

THE EFFECTIVENESS OF FUNCTIONAL FAMILY THERAPY
IN AN IRISH CONTEXT:
AN EXAMINATION OF INTERNATIONAL IMPLEMENTATION

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To my family and friends:
for their unconditional love, encouragement, and support.

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The Effectiveness of Functional Family Therapy in an Irish Context:

An Examination of International Implementation

This study evaluated the implementation of Functional Family Therapy (FFT), as compared to a non-completing dropout group in an Irish community setting. With recent attention by Irish legislators to respond to an increase in youth crime, evidence-based practices have been recommended for working with at-risk youth that target parenting and promote prosocial behaviors. FFT was implemented in response to this recommendation for its proven efficacy with a variety of adolescent problems, including drug abuse, violence, and other delinquency problems. A sample of 60 cases that received FFT at the Families First Centre in an eastern suburb of Dublin in the Republic of Ireland over a three year period was compared to a sample of 20 cases that dropped out of FFT treatment before completion in order to evaluate outcomes of adolescent functioning and family functioning. Results indicate a significant difference between the FFT group and dropout group on the measure of overall adolescent functioning. Additionally, there was a significant difference between the FFT group and dropout group on measures of family functioning and specific aspects of adolescent functioning, notably adolescent conduct problems, which is most relevant to the main aims of FFT. Additionally, therapist adherence to the FFT model as a moderating variable, using the Therapist Adherence Measure (TAM), was found to be a significant predictor of change in adolescent functioning from beginning to end of therapy from the parent perspective. Finally, in examination of additional variables as treatment adherence, the variables of therapist dropout rate, adolescents' perception of the counseling process during the first and third phase of therapy, and parents' perception of the counseling process during the third phase of FFT treatment were all found to be

significant predictors of family functioning from the parent perspective, change in adolescent functioning from the adolescent perspective, and perceived change in counseling, respectively. Thus, viewing treatment adherence with additional variables other than the TAM can help better moderate client outcomes and can help shed light on necessary factors to consider when transporting an evidence-based practice to international settings.

Keywords: family therapy, adolescence, Ireland, implementation, model adherence

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Chapter I

Introduction

Adolescent behavior problems are frequently encountered in clinical practice. The wide range of externalizing behavior disorders are the most common clinical referral within the adolescent population (Kazdin & Weisz, 2003). These behavior problems tend to be comorbid in nature, typically involving issues such as school problems, substance use, delinquency, violence, and other conduct problems. Actually, approximately 50% to 80% of delinquent adolescents meet the DSM-IV criteria for a mental disorder, such as conduct or substance-related disorders (Kazdin & Weisz, 2003). Adolescent behavior problems also involve many systems, including the child, parents, family, and community. Thus, many different clinical populations often become involved once these clinical referrals are made. Consequently, adolescents who become involved in the justice system have high rates of behavior problems, mental health disorders, and other behaviors that deem them to be “at risk” (Sexton, Robbins, Holimon, Mease, & Mayorga, 2003).

As in other countries, juvenile crime in Ireland has become a major problem. According to the Garda Public Attitudes Survey conducted by the Garda, Ireland’s national police service, 76% of respondents rated juvenile crime a major national problem. Furthermore, these respondents rated that lack of parental control contributed to crime in Ireland. (Browne, 2008). In 2001, legislators in Ireland attempted to respond to the issue of youth crime by creating The Children Act, which serves as a framework for responding to troubled youth and youth crime. In conjunction with this act, there are a range of interventions developed for young offenders, including The Garda Diversion Programme, Garda Youth Diversion Projects, Probation Service, and Children Detention Schools. Of particular focus in this study is the Garda Youth Diversion

Project, which is a crime prevention initiative with a primary mission of diverting young people away from criminal activities by providing them with suitable activities for personal development. In 2008, 100 projects were in operation, providing interventions for approximately 3,600 young people (Redmond, 2009).

The Children Act also led to the development in 2005 of The Irish Youth Justice Service (IYJS), a division of the Office of the Minister for Children and youth Affairs, to be responsible for coordinating the area of youth justice in Ireland (Redmond, 2009). The IYJS has created The National Youth Justice Strategy, which outlines five goals for the youth justice system. Of particular importance to this study is Goal 2, which aims to work to reduce offending by diverting young people from offending behavior. This goal guided the Garda Youth Diversion Projects baseline analysis, which allowed policymakers to gather data on the types of crimes committed by youth in Ireland, patterns of these crimes, and profiles of the young people involved in criminal activities. Alcohol-related offenses were found to be the single largest category of offenses committed by youth in Ireland, accounting for one fifth of all juvenile crime. Other key offenses were theft, drug-related offenses, violent offenses, vehicle theft, burglary, and minor traffic offense. Of the alcohol and public order related crimes, boys seem to be the main perpetrators. Although girls were involved in underage drinking, they tend to be less involved in other offenses related to drinking. Other patterns emerged from the data, including more offense committed on weekends, during summer months, and around certain calendar events (Redmond, 2009).

Of the 100 projects involved in the study, 90 projects provided information on how parents typically respond to the youth offending. 66 projects experienced parents in difficult circumstances and lacking effective parenting skills, 29 projects experienced parents who were

concerned about the youth, but were not consistent with actions such as supervision or discipline, 51 projects experienced parents who minimized the offending behavior, 45 projects experienced indifference by parents, and 21 projects identified parents having some culpability for the offense. The baseline analysis reflects the broad research finding that young people become involved in crime because of complex and multi-systemic reasons. The analysis suggests that multi-systemic responses are required to address the multiple risks that young people encounter. Among the recommendations for interventions from the analysis is that interventions with parents appear to yield results and should be used for youth crime, especially in situations where the young person's offending behavior is associated with lack of parenting skill (Redmond, 2009).

There is clear evidence that criminal activity is not the only major issue pertaining to Irish youth currently. Additionally, in a recent study of prevalence rates of psychiatric disorders, suicidal ideation, and parasuicide in Irish adolescents, researchers found that this population experience significant mental health difficulties. In a community-based sample of urban Irish adolescents, 15.6% had a current psychiatric disorder and almost 20% met criteria for a past psychiatric disorder (Lynch et al., 2006).

Moreover, 22% of the study population had a history of alcohol binge drinking (Lynch, et al. 2006). Specifically, according on the 2006 Irish census and the Irish Office of Tobacco Control, Irish adolescents spend around €145 million on alcohol each year. This was associated with the presence of an emotional and/or behavior disorder. As a culture, Irish people have a high tolerance and acceptance of excessive alcohol consumption, as the total alcohol consumption per capita in Ireland has increased and is now approximately 24% higher than the EU average. The European Monitoring Centre for Drugs and Drug Addiction reported that a

main factor in the substance abuse crisis in adolescents is children growing up in families with substance users. Adolescent substance use has increased in the last three years, specifically for “party drugs”, including alcohol, marijuana, ecstasy, and prescription drugs. In the same past three years, parents are working harder in the economic conditions and spending a third less time with their children, suggesting that they have less time to monitor their children’s behaviors (Kumpfer, Xie, & O’Driscoll, 2012) Alarmingly, despite these rates of psychiatric disorders and substance abuse problems, few had come to the attention of child and adolescent psychiatric services (Lynch, et al., 2006). These results highlight the need for more extensive epidemiological research of the mental health difficulties experienced by Irish children and adolescents, as well as effective interventions.

Due to the multisystemic nature of adolescent behavior problems, there is more of a need to broaden treatment approaches to include important relational contexts and subsystems in which the adolescent problems tend to develop (Kazdin & Weisz, 2003). There has been a dramatic, recent growth of family and evidence-based practices (EBPs) that has changed the way therapists do their jobs, the criteria for choosing specific programs to help youth and families, the techniques of clinical training, the accountability of interventions, and the expected outcomes (Sexton, Gilman, & Johnson- Erickson, 2005). The outcome evidence has been clear in the area of adolescent behavior problems, revealing that family therapy is effective and that specific models of family therapy are more successful than others (Alexander, Holtzworth-Munroe, & Jameson, 1994). In fact, family-based interventions are shown to be the treatment of choice for reducing adolescent behavior problems (Pinsof & Wynne, 1995; Stanton & Shadish, 1997; Waldron, 1997).

With the increasing severity of adolescent behavior problems, evidence-based practices are increasingly being adopted in community-based settings (Kazdin & Weisz, 2003). This trend is also occurring in community settings in countries other than the U.S. In 2009, the head of Young Offender Programmes at the Irish Youth Justice Service recommended that the organization implement evidence-based practices for treating youth. In particular, he suggested that these interventions target parenting in families of at-risk youth, while promoting prosocial behavior (Redmond, 2009). This interest in evidence-based practices raises questions as to whether or not American evidence-based treatments can be transported to cultures other than those in which they were developed and whether or not these treatments are culturally sensitive to be used in other countries (Breuk et al., 2006).

