Overview of the CEBC Scientific Rating Scale

In order for the CEBC to rate a practice:

It must have a book/manual that describes how to administer it

It must meet the requirements for inclusion into a CEBC topic area

Outcomes of research studies must be published in a peer-reviewed journal

Outcome measures are reliable/valid and administered consistently and accurately

1 Well-Supported by Research Evidence

- At least 2 rigorous randomized controlled trials (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice.
- In at least one of these RCTs, the practice has shown to have a sustained effect of at least one year beyond the end of treatment, when compared to a control group.

2 Supported by Research Evidence

- At least one rigorous RCT in a usual care or practice setting has found the practice to be superior to an appropriate comparison practice.
- In that RCT, the practice has shown to have a sustained effect of at least six months beyond the end of treatment, when compared to a control group.

3 Promising Research Evidence

- At least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list) has established the practice's benefit over the control, or found it to be comparable to a practice rated 3 or higher on the CEBC or superior to an appropriate comparison practice.

4 Evidence Fails to Demonstrate Effect

- Two or more randomized, controlled outcome studies have found that the practice has not resulted in improved outcomes, when compared to usual care.
- If multiple outcome studies have been conducted, the overall weight of evidence does not support the benefit of the practice.

5 Concerning Practice

- If multiple outcome studies have been conducted, the overall weight of evidence suggests the intervention has a negative effect upon clients served. and/or
- There is case data suggesting a risk of harm that: a) was probably caused by the treatment; and b) the harm was severe and/or frequent and/or
- There is a legal or empirical basis suggesting that, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.

NR Not Able to be Rated on the CEBC Scientific Rating Scale

- The practice does not have any published, peer-reviewed study utilizing some form of control (e.g., untreated group, placebo group, matched wait list study) that has established the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice.
- The practice does not meet criteria for any other level on the CEBC Scientific Rating Scale.

For more information on the CEBC Scientific Rating Scale visit www.cebc4cw.org/ratings/scientific-rating-scale

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Functional Family Therapy (FFT)

Topic Areas	Scientific Rating	Child Welfare Relevance
Alternatives to Long-Term Residential Care Programs	2 — Supported by Research Evidence	Medium
Behavioral Management Programs for Adolescents in Child Welfare	2 — Supported by Research Evidence	Medium
Disruptive Behavior Treatment (Child & Adolescent)	2 — Supported by Research Evidence	Medium
Substance Abuse Treatment (Adolescent)	2 — Supported by Research Evidence	Medium

About This Program

Target Population: 11-18 year olds with very serious problems such as conduct disorder, violent acting-out, and substance abuse

For children/adolescents ages: 11 – 18

Program Overview

FFT is a family intervention program for dysfunctional youth with disruptive, externalizing problems. ***FFT*** has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. Target populations range from at-risk pre-

adolescents to youth with moderate to severe problems such as conduct disorder, violent acting-out, and substance abuse. While ***FFT*** targets youth aged 11-18, younger siblings of referred adolescents often become part of the intervention process. Intervention ranges from, on average, 12 to 14 one-hour sessions. The number of sessions may be as few as 8 sessions for mild cases and up to 30 sessions for more difficult situations. In most programs, sessions are spread over a three-month period. ***FFT*** has been conducted both in clinic settings as an outpatient therapy and as a home-based model. The ***FFT*** clinical model offers clear identification of specific phases which organizes the intervention in a coherent manner, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption. Each phase includes specific goals, assessment foci, specific techniques of intervention, and therapist skills necessary for success.

Program Goals

The goals of ***Functional Family Therapy (FFT)*** are:

- Eliminate youth referral problems (i.e., delinquency, oppositional behaviors, violence, substance use)
- Improve prosocial behaviors (i.e., school attendance)
- Improve family and individual skills

Essential Components

The essential components of ***Functional Family Therapy (FFT)*** include:

- Five distinct intervention phases:
    - Engagement: Introduction/Impression (Pre-Intervention)
    - Motivation: Induction/Therapy (Early sessions)
    - Relational Assessment (by conclusion of early sessions)
    - Behavior Change (Middle sessions)
    - Generalization (Later sessions)
- Each phase has its own unique goals, risk and protective factors addressed, assessment focus, and therapist skills and intervention focus.
    - Engagement:
        - Goal: Maximize family initial expectation of positive change
        - Risk and Protective Factors Addressed:
            - Negative perception about or experiences with treatment

