and impact statements. Family members are encouraged to own and take responsibility for communication because keeping communication at a personal level helps reduce blame and defensive reaction. It is not critical that the family use the traditional “I” statements, although those might be a helpful way to express source responsibility. Instead, the family members need to find a way, within their way of interaction, to make it clear that the communication, the request, the statement is theirs. Thus, what we attempt to avoid are statements like, “In this house...”, Kids shouldn’t...” “It would be nice if people around here would.”

2. **Directness** is an important complement to source responsibility in that it specifies who the communication is directed to and intended for. Directness in communication is the specification of the “who.” By specifying the “who” it avoids third person comments, innuendo, and unhelpful generalizations. The goal is to reduce statements such as “No one around here...,” “He never...”
3. **Brevity** is important if communication messages are to be understood and acted upon in the intended manner. Communications need to be short to avoid overloading and to facilitate listening. Brevity may involve using as few words as possible to specifically and effectively deliver the message.

4. **Concreteness and behavior specificity** are important particularly in negotiations among family members. The goal is to translate broad statements (e.g. “be responsible”) into specific statements that can be understood, acted upon, and measured. Specificity often involves helping family members translate their feelings and demands into specifics that facilitate negotiation, contracting, and presenting alternatives.

5. **Congruence** is important because it helps overcome the confusion in communication. Because of the high emotion and long history of struggles simple communication often contains mixed verbal and non-verbal messages. The goal is to help decrease the discrepancy between these messages to reduce the likelihood of confusion, misunderstanding or a seemingly inappropriate responses to a request.

6. **Presenting alternatives** promotes cooperation and an atmosphere of working together that overcomes the negative interactions often understood as non-negotiable demands. When requests are made with alternatives it demonstrates the desire for continued discussion and involvement in a process of talking. When done by presenting alternatives, parents and youth can retain a sense of control while providing an open channel for discussion. It is the atmosphere that is developed when alternatives are presented that is even more important than the alternatives themselves.

7. **Active listening** is an important complement to all communication. By actively listening to a statement or a request the listener demonstrates involvement and collaboration. Similar to impact statements, active listening must take a form that “fits” the family. Thus, it may not follow the prototypic, “what I hear you saying is…” Instead active listening may be communicated in a non-eye contact, restating, or even a “grunt” that notes that the message has been received.

These principles of successful communication come together in two major communication functions within families: negotiation and impact statements. Both help regulate behavior, but through
different mechanisms. **Negotiation** occurs when someone in a family wants a change in the family, the behavior of another person, or a change in issues. Successful negotiation requires use of the principles of positive communication noted above. There must be clear source responsibility and the negotiation must be directed to a specific person. The negotiation must contain an assertion, in this case a behaviorally specific statement of possible changes, presented in the form of alternatives. Finally, successful negotiation requires an active or validating response from the other party that clearly indicates the request has been received and understood.

**Impact statements** have the goal of communicating the impact of an event, behavior or situation on the person speaking to another. Impact statements provide information about the internal state of another. Behavior and relationships are regulated through knowledge of this impact and self determined changes. Impact statements include similar source responsibility and are directed to a targeted person. Unlike negotiation these are followed by self descriptive statements of feeling, thinking or concern that describe an individual reaction and impact. These impact statements need to be clear and non-blaming to be successful. Impact statements can have the desired behavioral regulation effect when followed by an acknowledgement that they were received and understood. Unlike negotiation, impact statements don’t require any further immediate action by the receiver.

When mixed together, it is almost impossible to respond to both an impact and negotiation request. If the receiver tries to solve the problem (negotiation) they don’t demonstrate understanding, if they only understand, (impact) negotiation needs are not met. Thus, many times FFT therapists focus communication change on separating negotiation and impact statement activities from one another.

**PRINCIPLES OF POSITIVE PARENTING.** There are a number of aspects of the ways in which parents negotiate their roles as the teachers, monitors, and managers of homes that can either serve as risk or protective factors that increase the potential for externalizing behavior disorders with adolescent children. Among these, coercive and negative communication strategies, inconsistent parenting practices, limited/excessive monitoring and supervision are all important risk factors. Thus, helping redirect current parenting practices to
those that are more positive reduces the potential family risk and is a common activity of FFT therapists.

There are many curriculum-based program that have been developed for parenting. Each has its strengths and weakness. On their own, parent education based interventions (where the focus is on the parent) are more effective with younger children. With adolescents, parenting change must be more family focused. Thus, in FFT the goal is to know the principles that eliminate the risk associated with certain styles of parenting in order to make changes in family patterns that may build parenting competencies. As with communication training, it is the therapist that takes these principles, identifies areas of need in the specific family with which they are working, and develops a strategy for implementing change that matches to the unique relational structure of the family.

The following areas are often important parenting target areas in FFT. Remember, other areas of parenting may also be useful. FFT therapists should draw on their knowledge of other parenting competencies. These other techniques need to be consistent with the primary principles of FFT therapy: e.g. alliance based and family

---

**Figure 22**

**Communication flow chart**

- **Negotiation**
  - Source Responsibility ("I")
  - Directness ("you")
- **Impact Statements**
  - Affect expression, validation, & regulation

**Assertion**
- Want
- Behavioral Specificity/alternatives
- Brevity
- Impact Statements

**Validation**
- Active Listening ("you want...")
- Active Listening ("you feel...")
focusd. The following are principles that are most useful with the adolescents and families often involved in FFT.

1. **Contracting** involves having family members identify specific things they would like other family members to do in exchange for tangible or agreed upon consequences. Contracting is particularly important to adolescents because it involves a mutual involvement of parent and youth. It is also useful in FFT because contracting requires involvement of all members of the system. Contracting should initially be conducted within an FFT session where the process can be guided by the therapist. Initial contracting should be as positive and successful as possible. Any contracting intervention needs to be based on the principles of good communication and involve: behavioral specificity, presentation with alternatives, clear source responsibility, and an active listening response. The goals of contracting must be realistic, obtainable, and easily identified. Finally, contracting must match the relational assessment of the family members and may be built on the organizing theme developed in the engagement/motivation phase.

2. Appropriate consequences are an important parenting tool. In fact, many parents come into therapy wanting new ways to use consequences. Unfortunately many times this request is like asking for a “bigger hammer” to force youth into compliance. With appropriate use of consequences parents can reinforce and sanction behaviors of their children and adolescents in ways that help promote change. In FFT the use of consequences involves both positive reinforcement and penalty-based sanctions. There are two basic types of consequences that can be used by parents.