There have been numerous research reviews that identify Functional Family Therapy (FFT) as a promising evidence-based intervention program for at-risk youth and their families (Elliott, 1997; Alexander & Sexton, 2002; Sexton, Alexander, & Mease, 2003; Waldron & Turner, 2008). FFT has proven efficacious with a variety of adolescent problems, including violence, drug abuse, and other problems related to delinquency. The three phases of FFT- engagement and motivation, behavior change, and generalization- and the intervention methods specific to each phase are outlined in a detailed treatment manual (Sexton & Alexander, 2004). Like other evidence-based intervention programs, FFT is also easily and effectively implemented in community settings. Because a treatment model like FFT is so specific, therapists are able to be trained, treatment can be monitored, and therapists can adhere to the model in ways that are not possible with less specific treatment interventions. FFT has now been implemented in over 300 community sites in the United States and four different international settings (Sexton & Turner, 2010). In addition to the phases and their interventions being manualized, FFT

supervision methods are also manualized (Sexton, Alexander, & Gilman, 2004). FFT therapists' adherence to the FFT model is tracked regularly using supervision adherence measures.

As evidenced by a study conducted by Breuk, et al. (2006), therapists in international contexts were able to successfully implement FFT across diverse client ethnic backgrounds, with adequate training and supervision. In that particular study, Dutch FFT therapists moved from low to high adherence ratings to the FFT model during the first year of FFT implementation. That is, the more the FFT therapists were able to work with the FFT model, the more they were able to accurately implement the treatment in their work with clients. Findings suggest that a specific model like FFT, with specific clinical protocols, helped staff to achieve success in transporting and implementing the model in diverse contexts.

FFT has been successfully implemented in many community settings that are characterized by being diverse, representing rural and urban settings with culturally diverse clients and therapists (Breuk et al., 2006). With that said, international implementation of the FFT model requires careful consideration of the model implementation. Many consider implementation to be one of the most critical aspects of evidence-based practices because without successful implementation, the clinical value of the treatment is not as powerful (Elliott, 1997). Thus, the implementation of FFT in Ireland was done extremely carefully and systematically, with direct training of therapists, consultation, and on-going site supervision. FFT is well-suited as a part of this research design because one of its core principles is 'matching to' the unique family system (Breuk et al., 2006). Within this principle is the idea that each individual should be viewed as unique and part of a larger family context, which has its own particular values, traditions, and norms. This allows the therapists to adhere to the goals and

principles of the FFT clinical model, but do so in a flexible way that meets the family where they are and fits within individual and family norms (Sexton & Alexander, 2004).

Present Study

This study serves as an extension of a preliminary evaluation of FFT services in Ireland. The specific context of this study took place in an eastern suburb of The Republic of Ireland, directly west of its capital, Dublin. The preliminary, descriptive study examined whether or not FFT produced outcomes that result in reduced crime and behavioral problems and improvement in individual and family functioning. In an analysis of sixty families at the Families First Centre in Clondalkin, Ireland, results showed that adolescent functioning improved from before FFT treatment to after FFT treatment. Specifically, adolescent functioning was in the normal range, which is an improvement from the clinical borderline range before FFT treatment. Further, parents' views of their adolescent's functioning before and after FFT treatment showed an improvement from the abnormal range to borderline range of functioning. In particular, adolescent functioning improved on five subscales, but with a statistically significant change on the emotional symptoms subscale. Parents' ratings of their adolescents' functioning showed statistically significant improvement on all subscales, indicating change in emotional, hyperactivity, conduct, prosocial, and peer influence symptoms. Moreover, families in the original sample were able to measure their perceived improvement in counseling by responding to items about their family functioning before and after FFT. Results showed that both parents and adolescents perceived a decrease in the severity of their problems from before FFT treatment to after.

While the preliminary evaluation helped to shed light on basic international implementation of FFT, it lacks a certain level of integrity without a comparison group. In the

current study, outcomes from the sixty families who completed FFT treatment will be compared to 20 of the families who did not complete FFT treatment. The families who dropped out of treatment before completion were contacted via telephone in order to gather follow-up data for comparison purposes. Thus, the overall goal of the current study is to examine whether or not FFT, when implemented by Irish practitioners, produces outcomes that result in improvement in adolescent and family functioning, as compared to non-completion of treatment.

The study also aims to provide specific insight into the interactive effects of therapist adherence on client outcomes. Studies have shown that therapist adherence to a treatment model is an important predictor of clinical outcomes, especially when conducted in community settings. (Henggeler, Prickel, & Brondino, 1999). Treatment fidelity, or therapist adherence, is the degree to which a therapy is implemented according to theoretical and procedural aspects of the model (Hogue et al, 2006). Treatment fidelity has also been linked to treatment outcomes in family-based therapies (Henggeler et al., 1999). In such, the assumption is that as the implementation of FFT improves, the program has an increased likelihood of having better outcomes and working in other contexts. In the preliminary analysis of FFT in Ireland, the study investigated therapist adherence to the FFT model, using the Therapist Adherence Measure (TAM). Results showed outcomes that were not significant and did not reveal much of a connection between therapist adherence to the FFT model, and client outcomes. Thus, the hypothesis was not concluded, that is, that the more adherent a therapist was, the more the adolescent and family functioning would improve.

As other studies have noted, treatment adherence is not a unitary construct (Dobson & Shaw, 1988; Monzer & Prinz, 1991) and could be best understood when evaluated from multiple perspectives. Adherence of complex treatment models like FFT may vary considerably

depending on the individual and unique needs of the family. While the TAM has been proven useful and significantly predictive of client outcomes in other studies (Sexton & Turner, 2010), it also may have methodological weaknesses when used alone. For example, in the preliminary study, TAM ratings were based on supervisors' clinical judgment of therapists' adherence to the FFT model during supervision. While some therapists may be able to articulate their understanding of the model while in supervision, they may not be as skilled in translating this understanding during sessions with clients. As Sexton and Turner (2010) suggested in their study, the use of other methods would provide stronger evidence for therapist adherence. Further, although the TAM provides a reliable and practical way of measuring treatment fidelity, there has yet to be a valid, community-based measure of therapist adherence (Sexton and Turner, 2010). Thus, using the TAM alone as the measure of therapist adherence seems to not be methodologically sound.

In order to expand upon the construct of treatment fidelity, this study aims to have a more precise definition and understanding of model adherence. In other words, the study aims to use not only TAM scores as the way of measuring therapist adherence to the FFT model, but also other variables, that are hypothesized to better predict client outcomes. Significant effects of model adherence have been found in other evidence-based treatment models (Henggeler et al., 2007; Hogue et al., 2008). However, these outcomes were found in research and university environments, with a high amount of control in therapist selection and training, which affects the quality of care given to clients (Sexton and Turner, 2010). Given the fact that FFT is being implemented at a community setting in Ireland, it is no surprise that there is much more variation amongst clients and therapists than there would be in controlled settings. While the therapists in Ireland are consistently trained and supervised in a real-world, community setting, they are much

more likely to be influenced by other various factors, such as personal (e.g. attitudes toward evidence-based interventions, busy schedules) and organizational (e.g. organizational resources to support FFT) factors that could affect their ability to provide quality care to their clients (Hoagwood, Hibbs, Brent, & Jenson, 1995). Thus, even though supervisors may deem therapists as showing a certain level of adherence on the TAM measure, there may be other influences that could make them more or less adherent, accordingly.

Specifically, the therapists in Ireland vary in the years of clinical experience they have had, which can have an effect on their abilities as a therapist and the variation of cases to which they have been able to apply the FFT model. Also, the amount of cases that dropped out of therapy are an indicator of the ability to engage families—a key ingredient in FFT. Even for a therapist with a high adherence rating on the TAM, their clients may not have completed treatment. Given that part of the FFT model is engagement of all family members, it is important for FFT therapists to adhere to the model enough to retain families on their caseload in order to complete treatment (Sexton & Alexander, 2004) Finally, while FFT supervisors may rate therapists as adherent, family members may have a different perspective of how well their therapist is facilitating change for their family. That is, with measures like the Counseling Process Questionnaire (CPQ), family members are able to rate how they believe the counseling process is going and the effect they feel that their therapist is having on their family. A goal of FFT therapists is to develop a balanced alliance amongst family members and between therapist and all family members (Sexton & Alexander, 2004). In such, family members' perception of the therapeutic process becomes an important part of therapist treatment fidelity.

Purpose

The study anticipates that FFT, compared to non-completion of treatment, will demonstrate effects of improvement in adolescent and family functioning. The current study also examines the hypothesis that clients receiving FFT from a model adherent therapist have significantly higher levels of family functioning and improvement in adolescent behavior. More specifically, treatment adherence is measured by TAM scores, therapist case experience, therapist rate of clients who drop out of therapy, and clients' perception of their therapists' adherence. The study will investigate whether or not treatment adherence, as measured by variables other than the typical supervisor-rated adherence measure, can predict outcomes of adolescent and family functioning. The assumption is that as the match between the FFT model and its implementation improves, the model is more likely to be sustainable in other locations throughout Ireland and throughout the world.