        - Reputation of treatment agency
        - Transportation
        - Therapist availability
        - Intake staff skills and attitudes

    - Assessment Focus: Superficial qualities inferred from referral source and initial screening
    - Therapist Skills/Intervention Focus:
        - High availability
        - Manage intake processes to present agency, self, and treatment in a way that matches to inferred family characteristics
        - Enhance perception of credibility

- Motivation:
    - Goal: Create a motivational context for long-term change
    - Risk and Protective Factors Addressed:
        - Family negativity and blame
        - Hopelessness
        - Level of motivation

    - Assessment Focus:
        - Behavioral (presenting problem)
        - Relational risk and protective factors

    - Therapist Skills/Intervention Focus:
        - Interpersonal skills (validation, positive reattribution, reframing, relational)
        - Build balanced alliances
        - Reduce negativity and blame
        - Create hope
        - Enhance motivation to change

- Relational Assets:
    - Goal: Complete relational (functional) assessment of family relationships to provide foundation for changing behaviors in subsequent phases
        - Risk and Protective Factors addressed: none

        - Assessment Focus:
        - Relational Autonomy/Connectedness
        - Relational Hierarchy
        - Therapist Skills/Intervention Focus:
        - Perceptiveness
        - Observation
        - Facilitate interactions or information about patterns of interaction

- Behavior Change:
    - Goal: Facilitate individual and interactive/ relational change
    - Risk and Protective Factors Addressed (note: below are examples, not an exhaustive list of potential factors that might be addresses in this phase):
        - Youth temperament
        - Parental pathology
        - Beliefs and values
        - Developmental level
        - Parenting skills
        - Conflict resolution/negotiation skills
        - Level of family support
        - Peer refusal skills

    - Assessment Focus:
        - Individual skills
        - Quality of relational skills
        - Relational problem sequence
        - Compliance with behavior change plans

    - Therapist Skills/Intervention Focus:
        - Directive/teaching /structuring skills
        - Modeling
        - Setting up, leading, and reviewing in-session tasks
        - Assigning homework

- Generalization:

- Goal: Maintain individual and family change, and facilitate change in multiple systems
- Risk and Protective Factors Addressed (note: below are examples, not an exhaustive list of potential factors that might be addresses in this phase):
  - Youth bonding to school
  - Parent attitudes about school, peers, drugs, etc.
  - Level of social support
- Assessment Focus:
  - Access to and utilization of community resources
  - Maintenance of change
- Therapist Skills/Intervention Focus:
  - Interpersonal and structuring skills
  - Family case manager
  - Accessing appropriate formal and informal community resources
  - Anticipate and plan for future extra-familial stresses

Program Delivery

Child/Adolescent Services

Functional Family Therapy (FFT) directly provides services to children/adolescents and addresses the following:

- Conduct disorder, violent acting-out, and substance abuse

Services Involve Family/Support Structures:

This program involves the family or other support systems in the individual's treatment: Family of youth is involved in all therapy

Recommended Intensity:

One-hour weekly sessions unless needed more frequently

Recommended Duration:

12 to 14 sessions; the number of sessions may be as few as 8 sessions for mild cases and up to 30 sessions for more difficult situations. In most programs, sessions are spread over a three or four month period.

Delivery Settings

This program is typically conducted in a(n):

- Adoptive Home
- Birth Family Home
- Community Agency
- Foster/Kinship Care
- School

Homework

Functional Family Therapy (FFT) includes a homework component:

As noted in the Essential Components, homework is provided as needed throughout treatment, but particularly in the Behavior Change phase. This homework consists of building on the specific skills that were taught during sessions. For example, homework may involve practicing communication skills, problem solving, and other skills throughout the week.

Languages

Functional Family Therapy (FFT) has materials available in languages other than English:

Dutch, Spanish, Swedish

For information on which materials are available in these languages, please check on the program's website or contact the program representative (contact information is listed at the bottom of this page).