   - **Response-cost** techniques are a useful framework that helps parents set non-coercive yet clear and firm penalties for certain pre-identified behaviors. These parenting techniques are most useful for preadolescents and younger children but can provide an important framework for delivering consequences to adolescents as well. For response-cost techniques to work, the expected behaviors and penalties should be fair and clearly stated, and
augmented by any technical aids necessary (e.g. notes, contracts, reminders etc.). Response-cost techniques involve both penalties and rewards.

- **Action-related** consequences represent another potential parenting tool when used correctly by parents. Action-related consequences are those natural real world results/consequences of an adolescent’s behavior (e.g., school detention, legal trouble). Action-related consequences are not initiated by parents but instead used, in a non-coercive way, as a predetermined clearly identifiable action that will result from the youth’s behavior.

- Changes in parenting practices around consequences, response cost, and action related consequences, take place within family sessions guided by FFT therapists in a way that is consistent with the organizing theme while matching the relational functions of the family. It is very important that parents see consequences as a way to guide rather than force a youth’s behavior. It is equally important that parents recognize that parenting changes may not result in immediate changes by the youth. Thus, it is critical that the use of consequences by parents be done in a way that is:
  
  - non-blaming and
  - supportive
  - while firm,
  - consistent,
  - and with informed consent (e.g. with everyone knowing the rules prior to the use of consequences).

3. **Relationship building** is an often times overlooked parenting technique. When families come into therapy they are in crisis mode, looking for answers to difficult problems. It is challenging at those times to remember that successful parenting is built upon a foundation of an alliance-based relationship between the youth and the parent. Thus, we often use relationship building as a parenting technique. In times of trouble the negative and blaming behavioral interactions among youth and parent are common. Relationship building is nothing more than a specific, guided and purposeful attempt by both
the youth and the parent to engage in small, non-conflicted, behaviors that will be appreciated by the other. These small behaviors must be meaningful to the other, must be done as an offer without expectation of a return, and must be done daily without request. Like other parenting techniques, relationship building is an activity that should begin during FFT therapy sessions guided by the therapist and built into activities of the family over time.

**PRINCIPLES OF SUCCESSFUL PROBLEM SOLVING.** Much of the problem solving that takes place between youth and their families/parents is accomplished through the negotiation process described in the communication section. There are times, however, when issues arise that require a more “formal” or specific procedure for working together. In fact, problems and struggles are a part of everyday life for all families. Using an effective problem solving strategy helps families overcome these struggles in a way that maintains alliance while specifically targeting changes and strategies for change. As noted above, successful problem solving builds on the strategies of positive communication. There are a variety of problem solving models available. The system described below contains the critical elements of successful problem solving. The steps include:

1. **Identify the problem.** The goal is to identify the specific problem to be solved (in behaviorally specific and concrete ways). Identifying a problem to be solved can be more difficult than it may seem because problem solving needs to be alliance based and collaboratively done. Thus, the approach to identifying the problem must also be based on source responsibility, active listening, and the presentation of alternatives.

2. **Identifying the outcome** desired is a critical step in having all involved working to the same end. As with problem identification it will require specificity of the outcome and the manner in which the outcomes are determined (e.g. with openness and alternatives) is crucial to the success of joint outcome determination.

3. **Agreeing on what it takes to “do”** or accomplish the goal should clarify the sub-goals (e.g. the steps to completing the task for each involved) and may also include contracts to specify time frames and specific agreed upon steps and outcomes.
5. Before problem solving ends, it is useful to brainstorm all of the barriers or ways that the plan might go wrong. When these issues are identified, the plan may need to be altered. These steps help sensitize all involved to potential pitfalls and enhance successful completion of the process.

6. Coming back and reevaluating to see if goals are met allows for problem solving to have accountability and be seen as a collaborative process that engages youth and parents in a process of constant improvement.

Problem solving is successful when it takes place within a relational context of alliance, collaboration, and “working together.” It is a successful strategy to alter risky behaviors when it is part of a comprehensive behavior change plan that matches to the family. Thus, problem solving is best initiated after communication training and within session guided by the FFT therapist to ensure success. Once experienced as a useful alternative, the family may take the strategy and use it in programmed ways as “homework.”

**PRINCIPLES OF CONFLICT MANAGEMENT.** There are times when past events and rigid and entrenched negative problem interaction patterns are quite difficult to “solve” or negotiate to a successful resolution. Given the sometimes lengthy history of problems and strong emotion that accompany therapy it is no surprise that some “old” issues seem almost impossible to change in traditional ways. Conflict management is a strategy to use in these situations. By managing conflicts and keeping them from getting “out of control” the family has the emotional and psychological space to find new ways of working together that ultimately will overcome past hurt and struggle. Conflict management is not a strategy to “solve” the problem but instead to contain it so that it does not interfere with other behavior change activities.

In many ways the best way to manage the types of conflicts not open to negotiation and problem solving is to avoid the situations and triggers that set off the automatic chain reaction of spiraling negativity. Avoiding such situations requires the therapist to have clearly identified the aspects of the central problem pattern (see relational function assessment section). Avoidance of the early triggers of spiraling negativity and conflict often times involves the interruption of the pattern. This might take the form of a parent and youth end-
ing a conversation for a time out when it gets to a certain level of negativity, it might involve a parent not asking about a “hot” topic or a youth not bringing up old situations and events that serve as triggers. The goal is to avoid the automatic verbal or physical triggers that begin the pattern. If successful, it might be that the family uses communication or problem solving to identify a more long-term solution. Conflict management can also play a role when the seemingly out of control patterns are under way. Here the goal is to contain the conflict and not let it spread and “infect” other successes and objectives in behavior change. To contain such a conflict it requires the therapist to help both parties adopt three states:

- Remaining issue focused helps reduce conflict by keeping the target a specific issue and not a “whole relationship” or “all that we have worked toward.” The goal for the therapist is to clarify the specific issue at hand and isolate it from other areas of the family life.
- Adopting a conciliatory set or a willingness to talk communicates the emotional aspect that contributes to a climate that promotes the reduction of a conflict.
- Staying present oriented keeps the focus on conflict reduction rather than on “rehearsing” and solving.

Reframing is a useful therapist tool to use in helping focus the conversation and emotional climate in the above directions. It might also be helpful for the therapist to “talk through” the issue with the person feeling the conflict and unable to use other solutions (e.g. negotiation) by directing them through the following questions. The process of asking these questions, rather than the specific answers, is what promotes movement toward an issue focused, present oriented, conciliatory climate.