Research Questions

The study will aim to answer the following questions:

- 1) When FFT is implemented in an Irish context, compared to non-completion of treatment, is there a significant difference in outcomes of adolescent and family functioning?
- 2) How does therapist model adherence predict client outcome?
- 3) Do other variables, adding to a measure of treatment adherence, predict client outcomes?

In sum, this study can advance our knowledge about implementation of evidence-based interventions in other contexts. Not only can this study provide information specifically about the effectiveness of the FFT model in an Irish setting, it can also show what modifications are necessary and the issues that arise when translating evidence-based interventions into

multicultural contexts. This can help researchers and practitioners make informed decisions when developing interventions and treatments that will eventually be used in diverse settings with diverse clients.

More specifically, this study is unique in that it will examine therapist adherence, an important part of international model implementation, and its interaction on client outcomes. Not only will the study be able to shed light on how therapist adherence predicts adolescent and family outcomes, but it will also investigate whether adherence can best be captured by more than one variable. In this case, in addition to TAM ratings, therapist case experience, client dropout rate per therapist, and client perception of therapist adherence will be analyzed in order to determine their interaction on client outcomes in FFT. The aim is that once it can be determined which processes might work together to characterize therapist adherence, clinicians may be able to better know the specific aspects to keep in mind in order to successfully implement an evidence-based intervention, such as FFT, in diverse settings.

Chapter II

Literature Review

The purpose of this chapter is to explore the literature related to the core domains of this study. This study proposes to examine the changes in adolescent behavior and family functioning of clients who received Functional Family Therapy (FFT) in an Irish setting. Five core domains are discussed in the following pages: youth crime in Ireland, the need for family-based treatments, Functional Family Therapy, international implementation of FFT, and the role of treatment adherence in client outcomes of FFT.

Youth Crime in Ireland

The juvenile justice system in Ireland is directed by legislation (Children Act, 1908) that was developed before the creation of the current Irish State. There is new legislation under The Children Act that was put into effect after Irish legislators attempted to respond to the issue of youth crime (Dooley & Corbett, 2002). The main foundation of the Children Act is that detention should be used as a last resort when responding to the issue of juvenile crime. In such, the Children Act maintains the principles of the UN Convention on the Rights of the Child, which states that detention of youth under the age of 18 should be a last resort and for the shortest appropriate time period possible. The Children Act also places emphasis on community-based, non-custodial approaches as alternatives for adolescent offenders, including restorative justice, family group conferences, cautioning, and the strengthening of the Garda Juvenile Diversion Projects (Dooley & Corbett, 2002). For the Children Act to be fully effective and successful as laid out in its development, there needs to be public investments in community services that offer preventative treatments, early intervention, and diversion for adolescent offenders. It also calls for full staffing of social work and child care services, which had been experiencing staff shortages at the time of the Act's development (Dooley & Corbett, 2002).

Despite the Children Act's focus on prevention and alternative treatments for youth offenders, Dooley & Corbett (2002) found that most of the court orders at the time of their research focused on punitive interventions. There also seems to be more of a focus on incarceration over rehabilitation following the Act because of the slow investment in prevention, early intervention, and diversion services. The authors further note that the Minister for Justice, John O'Donoghue, announced plans to open a temporary children's prison for 14 and 15-year old adolescent offenders at St. Patrick's institution, a prison designed for 16-21 year olds. This prison proposal represents a major setback for juvenile justice and is inconsistent with the principles laid out in the Children Act (Dooley & Corbett, 2002)

Ireland's child care and juvenile justice services have seemed to become intertwined due to the lack of appropriate services for adolescents with behavior problems. The failure to provide necessary mental health treatment for these youth with severe emotional and behavior problems has led to the court placing non-offending youth within the juvenile justice system. Unfortunately, youth who have been placed through the courts have been in the care of the government for years and have history of homelessness and a series of inappropriate placements (Dooley & Corbett, 2002).

The National Youth Justice Strategy (NYJS) was established in March of 2008 by the Minister for Children and Youth Affairs at that time, Brendon Smith. The first and primary strategy, covering the period of 2008-2010, established the framework of the implementation of the Children Act, 2001. Also, the strategy has an aim of improving the reduction in youth crime as well as protecting the needs and rights of youth. The strategy sets out to meet five general goals: to provide leadership to boost the public's confidence in the youth justice system, to reduce youth offenses by diverting young people from criminal acts, to increase use of

community programs to deal with youth offenders, to provide safe environments for youth to help in their community reintegration, and to develop research and data sources in the youth justice system to implement more effective policies and interventions (Redmond, 2009).

The second of the NYJS's goals focuses on the Garda Youth Diversion Project (GYDP), which represents a significant investment by the Irish government, with an expectation that the project will make a significant reduction in youth crime in the areas that GYDP is implemented. A baseline analysis of the GYDP began in March 2008 and 96 of 100 projects received a site visit, during in which GYDP staff was interviewed in regards to interventions for youth. Among the questions included in the semi-structured interview of staff, the analysis set out to gain information on patterns of youth crime in the areas serviced by GYDP. Alcohol-related offenses were the single largest category of criminal offenses by youth in Ireland endorsed by staff. According to the An GardaSiochana statistics, alcohol-related offenses represent one-fifth of all juvenile offenses. However, this statistic could increase to almost half of all youth offenses since many offenses could be clustered into the same category of alcohol-related offenses, where alcohol is a factor and part of the offense. The analysis also found that in regards to alcohol-related offenses, most offenses occurred during a small period of hours during the weekend, happens during certain calendar events, and occurred more during the summer. Of important note in the analysis is the significant finding that youth have easy access to alcohol. In geographical regions of Ireland where there are fewer places to purchase alcohol, alcohol use was less frequent and seemed to happen mainly by stealing or youth taking alcohol out of their homes. There were also a number of personal and social characteristics of the youth offenders that mirror the types of risk factors seen in adolescent crime research in the United Kingdom and the United States. Of particular note to this study is the risk factor of ineffective parenting,

which in the GYDP cases, ranges from parents who are working hard to supervise despite their lack of resources to parents who actively participate in the offending behavior. This risk factor becomes important in the design and implementation of interventions, as well as the probable outcomes (Redmond, 2009).

In the analysis of the GYDP, policy makers used research of Farrington and Welsh (2007), as well as Hawkins et al. (2008), which highlight the need for interventions for youth offenders that encourage these youth to have a greater consideration for others, as well as improve parenting and school outcomes. The Head of Young Offender Programmes at the Irish Youth Justice Service, Sean Redmond, recommended the use of evidence-based practices within the GYDP. Specifically, he proposed the provision of practices that improved parenting effectiveness in the families of at-risk youth and suggested that five trial GYDP sites implement these practices. It was his recommendation that these sites were to be regularly reviewed and that key findings be disseminated to all GYDP sites (Browne, 2008)

Family-focused Treatment

A vast amount of research shows that adolescent development occurs within the context of many nested systems, including family influences as well as peer and community influences (Liddle, Rowe, Dakof, Greenbaum, & Henderson, 2009). Given the importance of social contextual factors shaping adolescent development, ecological-contextual intervention models have been recommended for this population (Biglan, 1995). In fact, family-based treatments that target the multiple influences of adolescent functioning are recognized as one of the most promising interventions for substance use and related adolescent behavior problems (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998; Liddle, 2002). Thus, treatment approaches should be focused on including relational contexts and relevant subsystems in which

adolescents' problem behaviors tend to develop (Kazdin & Weisz, 2003). According to Sexton & Alexander (2002), there are three reasons why family-focused treatment is increasing in the field of counseling psychology. First, the issues that may appear to be individual in nature, such as substance abuse, anxiety, and depression, can be successfully treated with family-based treatments (Alexander, Holtzworth-Munroe, & Jameson, 1994; Gurman, Kniskern, & Pinsof, 1986). Second, there are now numerous qualitative and quantitative reviews, clinical trials, and research programs that support the efficacy of family-based interventions. Finally, there is an increasing amount of treatment protocols that have been shown to be successful with families with a wide range of problems, from diverse backgrounds, in a range of different communities. Thus, for adolescent behavior disorders, family-based interventions are now the chosen treatment by clinicians (Alexander & Barton, 1995).