Resources Needed to Run Program

The typical resources for implementing the program are:

Sites must provide each therapist with on-going computer and internet access so they can record progress notes and complete the other assessment, adherence and outcome instruments that are utilized during the course of the intervention.

Meeting space and a speaker phone are needed for weekly consultation with an offsite program consultant.

Education and Training

Prerequisite/Minimum Provider Qualifications

Qualifications can vary for therapists, but to become an onsite Program Supervisor a minimum of Master's level education is required.

Education and Training Resources

There is a manual that describes how to implement this program , and there is training available for this program.

Training Contacts:

- **Holly DeMaranville**
  Functional Family Therapy, Inc. (Founder, Dr. James F. Alexander)
  holly@fftllc.com
  phone: (206) 369-5894
- **Thomas Sexton, PhD, ABPP**
  Functional Family Therapy Associates
  thsexton@mac.com
  phone: (812) 369-7202

Training is obtained:

Please ask the trainer you choose to contact.

Number of days/hours:

Please ask the trainer you choose to contact.

Implementation Information

Pre-Implementation Materials

There are pre-implementation materials to measure organizational or provider readiness for ***Functional Family Therapy (FFT)*** as listed below:

There is an application process that is meant to help sites understand and review all of the readiness issues involved with implementation. For more information, please see www.fftllc.com or contact the program representative listed at the end of this entry.

Formal Support for Implementation

There is formal support available for implementation of ***Functional Family Therapy (FFT)*** as listed below:

Some states (California and Washington) that have formal FFT Statewide Coordinators who help sites with implementation and other issues.

Fidelity Measures

There are fidelity measures for ***Functional Family Therapy (FFT)*** as listed below:

FFT, Inc. includes intensive procedures for monitoring quality of implementation on a continuous basis. Information is captured from multiple perspectives (family members, therapists, and clinical supervisors). The two measures that are utilized to represent therapist fidelity to the model are the *Weekly Supervision Checklist* and the *Global Therapist Ratings*.

Weekly Supervision Checklist: Following every clinical staffing, the clinical supervisor completes a fidelity rating for the case that was reviewed for each therapist. This fidelity rating reflects the degree of adherence and competence for that therapist's work in that case in a specific session. Thus, the weekly supervision ratings are not global, but specific to a single case presentation. Over the course of the year, a therapist may receive up to 50 ratings, which provides the supervisor with critical information about the therapist's progress in implementing ***FFT***.

Global Therapist Ratings: Three times a year the clinical supervisor rates each therapist's overall adherence and competence in ***FFT***. The Global Therapist Rating (GTR) allows for the supervisor to provide feedback to the therapist on their overall knowledge and performance of each phase and general ***FFT*** counseling skills. The GTR specifically targets time period measures with the hope of displaying therapist growth. With respect to the GTR, we encourage supervisors to utilize the comments box under each phase to target specific strengths and specific phase areas of growth.

Implementation Guides or Manuals

There are implementation guides or manuals for ***Functional Family Therapy (FFT)*** as listed below:

Training manuals are handed out to sites implementing ***FFT*** during their clinical training.

Research on How to Implement the Program

Research has not been conducted on how to implement ***Functional Family Therapy (FFT)***.

Relevant Published, Peer-Reviewed Research

Child Welfare Outcome: Child/Family Well-Being

***Alexander J. F., & Parsons, B. V. (1973).** Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. *Journal of Abnormal Psychology, 81*(3), 219-225.

Type of Study: Randomized controlled trial
Number of Participants: 86 families

Population:

- **Age —** 13-16 years
- **Race/Ethnicity —** Not specified
- **Gender —** Not specified
- **Status —** Participants were recruited from referrals by the Salt Lake County Juvenile Court to the Family Clinic at the University of Utah made from October 1970 to January 1972.