1. Exactly what is the issue of concern to you?
2. Exactly what would satisfy you?
3. How important is that goal to you?
4. Have you tried to get what you want through problem solving?
5. How much conflict am I willing to risk to get what I want?
**Undertaking Behavior Change in FFT**

Whatever the behavior change target it is essential to remember that behavior change activities are therapeutic activities conducted by therapists within a unique family relational system. Therefore, none of the above strategies can be conducted as “curriculums” or “interventions” done by the therapist. Instead, these are principles that guide and direct the therapist who works with the family. Families bring in salient issues and concerns and the therapist uses his or her assessment of risk and protective factors and relational functions to direct the conversation toward specific behavioral targets in ways that are a unique match to the family. Thus, the communication change target and strategy with one family will look quite different than with another. In some families the work is done primarily in session while in another “homework” is the more common forum for change. Behavior change is a “therapeutic” activity that requires great therapist creativity in taking stable principles and matching them to unique families.

**Outcomes of the Behavior Change Phase**

Successful behavior change is accomplished by identifying the risk factors that contribute to the specific problem behavior for which the family was referred and helping change these in a way that matches the relational functions of the individual family. The emphasis in this phase is on building protective family skills that will improve the factors that put the family and adolescent at risk. The desired outcomes of this phase are the competent performance of the primary activities associated with risk factors: parenting, rewards and punishments, communication between adolescent and parent, negotiation of limits and rules, problem solving and conflict management in a way that matches the relational capabilities of the particular family, that is developmentally appropriate, and that is possible for this family with these abilities in this context. FFT therapists do not attend to and target every risk behavior in each family. Instead, the goal is to successfully change a few central risk behaviors that can be built on and extended in the generalization phase.
What is next...

The therapist has now moved the family into a mindset of “fixing” and “changing” and “addressing” the specific issues that they face on a daily basis. The therapist has taken a seemingly large group of “issues” linked them to the organizing theme developed in engagement and motivation, targeted specific risk factors and developed and implemented strategies to change those risk patterns in ways that match the relational functions of the family. It is now time to move away from “fixing” and changing specific problem issues and focus on empowering the family to be able to confront these challenges on their own. The next goal is to empower them to be their own problem solver by using these new behavioral competencies in a wider range of areas and use community resources available to support the important changes they have made. The next goal is to systematically move the family toward self-sufficiency in the maintenance of the changes accomplished in the behavior change phase.

Generalization phase

In the generalization phase, the focus of attention turns from changing family behaviors to extending the application of these changes to other areas of family relationships.

There are three primary goals in this phase:

- **Generalize** the changes made in the behavior change phase to other areas of the family relational system
- **Maintain** changes made in generalization through focused and specific relapse prevention
- **Support and extend** the changes made by the family by incorporating relevant community resources into treatment.

In the generalization phase the focus of attention changes from within family changes to the ways in which the family will respond to other similar and future struggles and how the family interacts with the systems around them (e.g. schools, community, extended family). As in behavior change, the family continues to bring salient issues/concerns to the therapy room. It is the therapist, upon deciding it is time to move to generalization, who redirects the conversation to a new set of goals—those of generalization.
Generalization takes place both within the family and between the family and its environment. The goals of generalization are accomplished by the therapist focusing on both within the room (within therapy) and outside the room factors. In the room, the therapist redirects the family issues from solving problems (behavior change) to relying on their own newly learned competencies (generalization), and preparing for more struggles by learning to identify and build an expectation of success for addressing future challenges (relapse prevention). In focusing on the systems external to the family that may contribute to the presented symptoms the therapist starts to think of themselves as a “family case manager” and begins to identify and interact with those relevant community resources that will help the family support their changes over time.

It is important that the FFT therapist focus on both within therapy and outside therapy factors when working in the generalization phase. In generalization the organizing theme, developed in engagement and motivation becomes a central feature once again. The organizing theme helps bring together and provide motivation for moving forward in new ways by laying the groundwork that struggles are normal it is how they are handled that is of most concern. In most cases generalization proceeds in the following sequence:

- As the generalization phase begins the therapist helps the family generalize changes that have occurred in the behavior change and engagement/motivation phases to other areas of family functioning that have not been specifically addressed.
- Then, the therapist works to help the family maintain change by helping families overcome the natural “roller coaster” of change. Maintenance of change occurs through using relapse prevention techniques to normalize the typical problems that may occur in the future while having confidence that their newly acquired skills will work in different situations over time.
- Finally, the goal of supporting change is usually accomplished by bringing the necessary community resources and support to the family. In general, long-term change is accomplished when the family is helped to use their own skills to obtain these changes with the guidance of the therapist.

The generalization phase in FFT is like the old fishing adage: “Feed a man a fish and he eats today, teach him to fish and he feeds
himself for life.” FFT also tries to help families “learn to dig for the bait” so that they can have the resources necessary to be self sufficient in managing the normal challenges of family life. Unlike other approaches, FFT tries to help the family help themselves. As a result, the first choice in all generalization phase activities is to teach the family how to access a resource rather than to do it for them. Unless absolutely necessary the FFT therapist is unlikely to actually arrange resources and instead helps the family to learn the skills of arranging, organizing, and accessing needed resources.

Assessment in the Generalization Phase

As you enter generalization there are phase specific areas that are important to understand in order to accurately determine the specific direction of your activities. As in behavior change, the focus is on the risk factors that may limit the individual and/or family’s ability to generalize or maintain change and/or contextual ecosystemic factors...
that need attention to help the family support change. One area of assessment is focused on what goes on within the family or “within the room/therapy” goals of generalization, while the second is aimed at understanding the multisystemic context or “outside the room” areas. It is important to note that any generalization phase strategy (whether targeting in room/family or multisystemic context) is based on the systematic relational assessment developed in behavior change as well as formal assessment that occurred prior to therapy. Identifying relational functions helps determine the relational strategies through which changes in the targeted risk factors will occur. Thus allowing the therapist to match the behavior change strategies to the individual family. Using pre-assessment risk assessment helps target ecosystemic factors of relevance to the family.

- **Within family assessment** focuses on the ways in which the central relational patterns of the family may represent barriers to generalizing and maintaining change. In addition, it is important to determine the factors apparent in the family relational system that may become barriers to relapse prevention, including: confidence in their ability to tackle ongoing struggles, an awareness that ongoing problems are likely, and their confidence in their ability to draw on within family resources to solve future struggles. Finally, it is probably important to assess the degree to which the organizing theme, developed in engagement and motivation, which served as a rationale in behavior change, is still the shared explanation for the “struggles” in the family.