Based on the well-established assumption that family relationships can have a positive or negative impact on child development, family-based interventions aim to decrease negative interactions between family members and to increase protective interactions between family members (Rutter, 2002). Examples of family processes associated with healthy child development are secure attachment relationships, effective parenting practices, and healthy family environments (Cicchetti & Toth, 1998; Cowan and Cowan, 2002; Gottman, Katz, & Hooven, 1996). On the other hand, examples of risk factors associated with unhealthy child development and psychiatric disorders in children and adolescents are parental psychopathology, family conflict, and ineffective parenting practices (Cummings, Davies, & Campbell, 2000). Thus, given the large impact that family can have on child development, family-based interventions have become increasingly popular. Specifically, in the United States, many family interventions have been identified as best practice models in reports produced by the National

Institutes of Drug Abuse and Mental Health, the Office of Juvenile Justice, the Center for Substance Abuse Treatment, and the U.S. Surgeon General (Child Trends, 2002; Mihalic, Irwin, Elliott, Fagan, & Hansen, 2001; National Advisory Mental Health Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001; U.S. Department of Health and Human Services, 1999).

While certain treatments are not identified as family-based interventions per se, children and adolescents can usually only participate with parental support and consent (Weisz, Donenberg, Weiss, & Han, 1995). Interventions such as psychoeducational or cognitive-behavioral treatments may not be effective with young children who typically do not have the cognitive ability to engage in these treatments without parental support (Freeman et al, 2003). Furthermore, adolescents may be able to engage in these treatments, but benefit from the help of parents to overcome treatment resistance and maintain treatment gains (Liddle, 2004).

Empirical support for family-based treatments has developed during the past decade (Liddle et al., 2001; Sprenkle, 2002). In a review of child-focused intervention models funded by the National Institute of Mental Health (NIMH), more than half of the treatments included a family component (Hibbs and Jensen, 1996). Further, development of a relational diagnostic system (e.g. marital conflict) for DSM-V has progressed (Kaslow, 1996). Notably, family-based treatments have been empirically tested for nearly every child and adolescent disorder (Pinsof and Wynne, 1995). Moreover, there have been several meta-analyses that show marital and family therapies being significantly more effective than no treatment and at least as effective as other treatment forms (overall effect size of 0.53) (Shadish and Baldwin, 2002). With all that said, the past decade of research has defined family-based interventions as effective treatment approaches for child and adolescent psychiatric disorders (Diamond and Josephson, 2005).

Reviews of outcome studies have documented the efficacy of family therapy for youth with behavior problems (Alexander, Holtzworth-Munroe, & Jameson, 1994). Specifically, family-based interventions are cited as a treatment of choice for adolescent behavior problem reduction (Brestan & Eyberg, 1998; Elliot, 1998; Friedlander & Heatherington, 1998). Given the strong association between family problems and behavior problems in adolescents, the effectiveness of family-based interventions for adolescents with behavior problems seems obvious (Robbins, Alexander, and Turner, 2000). A number of family factors have been associated with behavior problems in youth, including parental substance use, child abuse and neglect, and inadequate parental monitoring and supervision (Dishion, Andrews, & Crosby, 1995; Kumpfer & Szapocznik, 1998; Steinberg, Darling, Fletcher, Brown, & Dornbusch, 1995). Family interaction patterns has also been found to be associated with adolescent behavior problems, including parents showing less warmth and affection to their children, negative parental communication, and less parental participation in family activities (Alexander, 1973).

Adolescents with behavior problems represent one of the most difficult treatment populations (Henggeler, 1989; Kazdin, 1987). For example, in family therapy, families with delinquent youth tend to present with high levels of conflict that may intensify the family interactions (Alexander, Waldron, Newberry, & Liddle, 1988). Alexander, Barton, Schiavo, and Parsons (1976) found that therapists' skills in a relational context predicted family therapy outcomes. Specifically, these skills predicted whether or not families dropped out of therapy, the adolescents recommitted crimes, and whether or not defensive communications reduced in session over time.

Alexander, Sexton, and Robbins (2002) coined the term family-based empirically supported treatments (FBESTs) to include well-supported systematic treatment programs with a

large amount of both process and outcome research conducted with diverse clients in various communities. So far, a major concentration of FBests has been on the range of adolescent behavior disorders. While they are different from each other in many ways, the FBests for adolescent behaviors all combine specific treatment protocols developed using realistic client populations in actual clinical settings with ongoing program evaluation (Alexander et al., 2002). In their article, Sexton and Alexander (2002) highlight four interventions that meet these FBest criteria: Functional Family Therapy (FFT) (Alexander & Parsons, 1973), multidimensional family therapy (MDFT) (Liddle, 1991, 1995), multisystemic therapy (MST) (Bourdine, Henggeler, Blaske, & Stein, 1990), and structural family therapy (Szapocznik & Kurtines, 1989). These FBest treatment models that have focused their approaches on adolescent behavior disorders, delinquency, substance abuse, and family conflict. FFT and MST have the most comprehensive research programs and therefore, serve as the best example of systematic treatment models for adolescent-behavior disorders (Sexton & Alexander, 2002).

Functional Family Therapy

Functional Family Therapy (FFT) has been described in the literature as a systematic clinical model that evolved from a process of model integration (Alexander, Sexton, & Robbins, 2002). Thus, instead of being explained from any one theoretical orientation (i.e. behavior, multisystemic, interpersonal), it is based on theoretical principles from these models, which have been essential to its maturity since its development in 1969. FFT developed out of a need to serve a population of at-risk youth and families. The founders of FFT aimed to help this underserved population by focusing on understanding why they presented so many clinical challenges and why other interventions had not been successful in helping them. Thus, the early contributors to FFT set out to develop a innovate set of ideas and techniques that would decrease

this population's resistance, motivate them through interventions, reduce negativity, and instill hope. Further, FFT is based on the premise that the techniques used to motivate families would be based on each individual family's values, beliefs, and ideas (Sexton & Alexander, 2004).

At the time of FFT's development, clinical interventions did not provide any understanding of family functioning or clinical change with regards to the dysfunctional youth population. Therefore, it became important to develop a clinical model or "roadmap" that would guide practice (Sexton & Alexander, 2004). The basis of FFT heavily relied on the work of early communication theorists, by explaining the idea that behavior has meaning only within the context of relationships (Alexander & Parsons, 1982). As the model continued to develop, cognitive theory, specifically attribution and information processing theories helped to explain the meaning and emotions involved in blaming and negativity in family interactional patterns (Jones & Nisbett, 1972; Kelly, 1973; Taylor & Fiske, 1978). Most recently, social constructionist ideas have contributed to FFT through a focus on the constructed nature of problems in regards to reducing family negativity and creating organizing themes in therapy (Gergen, 1995; Friedlander & Heatherington, 1998). Although FFT is an integrative model, it is a systematic treatment protocol that has clearly articulated intervention phases, phase goals, mechanisms of change, therapists' skills, and desired outcomes (Sexton & Alexander, 2005).

FFT has always been informed by scientific inquiry, sought to explain the process and outcomes of the model (Sexton & Alexander, 2005). Specifically, process studies have helped to inform the specific clinical mechanisms included and the model (Alexander, Barton, Schiavo, & Parsons, 1976). On the other hand, outcome studies suggested that when clinicians adhere to the FFT principles and techniques, FFT was applicable across an even wider client population, in diverse settings, with real therapists, and in local communities (Barnoski, 2003; Sexton, Mease,

& Holliman, 2003). The program developers believed that while theory and beliefs were critical for understanding complex clinical problems, there also needed to be some level of feedback and accountability. In such, FFT, based on belief that clinicians should no longer use interventions that do not help the clients we intend to serve, has always been informed by evidence from scientific inquiry (Sexton & Alexander, 2004). Early clinical trial studies established FFT as an effective intervention with a variety of offending adolescents (Alexander & Parsons, 1973; Klein, Alexander, & Parsons, 1977). Process studies at the time of FFT's inception attempted to identify the mechanisms that made FFT successful. The outcomes of these studies indicated that family negativity effected engagement and motivation (Alexander, Barton, Schavio, & Parsons, 1976) and that therapist gender was related to both the rate and quantity of speech of family members (Mas, Alexander, & Barton, 1985). There was a second wave of clinical trials that focused on the effectiveness of FFT with different populations in different settings (Barton, Alexander, Waldron, Turner, and Warburton, 1985; Sexton, Ostrom, Bonomo, & Alexander, 2000). Most recently, studies have focused on clinical techniques in FFT (Robbins, Alexander, Newell, & Turner, 1996), the effect of alliance on client retention (Robbins, Mayorga, & Szapocznik, 2003), and the effect of therapist model adherence on outcomes (Sexton, 2002).

These long-term, independently replicated series of outcome and process studies led to 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 the prevention of delinquency (Alverado, Kendall, Beesley, & Lee-Cavaness, 2000). Moreover, the Center for the Study and Prevention of Violence (CSPV) reviewed over 500 programs and interventions and selected FFT as one of the eleven "Blueprint" programs (Elliott,

1998). Further, FFT is an evidence-based intervention model that meets all of the current benchmarks of empirically-validated treatments (Sexton & Alexander, 2002).