Location/Institution: Family Clinic, University of Utah

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
This study examined the impact of a short-term behavioral intervention [now called ***Functional Family Therapy (FFT)***] on the recidivism rates of delinquent teenagers and their families. Families were randomly assigned to either the short-term behavioral family intervention program or to one of three comparison groups: client-centered family groups program, psychodynamic family program (Mormon church-sponsored), or a no-treatment control group. Juvenile court records were examined following termination to assess recidivism, (i.e., referral for behavioral offense). Results showed that the no-treatment control group had a 50% recidivism rate, the client-centered family group had a 47% recidivism rate, the psychodynamic family treatment group had a 73% recidivism rate, and the short-term family behavioral treatment had a 26% recidivism rate. Limitations of the study include the small sample size in each group and the lack of specific substance use related outcome.

Length of postintervention follow-up: 6-18 months.

Parsons, B., & Alexander, J. (1973). Short-term family intervention: A therapy outcome study. *Journal of Consulting and Clinical Psychology, 41*(2), 195-201.

Type of Study: Pretest-posttest with control group
Number of Participants: 40

Population:

- **Age —** Mean=Approximately 15 years
- **Race/Ethnicity —** Not specified
- **Gender —** 22 Females and 18 Males

- **Status —** Participants were families of adolescents involved with the juvenile court system for behavioral offenses (runaway, deemed 'ungovernable,' or habitual truancy).

Location/Institution: Family Therapy Clinic at the University of Utah, Salt Lake City

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
The study evaluated whether a short-term family intervention program [now called ***Family Functional Therapy (FFT)***], using a relatively rigorous experimental paradigm, effectively reduced maladaptive behavior patterns in adolescents. Study goals included developing reciprocity and periods of positive reinforcement; to ensure equality as well as the clarity of both verbal and nonverbal responsiveness; and to accelerate labile, solution-oriented communication patterns. Two treatment conditions and two control groups were used in a variant of the Solomon four-group study design that included an attention-placebo manipulation instead of a posttest-only control group. The study assessed activity levels and verbal reciprocity using four interaction measures: silence, frequency, duration of simultaneous speech, and equality of speech within the family. Families in the intervention groups completed the treatment manual in four weeks. Results indicated that treatment produced significant changes in the family interaction patterns with treatment families becoming less silent, talking more equally, and experiencing an increase in both the frequency and duration of simultaneous speech. Control families did not improve on any of the four interaction measures and the pencil-and-paper treatment components yielded no significant change among all groups. Limitations included unreliability with the paper-and-pencil components, a lack of comparison of individual therapy to the family systems approach, small sample size, and no follow-up.

Length of postintervention follow-up: None.

Alexander, J., Barton, C., Schiavo, R., & Parsons, B. (1976). Systems-behavioral intervention with families of delinquents: Therapist characteristics, family behavior, and outcome. *Journal of Consulting and Clinical Psychology, 44*(4), 656-664.

Type of Study: One group posttest-only design
Number of Participants: 21

Population:

- **Age —** 13-16 years
- **Race/Ethnicity —** Not specified
- **Gender —** 11 Females and 10 Males
- **Status —** Participants were families of adolescents involved with the juvenile court system for behavioral offenses (runaway, deemed 'ungovernable,' habitual truancy, curfew).

Location/Institution: University of Utah, Salt Lake City

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
The study evaluated therapist characteristics, therapist process, and family process in a short-term systems-behavioral model of family intervention [now called Functional Family Therapy (FFT)]. Families were randomized to therapists who received a 10-week training course prior to intervention and designated at the end of the study by therapy outcome: 1) terminated after 1 session, 2) terminated after several sessions with no resolution of problems, 3) competed treatment but still had some problems, or 4)completed treatment, with no remaining problems. Baseline assessments of therapists' structuring and relationship skills (affect-behavior, humor, warmth, directness, self-confidence, self-disclosure, blaming, and clarity) were strong descriptors of outcome variance. The main limitation was the use of a homogeneous sample that may affect generalization and the accuracy of therapist skill-structuring.

Length of postintervention follow-up: 12-15 months (involvement in the juvenile court system only).

***Klein, N., Alexander, J., & Parsons, B. (1977).** Impact of family systems intervention on recidivism and sibling delinquency: A model of primary prevention and program evaluation. *Journal of Consulting and Clinical Psychology, 45*(3), 469-474.