- **Assessment of the ecosystemic family context** requires the therapist to consider the other systems (e.g. schools, community, peers) that make up the broad context in which the family system exists. As noted in the core principles section, our view is that symptomatic behaviors are linked to within family (relational patterns and functions) and outside family (ecosystemic) factors both of which need significant attention. The generalization phase is the time to think about how this unique family system interacts and works within this larger system. Long-term maintenance of specific behavioral changes is dependent on understanding which of these systems are strengths to build upon and which might be barriers for maintaining change. Thus, by using the pre-assessment instruments and knowledge
from what was presented during other phases, it is critical to assess the existence of risk and protective factors and the future role of:

- School
- Peer group
- Larger community attitudes/values and beliefs about the youth
- Availability of pro-social community involvement
- Extended family involvement

Each of these areas may require attention from the family or support from available community resources. Understanding the relevant community systems that may either support or become barriers to maintaining change will become targets for the therapist and family to build upon.

**Therapist activities in the Generalization Phase**

When in the generalization phase the therapist's overarching goal is to help the family become self reliant and competent to
successfully deal with the many natural struggles they will face in the future. The primary challenge for the therapist is to stay focused on the goals of the phase as the family continues to bring in new challenges. Thus, the primary therapist activity is to focus on the important goals of this phase of therapy while being responsive to the family’s concerns. In addition, two specific areas guide therapist behavior in this phase: within therapy and outside therapy activities.

**WITHIN THERAPY ACTIVITIES.** Within the therapy room two possible scenarios often develop. First, families may continue to struggle with issues among themselves. Behavior change has not addressed each of these specific areas but has provided competencies and behavioral skills that could be generalized to these additional areas. It is more likely that self-reliance will develop if the therapist focuses on two specific competencies: generalizing and relapse prevention.

- **Generalization** occurs when the therapist helps the family use what they have learned rather than being directly involved in “solving” each of these new “problems.” The therapist responds to the salient issues that the family presents by linking new issues to the successful strategies used in the behavior change phase. Thus, families continue to present with new “problems” and it is the therapist’s response that now changes away from problem solving to a focus on family self-reliance.
- **Relapse prevention** occurs when the therapist normalizes the struggles as part of the broader change process (e.g., there will always be problems it is how you respond to them that is your future challenge) through reframing, attempts to build the families confidence in their ability to manage new problems and “stay on track” by not returning to the older negative and blaming interactions. Both generalization and relapse prevention are proactive activities of the therapist purposefully done in response to family issues and concerns.

In a second scenario the family’s successful behavior change has left them feeling ready to end therapy. The family no longer presents specific issues or problems. In this instance, the therapist must motivate the family to remain in therapy and prepare for the future. This can sometimes be difficult because from the family perspective,
things feel and are better between them. From that perspective it may not seem immediately relevant as to why further counseling is necessary. Thus, the therapist needs to rely on the organizing theme as the basis for motivating families to remain through this phase of treatment. Therapists may use their knowledge of the family to suggest possible future areas or contexts in which it will be difficult to maintain the changes.

- **Generalization** occurs when the therapist asks the family to identify similar situations. The goal is for the family to prepare themselves to link their previous changes to similar challenges in the future.

- **Relapse prevention** occurs when the therapist suggests and even predicts future struggles and facilitates a discussion of what the family might do, normalizes that problems are an important part of the change process, and identifies specific behavior change skills the family will use.

**THINKING LIKE A “FAMILY CASE MANAGER.”** FFT also recognizes that in order to support the changes made by families,
therapists must give attention to the community, extended family, peer and cultural context in which families live. These contexts provide, in many cases, valuable resources to help the family maintain the positive change trajectory developed during therapy. There are community organizations that help with positive mentoring, agencies that provide economic assistance, community sites that provide positive and pro-social activities for children, to name a few. Consequently, in the generalization phase it is also the goal of the therapist to help the family learn to access these resources to further support change. To accomplish these goals the therapist must in many cases adopt the role of family case manager. The family therapist best accomplishes this job because they understand the relational system of the family and can match it to available resources.

Unlike generic treatment planning which might wrap services around families and family members with little consideration of the unique nature of the family relational system, FFT focuses on the relational functions as a basis for determining which services and the manner in which services will be accessed. As a family case manager, the FFT therapist works from within the family system, as a person with the best view of the relational workings of the family, to promote change in the manner in which the family relates to ecosystemic circumstances and the resources that the family may access in that system. The goal is to help “anchor” the family and its members to the larger community support system thereby supporting change over time and preventing relapse.

In acting as a case manger the therapist is beginning to think about what services outside of therapy might be able to “add to” what has successfully occurred in the family. In generalization the FFT therapist thinks like a family case manager by looking for relevant community resources and/or useful professional services. It is critical not to “pile on” all available services but to thoughtfully and systematically link the services and activities that both fit the family and provide opportunities for continuing and supporting what has already gone on in FFT.

To be a successful family case manager the therapist must:

- Know the community by having lists of community providers, public transportation, service gatekeepers (e.g. probation
officers, after care workers, school counselors, and other mental health professionals)

- Develop other contacts within the community like mental health services, school contacts, boys and girls club directors, YMCA/YWCA or other youth recreational program coordinators, and educational/vocational service providers
- Have a clear knowledge of the ethical issues that accompany increased contact with other service providers including releases of information and informed consent, exceptions or limits to confidentiality, knowledge of reporting laws, and privacy laws.

Take care to:

> Remain “therapy focused” by extending the treatment that occurred in the room to the social environment of the family
> Not act as an agent of special interest groups (e.g. probation, school)
> Only make referrals to those resources that are relevant and a match to the unique family
Outcomes of the Generalization Phase

The desired outcomes of the generalization stage are to stabilize emotional and cognitive shifts made by the family in engagement and motivation and the specific behavior changes made to alter risk and enhance protective factors. This is done by having the family develop a sense of mastery around their ability to address future and different (generalize) situations. In addition, the goal is to maintain the changes through the roller coaster of life events using relapse prevention techniques. Finally the hope is that the family is able to act in self-reliant ways by identifying and using relevant community resources. When successful the family: attributes the change to their effort, is realistic about future struggles, has a plan for how to continue to apply what they have learned to new situations, and they continue to maintain within family alliance and a view of the family based on the organizing theme developed early in therapy. It is not uncommon for final sessions of FFT to be ones in which the family and therapist have little to say as a result of the responsibility of the change process being shifted from therapist to family.