FFT has shown outcomes in many settings with a wide range of diverse clients. Particularly, these outcomes have focused on the range of behaviors associated with adolescent externalizing behavior disorders, the engagement and retention of youth with difficult problems and the reduction of dropout, and the cost-effectiveness of FFT. Thirteen published, clinical trial studies of FFT indicate that it is effective in reducing recidivism between 26% and 73% with offending, moderate, and seriously delinquent youth as compared to no treatment and typical juvenile court probation services (Alexander, Pugh, Parsons, & Sexton, 2000). These positive outcomes remain stable at follow-up times as long as five years (Gordon, Arbuthnot, Gustafson, & McGreen, 1988). Further, the positive outcomes of FFT also affect siblings of the identified adolescent (Klein, Alexander, & Parsons, 1997). While recidivism was typically used as the dependent measure in these outcome studies, a community-based effectiveness study of violent and substance abusing adolescents in a large urban setting found that adolescents who received FFT has lower recidivism rates and also committed significantly fewer crimes that were less severe (Sexton, Ostrom, Bonomo, & Alexander, 2000). A number of studies have identified the engagement rates of families in FFT as compared to other interventions with externalizing behavior disorder problems. The outcomes suggest that FFT is successful in engaging between 78% to 89% in settings where FFT was delivered by community-based therapists (Sexton & Alexander, 2004). Finally, Sexton and Alexander (2000) found FFT to be \$5000 less costly per case than an equivalent juvenile detention intervention, and \$12,000 less costly than residential treatment. Further, the State of Washington found that FFT had the highest cost savings when

compared to other juvenile delinquent programs, noting a cost savings of \$13,908 (Aos & Barnoski, 1998).

The FFT model is one that is both structured with a treatment protocol, while also one that is creative in order to produce complex therapeutic change. The manualized clinical procedures provide a ‘map’ with process stages through which therapy progresses. The procedures provide detailed goals, along with specific targets of family interaction on which to focus during the different stages of therapy. The three phases of the FFT treatment program are Engagement and Motivation, Behavior Change, and Generalization (Sexton and Alexander, 2005).

The Engagement and Motivation phase begins with the first contact between the therapist and family, as the therapist attempts to involve the family in the activities of the session, such that they are interested in taking an active part in the therapy. The goals of this first phase are to reduce negativity and blame between family members, develop a family focus of the problems defined by the family, and develop alliances between both therapist and family members and between all family members. The engagement and motivation phases is successful when family members begin to believe that each family member may contribute to the family problem and all family members share in the family’s emotional struggle. During this phase, the FFT therapist uses reframing as the primary counseling intervention in order to deliver an alternative perspective of the client problem in hopes of producing change. Moreover, in FFT, reframing serves as an ongoing technique in order to validate the client’s perspective of the problem, while reattributing possible alternative motivations and contributions. The ultimate goal of reframing in FFT is to reduce negativity in blame in a way that develops alliance and highlights family members’ responsibilities in the problems. The reframing process always

includes validation, which aims to support the family members by showing understanding and respect for their perspective on their family and the problem. Finally, reframing statements are followed by the therapist assessing for their impact, incorporating changes or alternative ideas into the next reframing statement if needed. Thus, reframing serves as a constant loop of therapist and family member interaction that works together and builds upon each other toward the therapeutic goal. The reframing process helps to begin the development of a theme that explain the family problems and organize targets for future behavior change (Sexton & Alexander, 2005).

Once the goals of the engagement and motivation phase are reached, the therapist begins to focus on changing behavioral skills of the family in the Behavior Change phase of FFT. Specifically, the therapist focuses increasing family members' abilities in tasks such as communication, supervision, problem solving, and parenting that contribute to family functioning. A main goal of this phase is to build family protective skills that may help to avoid factors that put the family and adolescent at risk. The focus is on primary activities associated with risk factors known to contribute to problems of adolescent externalizing behaviors, including rewards and punishment, family communication, and negotiation of limits and rules. Moreover, this phase focuses on strengthening protective behaviors, such as family bonding, validation, problem-solving and conflict management. Extensive literature on risk and protective factors for externalizing behaviors in adolescents shows that behavior targets in this FFT phases are common regardless of the initial family presentation. Although these behavior change targets are similar between families, the way in which those changes are made must be unique to the family relational functioning. Thus, in one family the implementation of behavior change might

take a different form than another family depending on the family hierarchy and connectedness of family members (Sexton & Alexander, 2005).

The final phase of FFT, the Generalization phase, has a goal of generalizing, maintaining, and supporting the changes that the family has made during the behavior change phase.

Generalization takes place both within the family and between the family and systems around them (i.e. schools, community, and extended family). During this final phase of treatment, the therapist helps the family generalize changes that have occurred in the first two treatment phases to other areas of family functioning that have not been addressed. The therapist also works to help the family maintain these changes by predicting the ‘ups and downs’ of the change process. Specifically, the therapist helps to normalize family problems that may occur in the future and reminding the family members of their newly acquired skills and their ability to overcome future problems in different situations. Finally, the therapist supports the family changes by integrating necessary community resources and working to avoid any negative effects of community systems that may prevent positive change (Sexton & Alexander, 2005).

International Implementation

While FFT has emerged as a preferred treatment approach for adolescent behavior problems (Sexton & Alexander, 2002), there still seems to be a gap between research and practice, and specifically, a complete understanding of how to effectively implement evidence-based family therapies into clinical practice (Duncan, Davey, & Davey, 2011). The growth of evidence-based practices (EBPs), including FFT, has made major changes in the way that clinicians operate, criteria from which policy holders select programs and treatments, and the accountability of programs and interventions (Sexton, Gilman, & Johnson-Erickson, 2005).

However, a limitation of these current family and evidence-based programs, like FFT, is the ability to successfully implement them into community-based practice settings.

Duncan, Davey, and Davey (2011) conducted a study to identify facilitators and barriers of the implementation of FFT into community-based settings. They used translational research (Tashiro & Mortensen, 2006) and the Diffusion Innovation Model ([DIM] Rogers, 1983) to examine the experience of implementing FFT from the perspectives of administrators, therapists, and supervisors, in different community agencies. Translational research focuses on the amount of time it takes to disseminate findings of research and then applying them into a practice setting (Tashiro & Mortenson, 2006). Further, the DIM highlights guidelines for the transportability of new interventions or programs into community-based settings. The model was developed by Rogers (1983) and involves developing an innovative idea for an intervention, communicating information about the idea, deciding to adopt the program, and then learning how to use the new program. Their study revealed that expert panelists in the study reached consensus on four facilitators of implementing FFT into their agencies: collaboration, training, agency readiness, and funding source expectations. Specifically, the panelists suggested that the hands-on training in the FFT model was helpful for all levels of staff (Duncan, Davey, & Davey, 2011).

When considering the transportation of American evidence-based treatments to another country, an obvious concern is whether or not these models can be successfully transported to cultures other than those in which they were developed. Specifically, the concern is whether or not the manualized treatments will be culturally sensitive enough that they can be used in other mental health systems of other cultures with different values and assumptions. It is also necessary to know whether or not these evidence-based treatments can be transported by the staff and organizations in culturally diverse settings (Breuk et al., 2006). These concerns are similar

to those related to transporting evidence-based programs to community settings with diverse clients in the U.S. In such, Hoagwood (2005) states that one of the major barriers to successful adoption of evidence-based practices is the lack of knowledge about implementation.

In different cultures, there are different treatments and systems of care, which further complicates the adoption of evidence-based practices. The current research suggests that a small number of family-based interventions are the most successful with difficult adolescent behavior problems (Kazdin, 1997; Kazdin & Weisz, 2003; Sexton, Alexander, & Mease, 2004). However, in Ireland, services for adolescents are typically provided within traditional mental health treatment programs for adolescents with both externalizing behaviors and other mental health issues. Thus, because of the cultural assumptions about traditional, individually-focused treatment, the adoption of a family-based intervention program can pose a major challenge (Breuk et al. 2006). Liddle, Rowe, Quille, Dakof, Mills, Sakran, and Biaggi (2002) found a successful implementation of Multidimensional Family Therapy (MDFT) in an American-based treatment setting in which systematic training of therapists resulted in sustained provision of family-based treatment. There are also important concerns about the cultural barriers to the implementation of evidence-based practices. Specifically, there is increasing concern as to whether or not evidence-based practices are individualized enough to meet the needs of various cultures (Hoagwood, 2005).

An intervention program like FFT is well-suited for international implementation as one of its core principles is ‘matching to’ the unique family system (Breuk et al., 2006). Within this principle is the idea that each individual should be viewed as unique and part of a larger family context, which has its own particular values, traditions, and norms. This allows the therapists to adhere to the goals and principles of the FFT clinical model, but do so in a flexible way that

meets the family where they are and fits within individual and family norms (Sexton & Alexander, 2004). Matching to the client lets the FFT therapist respect, value, and meet FFT goals within important cultural, racial, religious, and gender-based values of the family. This helps the therapist to avoid imposing their own biases, value systems, and needs on the youth and family. Thus, treatment goals are individualized for each family and the way in which they live their life (Sexton, 2005- handbook)

Further, FFT has been successfully implemented in many community settings that are characterized by being diverse, representing rural and urban settings with culturally diverse clients and therapists (Breuk et al., 2006). In addition, research about therapists' ability to conduct FFT with model adherence suggest that it can be taught, replicated, and provided by staff in an effective way. Without successful implementation, the clinical value of any treatment model may not be recognized (Breuk et al., 2006). The implementation of FFT is based on direct training by the model developers (Alexander & Sexton, 2002), further training and consultation by a trained FFT consultant, and on-going supervision by an FFT expert (Alexander et al., 2000).