Type of Study: Randomized controlled trial
Number of Participants: 86

Population:

- **Age —** 13-16 years
- **Race/Ethnicity —** Not specified
- **Gender —** 48 Females and 38 Males
- **Status —** Participants were families of adolescents involved with the juvenile court system for behavioral offenses.

Location/Institution: University of Utah Family Clinic, Salt Lake City

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
This study served as a follow-up to the 1973 Alexander and Parsons study. The current study measured outcomes on three levels of evaluation: changes in the family interaction process at the termination of treatment (tertiary prevention); recidivism rates 6 to 18 months following treatment (secondary prevention); and rate of sibling contact with the court 2.5 to 3.5 years following intervention (primary prevention). Families were randomly assigned to one of four treatment conditions: the treatment program [now called ***Functional Family Therapy (FFT)***], one of two comparison groups, or a no-treatment control group. The family systems approach, when compared to the other conditions, produced significant improvements in family interaction process measures and a significant reduction in recidivism. Limitations include study reports on prevention outcomes rather than the actual effects of the initial treatment measures, small sample size in each group and the lack of specific substance use related outcome.

Length of postintervention follow-up: 6-18 months (recidivism only).

Friedman, A. (1989). Family therapy vs. parent groups: Effects on adolescent drug abusers. *American Journal of Family Therapy, 17*(4), 335-347.

Type of Study: One group pretest-posttest design
Number of Participants: 135

Population:

- **Age —** 14-21 years
- **Race/Ethnicity —** 89% Caucasian and 11% Other
- **Gender —** 60% Male and 40% Female
- **Status —** Participants were families of emotionally disturbed adolescents with substance abuse.

Location/Institution: Six outpatient drug-free treatment programs

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
Families were randomly assigned to a 24-week family therapy group or parent-only group. Under these conditions, the parent group procedure was demonstrated to be as effective as the ***Functional Family Therapy (FFT)*** group in reducing drug abuse and in behavior and attitude modification in adolescent drug abusers. Considerable improvement was noted at 9 months post-treatment for both groups according to the clients' reports and the mothers' reports. Out of the 65 outcome criteria evaluated, 56 and 58 significant positive changes from pretreatment to follow-up were reported in the parent and family therapy groups, respectively. Improvements included a reduction of adolescents' drug use by more than 50 percent, a decrease in adolescent psychic symptomology, a decrease in adolescent negative family role task behavior, an increase in positive behavior within the family, and an improvement in adolescent communication between mother and father. Limitations include lack of randomization of participants, lack of control group, and generalizability due to ethnicity.

Length of postintervention follow-up: 9 months.

Waldron, H. B., Slesnick, N., Brody, J. L., Peterson, T. R., & Turner, C. W. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7-month assessments, *Journal of Consulting and Clinical Psychology, 69*(5), 802-813.

Type of Study: Randomized controlled trial
Number of Participants: 114 (demographic breakdown below reflects initial 120 participants)

Population:

- **Age —** 13-17 years
- **Race/Ethnicity —** 56 Hispanic, 46 Anglo American, 9 Native American, and 9 Mixed/Other
- **Gender —** 96 Males and 24 Females
- **Status —** Participants were referred by the juvenile justice system, public school system, themselves, a parent, or other treatment agencies. Most were mandated to treatment by court order, by probation officers in lieu of a court order, or by schools in lieu of suspension or other consequence.

Location/Institution: University of New Mexico Center for Family and Adolescent Research, NM

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
Participants were randomly assigned to one of four treatment conditions: ***Functional Family Therapy (FFT)***, individual Cognitive Behavioral Therapy (CBT), a combination of ***FFT*** and CBT (joint), or a psychoeducational group. Measures to assess substance abuse included the *Timeline Follow-Back (TLFB)* interview, as well as collateral reports from parents and siblings of adolescents, and urinalyses. In order to assess problem behaviors that may be associated with substance abuse, the *Problem Oriented Screening Instrument for Teenagers (POSIT)* and Child Behavioral Checklist *(CBCL)* were used. Adolescents in both of the family therapy conditions (***FFT*** and joint CBT/***FFT***) had significant reductions in heavy marijuana use from pretreatment to the 4-month assessment, and this reduction persisted until the 7-month assessment. The initial changes in those in the CBT condition from pretreatment to 4 months, however, did not persist through the 7-month assessment. All of the interventions in this study demonstrated some degree of treatment efficacy. Limitations include an unequal number of sessions across treatments, as well as the self-report nature of substance use.