What is next…

Three things can happen at the end of the “formal” generalization phase. It may be that contact between the therapist and family ends. The family uses their new competencies to deal with the ongoing but normal challenges of family life or it may be that there are requests for additional services and systematic booster sessions.

REQUESTS FOR ADDITIONAL SERVICES

When helped in an efficient and respectful manner it is not uncommon for a family to seek out the therapist in future times of struggle. In traditional services the family would begin therapy again. In FFT these requests are viewed as opportunities for additional generalization sessions. The therapist would of course engage, motivate and reduce any negativity and blame that is apparent. However, rather than starting anew, the FFT therapist moves quickly to reestablish the original organizing theme, including new elements,
and focusing on generalizing behavior change accomplishments to
the newly presented issues. Thus, it is very rare that an FFT therapist
would “repeat” therapy or go back to behavior change. Instead, they
would use what was done (e.g. themes and previously established
competencies) to push the family to generalize their skills, and use
available community resources. In this way the FFT therapist uses
additional requests for services as an opportunity to prevent relapse
by helping the family rely on themselves to work through a crisis.

**BOOSTER SESSIONS**

Booster sessions have been found to be increasingly helpful in
maintaining and supporting therapeutic change. In many settings
FFT therapists systematically conduct booster sessions as extensions
of the generalization phase. In fact, if the treatment setting allows,
systematically sequencing booster session can be quite helpful to the
goals of generalization. It is critical that the therapist view these
booster sessions as opportunities to help the family achieve the goals
of generalization. It is also essential that the FFT therapist resist the
temptation to “begin again” or do more behavior change. Instead,
the therapist must view boosters as planned opportunities to experi-
ence the natural up and down process of change and guide the
family to use their behavior change strategies in increasingly diverse
situations. Boosters also allow for the therapist to monitor the
progress of community resource utilization. If initially assigned
resources do not work out, the therapist can help the family access
others that may provide a better relational fit for the family.

**Implementing FFT**

FFT has been implemented as the primary intervention model
in over 90 community sites in more than 15 states between 1998 and
2002 (Sexton, 2002). At those sites, approximately 375 therapists
have helped approximately 10,000 families each year with
Functional Family Therapy. The organizations, therapists, and clients
at these replication sites represent a very diverse cultural, communi-
ty, and ethnic range. To date FFT has been used in agencies that
primarily serve clients who are Chinese Americans, African Americans,
White-Caucasian families, and Vietnamese, among others. The agen-
cies in which FFT has been replicated range from community not for
profit youth development agencies, to drug and alcohol groups, to
traditional mental health centers. The therapists at these sites are as
diverse as the clients in regard to gender, age, and ethnic origin. At
these sites FFT is delivered both as an in home service and as a tradi-
tional outpatient program. Increasingly, FFT is being implemented
in school-based settings (Mease & Sexton, in press). An increasing
emphasis has been on statewide implementation of FFT in various
treatment systems. For example, FFT has worked within the juvenile
justice system in Washington State for over 5 years. FFT recently
began a project to train all adolescent and family therapists in the
New York Mental Health system (over 60 individual sites).

Successfully disseminating FFT has been a complex task. To
accomplish the task of replication with high fidelity FFT developed a
systematic training and implementation program as well as a model
specific clinical supervision approach (Sexton, Ostrom, Bonomo,
2001). Each participating site is trained and supervised using a simi-
lar protocol, each is implementing the same clinical model, and
thus, comparative information across sites can be used to improve
practice. Each site engages in ongoing fidelity monitoring and out-
come assessment, and each site participates in the national network
of FFT sites by using the web-based CSS system.

In each domain of training and implementation the primary
objective is to help therapists adopt both the guiding principles and
the clinical “map” of FFT as their primary sources of clinical deci-
sions. We have described this process as one in which the therapists
adopt the “lens” of FFT using it to focus their inherent and devel-
oped strengths so that precise, high quality and systematic clinical
decisions can be made that increase the likelihood of success with
families. Therapists bring their professional and personal knowl-
edge, individual strengths and abilities, and relational qualities to
the process of delivering FFT. The FFT model provides a focusing
“lens” that takes these individual therapist strengths and focuses
them through the principles of the approach and the “map” that
guides service delivery.

Being a successful FFT therapist requires more than learning the
three phases and adopting the core principles. It requires the thera-
pist to engage in FFT in an active, and multisystemic manner.
Successful implementation requires a willingness on the part of the
FFT therapist to struggle with the seeming ambiguity of a model: its
structure and flexibility, its relentless model focus and intense client
responsiveness, its demand to give full attention to what “goes on in
the room” while at the same time working in and with the community. Successful implementation of FFT requires that the therapist apply the model with high adherence to the technical and core values of the model so that they can develop competence in delivering it with various families.

In this section we again focus on the therapist, how they think, and how they implement FFT in a way that promotes high fidelity, and as a result, successful outcomes. Our goal here is to give you an “anchor” to hold you midst the storm of emotional and behavioral experience that occurs in family therapy. To successfully implement FFT an understanding of the service delivery implementation (how the phases unfold over time) as well as a discussion of how therapists can “anchor” themselves within session to stay model focused are both important. Finally, our goal in this section is to identify for you the tools that have been built into the FFT service delivery system that will aid you in developing model adherence and competence so that we can increase the probability that families get the help they seek. First we begin with a discussion about therapist and family roles within the implementation of FFT.

**Therapist and Family Reality**

As noted in the introduction to this manual, successful FFT requires two experts who work together in a systematic change process. As a result, there are two “realities” that exist in FFT therapy: that of the therapist and that of the family.

- **Family reality.** The reality of the family is one for which the elaborate features and goals of FFT have little direct importance. Families rarely care much about the goals of a family focus or negativity reduction, about relational assessment, or risk factors. Instead, family members are interested in the outcome of this process. Early on they are interested in whether they are heard, whether the therapist is protecting and working with and for them, and whether therapy can make a difference. In later phases the family focuses on specific skills and whether or not they seem relevant and helpful. Thus, the family’s reality is one marked by alliance and outcome.
- **Therapist reality.** When successfully conducted the therapist delivers FFT by adhering to the model and delivering it with
Figure 27

IMPLEMENTING FUNCTIONAL FAMILY THERAPY

THERAPIST REALITY:
• what phase am I in?
• what are the goals of the phase?
• what do I need to assess?
• how do I need to intervene to accomplish the goal?
• how do I "match to?"
• what do I need to know about?