Treatment Adherence

The provision of effective treatment interventions for youth relies on understanding the mechanisms through which change occurs with children and adolescents (Kazdin & Kendall, 1998). Identifying what works in these effective treatments becomes important so that these "active ingredients" can be further improved to enhance therapy outcomes (Weisz, Huey, & Weersing, 1998). Even when there are poor outcomes in treatment, attention to change mechanisms is important. Poor outcomes may be a result of important moderating or mediating effects, or a failure of the therapist to adhere to the treatment as intended (Huey, Henggeler, Brondino, & Pickrel, 2000). There has been significant emphasis on the issue of change

processes in the adult psychotherapy literature, highlighting the need for more attention to these mechanisms in mental health treatment for youth (Lambert & Bergin, 1994). In such, only few studies have explored the role of treatment fidelity and its effect on treatment outcomes for children and adolescents (Hogue, Liddle, & Rowe, 1996).

While the use of evidence-based interventions has increased, the field has shifted its focus on the dissemination of these evidence-based interventions into community settings, and to the factors that explain successful implementation (Silverman, Kurtines, & Hoagwood, 2004). One factor that researchers have found to be critical for successful dissemination is treatment fidelity (Elliott & Mihalic, 2004). Treatment fidelity has often been understood as “therapeutic accountability” (Yeaton & Seachrest, 1981). Treatment fidelity can be explained by both a therapist’s ability to adhere to a treatment protocol, as well as the level of competence with which he or she implements the protocol (Martino, Ball, Nich, Frankforter, & Carroll, 2009).

According to Lambert and Bergin (1994), treatment fidelity is a basic component of contemporary psychotherapy. Treatment fidelity consists of both treatment integrity and treatment differentiation (Waltz, Addis, Koerner, & Jacobson, 1993). Treatment integrity, or treatment adherence, is the degree to which therapists implement the central theoretical aspects and procedures of a given treatment model. Thus, treatment integrity becomes necessary for the replication and transportability of therapy models (Yeaton & Sechrest, 1981). The other aspect of treatment fidelity, treatment differentiation, refers to the degree to which different treatment conditions actually differ as intended in efficacy research. Treatment fidelity, in particular, is significant for studies about manualized treatments, which are intended to assist with internal consistency in the delivery of interventions (Lubrosky & DeRubeis, 1984). To date, adherence and competence are the two aspects of treatment fidelity that have been discussed the most in the

literature (Waltz, Addis, Koerner, & Jacobson, 1993). Adherence refers to the extent to which a model is delivered as prescribed and competence refers to the quality or skill with which the therapist delivers the intervention (Hogue et al., 2008).

Research on treatment adherence is becoming a major focus of treatment dissemination. There is some evidence indicating that fidelity to evidence-based interventions may be crucial for effective outcomes in real world settings (Hogue, Dauber, Barajas, Fried, Henderson, and Liddle, 2008). For example, Henggeler, Pickrel, Brondino (1999) found that adherence to multisystemic therapy (MST) for delinquent adolescents was poor when therapists used the model without continuous supervision from MST experts. Further, poor adherence was correlated with worse outcomes, compared to previous efficacy studies. Additionally, Morgenster, Morgan, McCrady, Keller, and Carroll (2001) found that therapists trained in cognitive-behavioral therapy (CBT) for adult substance abuse could reach adherence and outcome goals set by researchers and therapists with no additional training could reach the same outcome goals. Thus, it seems highly important that adherence issues remain a priority for treatment developers, administrators, and policymakers (Hogue et al., 2008).

There have been many studies that have found adherence to treatment models to be an important predictor of clinical outcomes, specifically in community settings (Henggeler et al., 1999; Hogue et al., 2008; Huey, Henggeler, Brondino, & Pickrel, 2000; Schoenwald, Henggeler, Brondino, & Rowland, 2000). However, there is still a need for more research on the role of adherence in community replication trials of family-based treatments (Sexton & Turner, 2010). In a few cases, there is evidence linking treatment adherence to outcomes in family-based therapy (Henggeler et al., 1999; Huey et al., 2000; Schoenwald, Henggeler, Brondino, & Rowland, 2000), however, treatment adherence is not always linked to successful outcomes

(Sexton & Turner, 2010). Barber, Sharpless, Klostermann, and McCarthy (2006) and Hogue et al. (2008) state that being too lax or too strict when adhering to a treatment model can limit a therapist's effectiveness.

Evaluation of treatment adherence aims to determine which parts of a given therapy model are implemented by therapists as laid out in theory. This type of evaluation can shed light into what works and doesn't work in treatment model delivery, as well as practical guidelines for implementing treatments with various client populations (Hogue, Turner, LaPann, Liddle, Rowe, and Dakoff, 1998). Therefore, treatment adherence evaluation serves as an important phase of effective treatment development (Kazdin, 1994). Several areas of individual psychotherapy, including cognitive-behavioral therapy, brief psychodynamic models, and interpersonal therapy have all produced adherence research that has helped strengthen treatment integrity (DeRubeis, Hollon, Evans, & Bemis, 1982; Shapiro & Startup, 1992; Rounsaville, O'Malley, Foley, & Weissman, 1988). It is now common for studies to highlight procedures for monitoring treatment adherence and evaluate the level of adherence reached. Adherence research studies, or studies that make treatment adherence evaluation the centerpiece of the study, explore a range of issues: identifying manualized treatments (Butler Henry, & Strupp, 1995), adherence gains through manual-driven therapist training (Multon, Kivlighan, & Gold, 1996), the relationship between adherence and client outcome (DeRubeis & Feeley, 1990), and respective impact of adherence and therapist competence on outcome (Barber, Crits-Christoph, & Luborsky, 1996).

Hogue et al. (1998) conducted a study to demonstrate the specific strengths and limitations of adherence evaluation with a family therapy model. The researchers used adherence process methodology to evaluate the fidelity of two treatments of adolescent substance use and externalizing behaviors. The two treatments, dynamic cognitive-behavioral therapy

(DCBT; Turner, 1991) and multidimensional family therapy (MDFT; Liddle, 1991) have treatment manuals based on clear principles that allow for flexible implementation of techniques to meet each specific case (Havike & VandenBos, 1996). This particular study used observational ratings that measured the frequency and thoroughness of therapeutic interventions used by therapists during session. Results showed that therapists in the DCBT condition were adherent to the structuring techniques outlined by the model and put less emphasis on interventions that were based in psychodynamic and cognitive approaches. One explanation for this could be that therapists in the DCBT condition were less competent in adhering to the treatment manual than were therapists in the MDFT condition. Although, it could be that DCBT therapists made appropriate adjustments in delivering the treatment to meet the specific clinical needs of the population. Therapists in the family therapy condition were more inclined to use emotionally focused interventions, such as establishing a supportive environment in therapy and encouraging the expression of emotion in session. All in all, the findings of the study suggest that integrative treatment approaches can be successfully implemented in a differentiated way with adolescent substance abusers. The family-based model stressed affective elements and the individual model emphasized behavioral elements. Researchers note that the differences in therapeutic focus between the family and individual models may not be differentiated with other client populations or approaches, and that successful model implementation does not guarantee positive outcome (Hogue et al., 1998). Most importantly, the results of the study show that treatment adherence process research can be conducted with family-based approaches. This furthers the efforts to establish stronger empirical support for family therapy modes, a crucial step to strengthen a mode of therapy that is commonly used by therapists in the treatment of a

variety of clinical problems (Kazdin, Siegel, & Bass, 1990; Diamond, Serrano, Dickey, & Sonis, 1996).