Length of postintervention follow-up: 3 months.

Slesnick, N., & Prestopnik, J. (2004). Office versus home-based family therapy for runaway, alcohol abusing adolescents: Examination of factors associated with treatment attendance. *Alcoholism Treatment Quarterly, 22*(2), 3-19.

Type of Study: Randomized controlled trial
Number of Participants: 77

Population:

- **Age —** Mean=15 years
- **Race/Ethnicity —** 36 Hispanic, 20 Anglo, 10 Native American, 5 African American, and 6 Other
- **Gender —** 46 Females and 31 Males
- **Status —** Participants were recruited from two runaway shelters in a large southwestern city.

Location/Institution: University of New Mexico; Albuquerque

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
This study examined predictors of treatment attendance for runaway, substance abusing youth and their families. Participants were randomly assigned to either Ecologically Based Family Therapy (EBFT) or ***Functional Family Therapy (FFT)***. Measures included the *Youth Self-Report of the* Child Behavior Checklist, as well as the *Form 90 Interview*, which was the primary measure of quantity-frequency of adolescent substance use, yielding the total percent days, in the last 90, of all alcohol and drug use. More families assigned to home-based EBFT were both engaged and attended more sessions compared to families assigned to the office-based ***FFT***. 76% of the EBFT families participated in four or more sessions, while only 50% of the families assigned to ***FFT*** participated in four or more sessions. Adolescents' externalizing problems was associated with increased treatment attendance in EBFT, but not in ***FFT***. However, severity of the adolescent's alcohol and drug use did not significantly predict treatment attendance in either EBFT or ***FFT***. Limitations include sole focus on shelter-residing runaway youth with primary alcohol problems, reliability on self-reported measures and lack of follow-up.

Length of postintervention follow-up: None.

Slesnick, N., & Prestopnik, J. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. *Journal of Marital & Family Therapy, 35*(3), 255-277.

Type of Study: Randomized controlled trial
Number of Participants: 119

Population:

- **Age —** 12-17 years
- **Race/Ethnicity —** 44% Hispanic, 29% Anglo, 11% Native American, 5% African American, and 11% Other
- **Gender —** 55% Female and 45% Male
- **Status —** Participants were primarily alcohol problem adolescents and their primary caretakers from two runaway shelters.

Location/Institution: Albuquerque, NM

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
Participants were assigned to either (a) home-based Ecologically Based Family Therapy (EBFT), (b) office-based ***Functional Family Therapy (FFT)***, or (c) service as usual (SAU) through the shelter. Measures included the *Youth Self-Report* of the *Child Behavior Checklist*, the computerized version of the *Diagnostic Interview Schedule for Children (CDISC),* the *Beck Depression Inventory (BDI),* and the *Conflict Tactics Scale (CTS).* The *Form 90* was used to assess alcohol and drug patterns; urine toxicology screens were collected at pretreatment and posttreatment assessment to verify self-reported illicit drug use. Findings showed few significant differences between the three groups at the assessment time points. Limitations include difficult to conclude whether the findings are the result of the context of treatment (home vs. office) or of treatment condition (***FFT*** vs. EBFT), small sample size, and may not be generalizable to youth not in shelter care.

Length of postintervention follow-up: 6-11 months.

Additional References

Alexander, J., Barton, C., Gordon, D., Grotpeter, J., Hansson, K., Harrison, R., … Sexton, T. (1998). *Functional Family Therapy: Blueprints for violence prevention, Book Three*. Blueprints for Violence Prevention Series (D.S. Elliott, Series Editor). Boulder, CO: Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado.

Alexander, J. F., & Parsons, B. V. (1982). *Functional Family Therapy: Principles and procedures*. Carmel, CA: Brooks/Cole.

Alexander, J. A., Waldron, H. B., Robbins, M. S., & Neeb, A. (2013). *Functional Family Therapy for adolescent behavior problems*. Washington, DC: American Psychological Association.

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