Therapist Reality
"process issues"

Family Reality
"alliance/outcome issues"

FAMILY REALITY:
• how do I feel about this?
• how does this fit with what I think about this?
• does this make sense to me?
• what does this mean I will have to do?

high competence. To do so the therapist must be anchored in a process focused reality while working in intimate, personal and responsive ways with a family. A process focus requires the therapist to think less about the exact details of who did what to whom and instead focus on the relational and attributional features of what is being presented and on accomplishing the goals of the phase of treatment. For example, the internal dialog of the successful therapist in engagement and motivation is filled with assessment questions regarding the levels of negativity and blame, the degree of family focus, the level of between family and therapist and family to family alliance (the goals of engagement and motivation). The therapist’s mind is also filled with attention to reframing, the family’s response to a reattribution, deciding on what might be added to the validation portion and how to change the meaning of a behavior, emotion, or intention. In other words, in each phase of FFT the therapist is primarily concerned with the process of therapy rather than the content details of what the family reports.

A process focus is not intended to suggest that the therapist “not listen” or “not pay attention.” Instead, the content details become background to a foreground of phase based assessment and inter-
vention that is prescribed by the model. It is only by having a foreground of attention on process that the therapist can successfully accomplish the goals of each phase. In FFT the therapist must attend to the realities of the family through accomplishment of the phase goals of the model.

**Therapist Reality: the Role of Adherence and Competence**

The role of therapist adherence and competence cannot be overstated. If families are to be helped, FFT must be delivered in the way it was designed (adherence) and delivered well, or with a high degree of skill (competence). In fact, if not delivered with adherence and competence, as prescribed by the model described here, it is really not FFT.

The importance of model adherence was highlighted in a recent study (Sexton, et al, 2002) in which FFT was delivered in a state-wide service delivery system by therapist trained using the same protocol you are experiencing. Those therapists who delivered FFT with high adherence (as rated by their supervisor on a weekly basis) had

---

**Figure 28**

**Therapist Competency Ratings**

- Not competent: 35.0%
- Marginal: 29%
- Competent: 25%
- Highly Competent: 17%

---

**12 Month Felony Recidivism**

- Control Group Recidivism Rate: 22%
outcomes (as measured by recidivism) significantly lower than a random-
ized control group. Those therapists who delivered FFT in a manner that was rated as low adherence had outcomes that were worse than traditional services. For these therapists FFT was delivered in a way such that the families might have been better not receiving family therapy. It is important to note that the outcomes measured here were clinically significant ones, measures of arrest 18 months following FFT.

These findings have a major impact on the issues surrounding the implementation of FFT. FFT is not a model from which a therapist can "pick and choose" various intervention techniques to be applied in a manner that seems correct to them. Instead, FFT is, as noted throughout this manual, an integrated treatment delivery system that must be implemented by the therapist in its entirety, based on its core theoretical principles, in the phasic manner outlined. When this is not done, data clearly indicate the probability of successful outcome decreases dramatically, to the detriment of clients—future potential victims, and to the mental health and juvenile justice systems involved.

Delivering FFT with adherence and competence is difficult given the complexity of the families and the complex nature of the delivery systems in which you work. We have created a number of tools to help increase your adherence and competence. These tools are integral to the service delivery system of FFT. Thus, these are the implementation tools used by all therapists doing FFT. In the next section we discuss these tools including: The service delivery of FFT, using the CSS.

The delivery of FFT: Contingent and Organized Implementation

When you look at the phase model of FFT it looks as if FFT is a linear process applied in equal amounts and in rote ways regardless of the family. This perception is misleading. FFT is both systematic in its approach and contingently directed and dynamic in its application. The clinical model and accompanying treatment manual is a "map" that details the specific goals and strategies of each phase of change. However, recognizing individual differences and the need to be responsive, the clinical model applies these strategies and approaches these goals in ways that are unique to each family.

The engagement and motivation phase of FFT actually begins
well before a first “session” with a family. The initial phone call to a family is a therapeutic opportunity, it is a chance to make contact, engage and begin reframing and directing the conversation, building alliance by demonstrating responsiveness and understanding yet building a family focus through alliance with all members. In a recent study (Sexton, Bonomo, Ostrom, & Alexander, 2000) we tracked the number of phone calls prior to a first session. In a large multiethnic, urban clinic based setting the average number of phone contacts before a first session was 8. The effort demonstrated in this project was based on the principle that the therapist (not the family) should work hard to overcome all barriers to initial contact. The outcome of this effort was an exceptionally low drop out and non-engagement rate for the project (22% and 11% respectively).

Once FFT begins, the length of each phase is goal rather than time driven. Therapists move to the next phase when they have accomplished the goals of the phase. For example, in one family the negativity and blaming may be so intense that the therapist spends
significant time (3 to 5 sessions) during the early phase realizing that without the requisite level of motivation any move into behavior change would likely produce noncompliance and not allow the family to accomplish change successfully. In another family, the initial motivation level, family focus on the problem, and negativity may take very little time to address. In this case the therapist may move more quickly to the behavior change phase where, it may be the development of competencies and the building of skills that takes significant time (4 to 5 sessions). In yet another family both of the early phases may be accomplished relatively quickly but maintaining change in the difficult peer and community environment of the family may take the most energy. In each of these examples, the model has retained its direction and the goals of each phase were accomplished, however, the distribution of these efforts was contingent on the needs of the family.

It is, however, important to remember you will never totally reduce family negativity, have a perfect alliance, or completely master communication. Thus, it is essential that therapists doing FFT remember, the total treatment length is between 12 to 14 sessions for most cases, with a small proportion of much more difficult cases requiring more sessions. Whenever a case is going to extend beyond the normal time frame it is important to discuss the case and the decision to extend treatment with the on site treatment team before automatically extending it. We do have extensive clinical experience that can guide your movement through each phase. Over many projects, with very diverse cases, in many different types of treatment contexts we have found that engagement/motivation takes between 3 and 6 sessions, behavior change between 3 and 5 sessions, and generalization between 3 and 5 sessions. Thus, if you find yourself moving to behavior change before 2 or 3 sessions it would be good to rethink the goals and determine if enough has been done. Similarly, if you find yourself in engagement and motivation at session 8 it is time to consider taking a different path with the family. Both of these cases require guidance from your local FFT team.