In a study conducted by Henggeler, Melton, Brondino, Scherer, & Hanley (1997) on the role of treatment fidelity in the dissemination of Multisystemic Therapy (MST), findings showed that when fidelity is not taken into account, there are minimal therapeutic effects on outcomes. However, when treatment fidelity is considered, the effects of MST are consistent with other trials that included weekly supervision procedures to enhance treatment fidelity. Specifically, therapist adherence to the MST treatment principles was an important predictor for outcomes related to adolescents' criminal activity and recidivism at 1.7-year follow-up. When parents and adolescents rated their therapist as adhering to MST principles, this predicted low rates of rearrest. Moreover, therapist ratings of treatment adherence predicted a decrease in criminal offenses and a low probability of incarceration. Therapist adherence to MST principles has also been correlated with improved family functioning and successful treatment completion (Huey et al., 2000; Schoenwald et al., 2003)

Few studies have explored the role of treatment adherence and its effect on child treatment outcomes (Henggeler, Pickrel, & Brondino, 1999; Schoenwald, Henggeler, Brondino, & Rowland, 1999), and even fewer have examined the impact of multiple, interrelated change processes on psychotherapy outcomes (Huey, Henggeler, Brondino, & Pickrel, 2000). Huey et al. (2000) aimed to address the gap in the research by exploring therapist and contextual pathways through which multisystemic therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998) reduces delinquent behavior. MST therapists adhere to a set of nine principles in order to reduce problem behavior by creating change in the multiple systems in the adolescents' lives. A major assumption in MST is that fidelity to the treatment protocol is

necessary to achieving therapeutic change. Thus, outcomes should directly relate to the degree to which therapists adhere to the treatment principles (Huey et al., 2000).

Measurement of Treatment Adherence

Measurement of therapist adherence in terms of therapist behavior during therapy sessions can be done in various ways, but typically involves evaluating the therapist's adherence to a model or protocol. The measurement may also involve an evaluation of the level of skill with which the intervention is implemented (Ellis, Weiss, Han, & Gallop, 2010). As various researchers have noted in their work, treatment adherence is not a unitary construct and could be best explained by various perspectives (Dobson & Shaw, 1988; Moncher & Prinz, 1991). For complex interventions such as MST or FFT, in which the protocol allows for flexibility to fit the individual needs of each family, the multilayered nature of adherence may be most applicable. That is, adherence for complex treatment models may need to differ considerably based on the varying perspectives of treatment participants (Huey et al., 2000). Due to this idea, Huey et al. (2000) conducted a study that aimed to improve typical ways of evaluating treatment adherence by asking caregivers, adolescents, and therapists to rate how well therapists were adhering to MST during sessions. Results indicated that the factor structure of adherence differed considerably depending on who rated the therapist adherence, indicating that informants had distinct ideas about how adherence should be understood. Some researchers argue that therapist adherence is best measured through objective ratings of session samples (Elkin, Pilkonis, Docherty, & Sotsky, 1988). Thus, there is more of a need to measure therapist adherence to child and family treatment models by the perspectives of multiple informants with objective observers as well (Huey et al., 2000)

The Therapist Adherence Measure (TAM) is an observational coding method used by FFT supervisors to rate FFT therapist adherence. While this method can add the accuracy of a more objective assessment, it is limited in that the FFT supervisors do not observe therapists in every session and are not able to measure clinical progress of the case across treatment. This may limit their ability to have fully-informed assessments of therapist competence (Barber, Sharpless, Klostermann, & McCarthy, 2007). Also, the TAM scores for the current study were averaged across sessions. This may hamper the possibility of measuring change in adherence across sessions, which somewhat ignores the ‘learning curve’ in therapists’ trainings (Crits-Christoph, et al., 2008).

There have been few studies that look at whether or not competence predicts outcome (Hogue et al., 2008). That is, there is little research about how the therapists’ skill in delivering a given intervention may affect outcome. The lack of research in this area may be a reflection of the difficulties in developing a clinically valid assessment of therapist competence. In order to assess competence, one would have to not only judge the skill of the therapist in delivering a model, but also measure the appropriateness and timing of interventions, and the degree the therapist responds to client behaviors (Stiles, Honos-Webb, & Surko, 1998). Thus, assessment of competence needs to be grounded in careful understanding of both the client and therapeutic context. (Hogue et al., 2008).

Further, studies have found that therapist adherence increases when therapists are working with academically and economically disadvantaged families. Thus, higher adherence is associated with families with adolescents that have healthy psychosocial functioning and with adolescents who are referred for substance abuse or other offenses, but adherence is lower for families with adolescents who exhibit severe antisocial behavior (Schoenwald et al., 2003).

These findings suggest that other factors, such as client and family factors, influence therapist adherence. Ellis, Weiss, Han, & Gallop (2010) conducted a study to examine various caregiver factors that potentially could influence therapist adherence to the MST treatment model. Results showed that parent factors, along with therapist factors, are significantly related to adherence.

Summary

In sum, the review of the literature lends itself to a logical argument that provides a theoretical framework from which this study operates. The problem of youth crime in Ireland forced legislators and policy makers to examine the existing interventions that address the issue. An analysis of the juvenile justice system provided insight into the types of crimes being committed and the fact that parental involvement, and lack thereof, can support or hinder improvement in adolescent functioning. Legislators then recommended evidence-based practices, particularly those that target parental involvement, for intervening with adolescents in the youth justice system. Since FFT has been proven efficacious with a variety of adolescent problems and has been implemented in over 300 community sites in the United States and four international settings, its translation into an Irish setting was a logical choice for targeting adolescent and family functioning, as well as reduction in youth crime. Additionally, the review of literature about treatment model adherence revealed the importance of adherence in effective model implementation. Specifically, researchers have examined typical ways of measuring therapist adherence and various factors that should be considered in this measurement. The literature that was reviewed provides evidence and rationale for the next step of studying the implementation of FFT in Ireland, how therapist adherence predicts outcome, and new variables that could be considered in measuring FFT treatment model adherence.

Chapter III

Methods

This study examines whether or not Functional Family Therapy (FFT) when implemented in an Irish setting, leads to an improvement in adolescent and family functioning, compared to non-completion of treatment. This study also examines how therapist adherence to the FFT model predicts outcome and if there is another way that therapist adherence could be better captured. FFT was implemented through a family therapy center in Clondalkin, Ireland as part of an initiative to bring evidence-based interventions to Ireland in order to reduce youth crime. This chapter contains the methods that were used to address the three aims in the study: to examine the outcomes of FFT in Ireland compared to non-completion of treatment, assess the interaction of therapist adherence on FFT outcomes, and evaluate other ways of measuring therapist adherence. Research Design, participants, procedures, measures, and data analysis will be discussed.

Research Design

Sixty juvenile offenders that were sentenced to probation services received FFT services with their families. Data from 20 other families who dropped out of treatment was collected as a comparison group. Both the FFT treatment and dropout groups completed pre-treatment measures. The FFT treatment group completed measures at the completion of treatment and the dropout group completed measures following the FFT treatment time period. Researchers contacted families in the dropout condition via telephone to complete two post-measures: the Strengths and Difficulties Questionnaire for Parents (SDQ-P) and the Counseling Outcome Measure for Parents (COM-P). Thus, these two measures were used to compare the outcomes between groups from the beginning of treatment until the time period when the dropout condition families were contacted. Since a central tenet of FFT is that adolescent problem behaviors are a

result of dysfunctional family processes, the hypothesis is that FFT, when compared to non-completion of treatment, will be more effective in improving adolescent and family functioning (Sexton & Alexander, 2004). A supervisor-rated measure of therapist model adherence was also used to test the variance in outcome of the FFT treatment group due to therapist adherence. In our examination of therapist adherence, we hypothesize that as adherence increases, adolescent and family functioning will also improve.

Participants

The study involved 9 therapists and 80 families in one treatment setting. Juvenile offenders became a part of this study because they were sentenced to probation for a criminal offense. Treatment data was collected for 60 families that completed treatment. Of the adolescents in the FFT treatment condition, 39 (65%) were male and 21 (37%) were female. The ages of the adolescent participants ranged from 10 to 17 (age 10 = 5.7%, age 11 = 7.5%, age 12=11.3%, age 13= 9.4%, age 14= 13.2%, age 15= 22.6%, age 16= 13.2 %, and age 17= 17 %), the ethnicity of the families in the population ranged from White Irish (93.3%), White Romanian (1.7%), White Zimbabwean (1.7%), to Bi-Racial Irish (1.7%). Furthermore, there was a wide range of problems for which adolescents were referred to treatment from their probation officers, including family relationship problems (50%), school problems (36.7%), parenting issues (5%), crisis (1.7%), mood disorders (1.7%), anxiety problems (1.7%), substance abuse problems (1.7%), and situationally precipitated problems (1.7%). Adolescents either lived with both parents (40%), only their mother (43.3%), only their father (3.3%), mother and stepfather (10%), or other relatives (3.3%). Most of the participants (55%) were from Clondalkin and the rest of the participants represented 12 other surrounding cities. While the population of research participants in the treatment condition is not necessarily diverse in terms of ethnicity, it is quite

representative of the larger population in Ireland and provides clear insight into outcomes of FFT in this context.