Application of the model may also require that the phases overlap to different degrees. For example, in one family the engagement and motivation changes may seem very distinct from behavior change. In this case it would feel as if engagement and motivation ended in one session and behavior change began in another. However, in another family, the attention to motivation may
continue through many of the behavior change interventions as the therapist continues to reframe negativity while simultaneously implementing a behavior change plan. The dynamic nature of the FFT model is one of its most unique features. By embracing the dialectic between structure, direction, systematic intervention and contingent individually focused and clinically responsive treatment, it is a model that has clinical relevance and widespread application.

Finally, FFT is a model that requires planning. Planning for how you will accomplish the specific goals of each phase is essential. Case planning is enhanced through the use of the progress notes that are a part of the Clinical Services System (FFT-CSS, see section below). In addition, regular case staffings help the FFT therapist get input from his/her team about directions to take in future sessions. In addition, the FFT therapist must take time - time to think through what happened in a session and make plans about how to accomplish goals in the next session. Planning is a critical aspect of successful FFT.

**Staying on Track: Using the CSS and Case Staffings**

Learning to apply FFT with adherence and competence requires considerable effort. While seemingly simple and straightforward, FFT is an exceptionally complex model. For those who are interested it offers an unlimited array of learning opportunities. One of the most difficult tasks in implementing FFT is to stay on focus and not to “drift.”

**CLINICAL SERVICES SYSTEM (FFT-CSS): AN ADHERENCE AND COMPETENCE DEVELOPMENT TOOL**

The FFT Clinical Services System is an intuitive user-friendly web-based program used by community based FFT therapists to record client information (e.g. contact information, demographic information, previous history), client contacts (visits, scheduled visits, phone contacts etc.), assessment information (individual, family, and behavioral assessment), adherence measures, and outcome measurements. The goal of the CSS is to increase therapist competence and skill by keeping therapists focused on the relevant goals, skills, and interventions necessary for each of the phases of FFT. The CSS provides immediate “real time” feedback to therapists on model fidelity, client outcomes, and service delivery profiles. In addition, it
provides the site clinical supervisor with specific information to be used in helping supervise cases and maintain model fidelity.

The CSS was designed as a “tool” to help FFT therapists manage the large amount of information necessary to successfully implement this model. The CSS was designed to be the primary information management system for FFT therapists. The CSS is used to track all clients, all sessions/contacts with clients, all client assessments, and all quality assurance information for each FFT case. Contained within the CSS are numerous tools to help new therapists build their adherence and competence in FFT and to help seasoned therapists maintain and further build their expertise in FFT. Use of the FFT-CSS is such an integral part of building and maintaining the quality of FFT services that it is a required part of the FFT services delivery system. On-line instructional tutorials are available to help learn the system. Technical assistance is available from your implementation consultant and the CSS-tech group.

The FFT-CSS is a secure web-based data system. As such we have built in a number of security safeguards. FFT therapists only have access to their own information. Site clinical supervisors only have access to site information. Your individual user password is highly sensitive and should be kept secure. In addition, the FFT-CSS has been designed to be HIPAA compliant and web-secure. Further information about these safeguards can be obtained from your FFT implementation consultant.

The following sections of the CSS are useful tools for new and seasoned FFT therapists implementing FFT:

- **Session Progress Notes** are an important part of good FFT. The session progress notes serve as both documentation for all FFT services and a method to help therapists think about the session through the “lens” of FFT. There are three progress note forms—one for each phase. Progress notes can be completed on-line, or on paper and transferred on line. If done on-line the notes can be printed for inclusion in local client records. As with any “tool” the progress notes will help therapists learn and maintain FFT ability to the degree to which they are used. If completed immediately after session, if completed in full, and if given time the progress note system can become an invaluable aid to FFT therapists.
The progress notes are intended to help the therapist consider the essential goals of the phase, the progress made toward accomplishing those goals, and future session plans. The notes are intended to model how the therapist can/should think about the process aspect of the session. As such, it is a helpful guide for new therapists to begin to pull the process aspects of sessions into the foreground and let the content aspects drift into the background. Specific training on the progress notes occurs in follow-up training.

- **Service delivery** tracking allows for FFT therapists to gain a “big” picture of how services were delivered to individual families and across their caseload. Each contact and session with a family is entered into the CSS. The report section of the CSS allows therapists to determine the number of contacts, the number of hours of services and, the service delivery patterns (attended sessions, no-shows, cancellations, etc.). The service and contact monitoring feature of the CSS gives therapists access to an enormously valuable source of information about the work they are doing. This information is not only useful documentation but will help therapists and supervisors determine areas of strength and areas of development that are needed.

- **Client assessment** sections of the FFT-CSS help organize the risk assessment and outcome evaluation information available in the FFT pre and post assessment protocol. Once entered, the client assessment information may be printed as a profile of the case to be used in case and session planning. At the completion of a case the CSS calculates the degree of client reported change as a result of therapy. This feature of the CSS gives the FFT therapist an immediate indication of the outcomes of FFT. The FFT client assessment system focuses on the domains of individual, family, and behavior in context functioning. The FFT assessment system includes cost effective, clinically sensitive and reliable measures of each domain that can be delivered in a way that reduces respondent burden while maximizing a broad approach to understanding the family.

- **Therapy outcomes** are measured within the CSS in two ways: from the client and from the therapist perspective. Each case entered into the CSS is, when complete closed as either a non-completed (e.g. dropout, moved) or completed case. Reasons
for non-completed cases, therapist and client evaluation about the success of a case, and pre post change on client assessments are all immediately available to therapists for use in improving their ability to delivery FFT.

- **Adherence and Competence** information to help therapists improve their delivery of FFT are also built into the CSS. Family members complete a biweekly adherence form (the CPQ-Counseling Process Questionnaire) that is entered into the CSS by the therapist. The site supervisor completes global and weekly adherence and competence ratings of therapists that are regularly put into the CSS. These two different sources of information can be used by therapists to determine the degree to which they are adequately delivering FFT as well as areas of strength and improvement.

**CASE PLANNING AND STAFFING**

The weekly case staffing meetings are a critical part of the successful implementation of FFT. Each FFT site is organized around a working group of therapists who learn and implement FFT together. Working groups meet weekly (in addition to the organized supervision and training) to staff cases. Case staffings provide a place for therapists to “think through the FFT lens” with a like minded group of peers in order to develop a long term case plan and a short term session plan. As such, the case staffing team becomes a valuable tool in developing adherence and competence if they discuss cases and make plans based upon the core principles and clinical protocol of FFT.

The early FFT training is aimed at helping develop FFT teams to stay model focused in their case planning in order to build team adherence and competence.

---

**CASE PLANNING PROTOCOL: “BIG PICTURE”**

1. **How can we understand the family?**
   - Presenting problems
   - Risk and protective factors in family, individual, context
   - Relational understanding of family

2. **How does the problem “function” in the family relational system?**

3. **What is the major theme/reframe that organizes therapy?**

4. **Individualized change plan...potential “outcome sample”**
   - Behavior change targets
   - Implementation of behavior change plan
   - What are the multiple systems involved that impact maintenance and support change?
Successful working group staffing focuses on two areas: *Case planning* and *session planning*. By using the case staffing protocol the team can begin to move the relational process aspect of the case (the primary interest when doing FFT) to the foreground and the content (only a secondary interest) to the background. Case staffing begins with a presentation of the case and broad *case planning*, input by the team, and the development of a specific next session plan. FFT focused case staffings initially feel very different than traditional staffings. Typically little of the traditional psychosocial history information is presented. Instead, the focus of case planning is on how to “understand” the way this unique problem functions within a unique family relational system. In this way the staffing mirrors the thinking process the therapist must follow to work within FFT. Specific *session plans* are based in the phase of the model (what are the phase goals) with unique implementation strategies based on the unique relational structure/functions of the family.

**Interfacing with Other Service Delivery Services**

Successfully working with at-risk youth and their families requires that different service providers work together each providing an important component of a multisystemic treatment plan. When families are referred to FFT they are often times simultaneously involved in other community (e.g. parenting, anger management, support services, etc.) or professional services (individual therapy for parents and adolescents, group therapy, etc.). In fact, many traditional “wrap around,” court mandated, or mental health systems purposefully

---

**Figure 31**

**SESSION PLANNING PROTOCOL: SPECIFIC PLAN**

1. What phase?
2. Goals of that phase? (process goals for this session)
   - Which goals are important for this session?
   - What progress have you made toward the goals?
   - Process issues to address (e.g. negativity/resistance)?
3. What do I need to assess? (assessment goals for this session)
4. What is the major theme/reframe organizing the case?
   - What part to develop? How to add to it?
5. How should I intervene?
   - Which phase goals are targets for session?
provide the family with a number of such resources early on in the treatment process. While helpful, the systematic coordination of services is important if families are to benefit from available resources. It is particularly important that the “messages” and approaches of each service builds together to a coordinated effort rather than inadvertently working against one another.

This is particularly important with FFT. FFT is family focused with early therapeutic intervention oriented toward a “family focus” of the problem. Services that have an individual focus, inadvertently place the problem on the youth or parent, or direct attention to something other than family relational systems which may hinder the progress of FFT. We suggest that during FFT all other professional counseling services be terminated or placed on hold. In addition, other “educational” services should be carefully evaluated to determine if it might not be possible to delay their initiation until after FFT. If delayed other professional services and educational activities can better serve to generalize change in a way that adds to the work in FFT. During the generalization phase of FFT additional services can be “matched to” the family in a way that increases their impact thus utilizing community services more efficiently. Delaying services in this manner often requires the FFT team to educate the community services providers by organizing a coordinated system of care. This is yet another challenging aspect of FFT that requires the relentless dedication of its therapists to serve at-risk youth and their families.
Concluding Comments
Closing Thoughts

Passion and Wisdom

As we finish this manual you will see that in a sense we have come full circle. We began by focusing on the principles and philosophy that represent the platform from which the FFT strategies and techniques emerge. We described conceptual principles and the techniques that represent their actualization in the clinic room, in the homes of families, in our case conferences, and in our assessments.

Just as muscles need a brain and car engines need steering mechanisms to guide and organize their power, responsible clinicians need a model—wisdom—to guide our passion. Note however that throughout this manual we have not presumed to give you the passion. We can share our passion with you, but each of you must do exactly the same as each of us have done; that is you must decide if you want to undertake working with passion and effectively with these very needy, high risk youth and families. They often do not come to us ready to change, and many have a history of opposing change. So we need our passion to carry us through. You provide the passion for each and every clinical contact - we cannot do that for you in this manual or in our training which is to follow.

We can, and have begun to in this manual, provide the wisdom. Webster’s New World Dictionary (1995) defines wisdom with the following terms: “being wise, good judgment, learning; knowledge.” In other words, it is not defined in terms of “growing old,” “having seen x-number of cases,” “having gone through this particular disorder...
yourself,” or “having studied with guru x or in program y.” It merely refers to good judgment, learning, and knowledge. This manual reflects a model that has been researched extensively (one source of knowledge which provides wisdom), examined and reviewed extensively (e.g., the Blueprints review [Elliot, 1997], the U.S. Surgeon General report [2001], and many others noted elsewhere in this manual). These reviews have provided additional knowledge for us. And finally there are thousands of people who have contributed to the wisdom of the FFT model: The colleagues who have contributed in various and important ways to the development of FFT (Cole Barton, Joan Coles, Greta Cushing, Crystal DeLoach, Donald Gordon, Kjell Hansson, Rich Harrison, Penny Jameson, Nancy Klein, C. Haydee Mas, John Malouf, Roberta Malouf, Susan Mears, Steven Morris, Alice Newberry, Robert Newell, Le Ngu, Bruce Parsons, Christie Pugh, Michael Robbins, Jill Sanders, Stewart Schulman, Charles Turner, Holly Waldron, Janet Warburton); the people who constitute hundreds—perhaps thousands by now—of clinicians who have undertaken FFT with adherence in the FFT SDS (Service Delivery System); and finally the thousands of families who have been treated in FFT with session-by-session tracking and intensive collaboration of clinicians as Certified Site Teams. The wisdom that has emerged from all these people, the passion that our therapists maintain, and the dignity that seems to emerge even from the most challenging clients—this is the wisdom that we have translated into this manual and the training that follows. Thank you for joining this team, for allowing us to share our wisdom, and for providing the passion that only you can bring to these families.
References


Lantz, B. L. (1982). Preventing adolescent placement through Functional Family Therapy and tracking. Utah Department of Social Services, West Valley Social Services, District 2K, Kearns, UT 84118. Grant # CDP 1070 UT 83-0128020 87-6000- 545-W.


115