Treatment data was also collected for the dropout group. Of the 20 adolescents in the dropout condition, 11(55%) were male and 9 (45%) were female. The ages of adolescent participants ranged from 12 to 18 (age 12 = 5%, age 13 = 15%, age 14=20%, age 15= 25%, age 16= 10%, age 17= 20%, and age 18= 5 %) and the ethnicity of the families in the population ranged from White Irish (95%) to Nigerian (5%). There was a wide range of problems for which the adolescents were referred to treatment, including family relationship problems (50%), school-related problems (20%), involvement in juvenile justice system (20%), and behavior problems (5%). The average number of sessions that families in the dropout condition completed is 5.55. Of the 20 families that did not complete treatment, 12 families dropped out of treatment during the first phase of treatment and 8 dropped out during the second phase of treatment. Of those 8 families that dropped out during the second phase, three families dropped out at after 6 sessions, two dropped out after 7 sessions, one dropped out after 13 sessions, and two dropped out after 14 sessions. It is important to note, however, that the amount of time spent in each phase of FFT greatly differs from family to family. The families that dropped out of treatment during the second phase of FFT may have been particularly challenging to engage and could have spent a majority of their sessions in the first phase of treatment. Nonetheless, in order for a family to be considered a ‘non-completer’, the individual therapist had to identify the case as a dropout.

There were nine total therapists that conducted FFT in this study. All of the therapists were White and most of them were Irish natives (7=Irish, 2=American). Of the nine therapists, seven of those therapists began treatment for families that were non-completers and were in the

dropout condition. All of the therapists have degrees in a mental health discipline and are members of professional associations, including Psychological Society of Ireland and the Irish Association of Counselors and Psychotherapists. Of the nine therapists, 6 were female and 3 were male. The therapists' counseling experience prior to this study ranged from 2 to 11 years. Therapists were divided into three groups based on their years of clinical experience (low=1-2 years, medium=3-5 years, and high=over 5 years). All of the therapists received clinical training in FFT and had been conducting FFT for at least a year at the point of data collection. Each of the FFT therapists received specific training and supervision according to the current FFT training manual (Sexton & Alexander, 2004; Sexton, 2010). The method for training and supervision according to the manual includes clinical training, follow-up training, and ongoing supervision. All of the therapists involved in this study participated in an international training program, involving monitoring by FFT experts in order to ensure that therapists were delivering the treatment as intended by the model.

Procedure

Service delivery data from the FFT Quality Improvement System (FFT Q-System) was analyzed of 60 families that were seen for FFT therapy at the Families First Centre between September 2007 and October 2010. In addition, data was gathered and analyzed from 20 different families that began FFT services, but dropped out of treatment during the first two phases of FFT. Of the 20 families in the dropout condition, 14 of those families began treatment during 2007 and 2010, and 6 of the families began treatment between November 2010 and December 2011.

Dropout Condition. Participants in the dropout condition received probation services and were assigned to receive FFT treatment services with their families. These 20 families

began FFT services between September 2007 and December 2011, and then dropped out of services during the first or second phase of FFT. Demographic data was maintained in the FFT Q-System for all of the dropout families, while maintaining confidentiality through unique IDs for each family. Participants completed pre-treatment measures (Time 1) before receiving FFT services, but therapist adherence (TAM) or counseling process (CPQ) data was not collected for these families. Upon completion of the FFT treatment, researchers contacted 20 families that had dropped out of services in order to complete the COM-P and SDQ-P post-treatment measures for follow-up data. Researchers contacted these families over the telephone between 9 and 46 months ($M=23$ months) after Time 1 data was collected and gathered answers to the items on the follow-up measures.

Functional Family Therapy. Data was collected of 60 adolescents and their families who received FFT services at the Families First Centre in Clondalkin over a 37 month period with an average amount of 17.4 sessions. The range of treatment duration for all families in the study spanned from two months to 14 months. The families spent an average of 6.6 sessions in the engagement and motivation phase of FFT, 6.5 sessions in the behavior change phase, and 4.4 sessions in the generalization phase. Archival data collected from both parents and adolescents at initial (Time 1) and final (Time 2) therapy sessions was analyzed.

Measures

Strengths and Difficulties Questionnaire (SDQ). The SDQ is a brief, self and parent-report behavior screening questionnaire for adolescents aged 11-16 years old. It is a measure of overall social, emotional, and behavioural functioning. The instrument includes 25 items that yield a total problem score and separate scores for emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behaviors (Goodman,

Meltzer & Bailey, 1998). All items have a three-point response format (0=not true, 1=somewhat true, 2=certainly true). A higher score on the SDQ indicates the experience of greater problems. Specifically, on the parent measure, an overall total score between 0-13 indicates average scores that are most likely not revealing of clinically significant problems, a total score between 14-16 is slightly raised and may reflect clinically significant problems, and a total score between 17-40 is indicative of a high risk of clinically significant problems. Moreover, on the adolescent measure, a total score between 0-15 indicates average scores, a total score between 16-19 is slightly raised and may reflect clinically significant problems, and an overall score between 17-40 reveals a high risk for clinically significant problems.

Since its development, the SDQ has become the most widely used research measure related to mental health of children and adolescents, detecting externalizing and internalizing behaviors, prosocial behaviors, and environmental and contextual influences in the adolescents' life (Barnes & Cheng, 2006; Peskin, Tortolero, Markham, Addy, Baumler, 2007; Vostanis, 2006).

The SDQ has been tested in various cultural contexts, schools, and clinical populations. The majority of studies of the SDQ have supported its five-factor structure in different populations. For instance, the five-factor structure was tested and supported for children and adolescents in Australia, showing moderate to strong internal reliability and moderate external validity. Similar results have been found in Germany, the Nordic countries, South Europe, Brazil, the Middle East, Asian countries, and African countries (Vostanis, 2006).

Since its development, the SDQ moved from its original use as a rating scale to a component of assessment packages for treatment purposes to its use as a measure of outcome studies. While the SDQ was not originally developed as an outcome measure, the predictive

validity of the SDQ has been supported by recent research. Notably, the SDQ is most often used with a number of other tools as an outcome measure in order to measure change (Vostanis, 2006).

Pre-treatment SDQ data was collected on all of the cases in the current study upon start of FFT treatment. In order to show how the implementation of FFT affected SDQ scores, all 80 families completed a post-treatment SDQ-Parent (SDQ-P) measure. However, the 60 families in the FFT treatment condition completed the SDQ measure as they completed FFT services. The 20 families in the dropout condition, on the other hand, verbally gave answers to the post-treatment SDQ Parent (SDQ-P) measure via telephone for follow-up data. It was hypothesized that there will be a larger improvement in SDQ scores for the families in the FFT treatment condition compared to families in the dropout condition. Thus, there is data for all 80 families on total SDQ-P scores, as well as the five individual subscales.

Counseling Process Questionnaire (CPQ). The CPQ is a 19-item self-report measure that is completed by family members who are present in therapy, through which they rate their experiences in treatment with an FFT therapist (Sexton, Ostrom, Bonomo, & Alexander, 2000). The CPQ is administered every other therapy session. On the first 16 items of the measure, clients evaluate the degree to which they perceive their therapists to be adhering to phase-specific goals of the FFT model. The first 8 items assess how clients perceive the engagement and motivation phase of therapy, including development of a therapeutic alliance, the degree to which the problems are linked to family relationships, and the development of treatment goals. Items 9-12 assess how clients perceive the therapist facilitating behavior change through teaching new skills and setting tasks. Items 13-16 assess clients' perceptions of the therapists facilitating generalization of new skills to other settings and to future problems. The responses for items 1-16 are given on 7-point Likert scales ranging from 1=completely disagree to

7=completely agree. On the last three items, clients are able to rate the severity of their problems (on 8 point scales) at the beginning of therapy and at the time of rating and also rate the degree to which they believe their problems will improve (on a 4-point scale). A higher score on items 1-16 of the CPQ is indicative of a client's positive perception of the counseling process and their therapist's investment in the process. In a preliminary study of 348 families, results showed that CPQ phases scores were highest for the FFT phase in which the CPQ was completed (Datchi-Phillips, 2011). This indicates that the CPQ measures the extent to which therapists implement interventions that activate FFT phase-specific change processes. In the current study, combined z-scores of each phase of therapy from both the CPQ-Adolescent and CPQ-Parent measures were used as a measure of therapist adherence. While CPQ data was collected for the 60 families in the FFT treatment condition, CPQ data was not collected for the dropout condition families since this measure is one that is given throughout the course of treatment. Since Items 17 and 18 of the CPQ (Item 17: *How things were when you first came to counseling* and Item 18: *how things are now*) measure the degree of how much better things are after counseling, the difference of these items from the CPQ-Parent measure will be used as a measure of perceived change in counseling when testing two of the hypotheses in this study.

Client Outcome Measure for Adolescents and Parents (COM-A and COM-P). The COM-A and COM-P measure outcomes of FFT from both the adolescent and parent perspectives, respectively (Barnowski, 2002). On both instruments, clients rate their level of improvement since the start of therapy in six areas: overall family functioning, communication, adolescent behavior, parenting skills, parental supervision, and conflict management. The six categories on the COM-A and COM-P were adapted from the Washington State Risk and Protective Factor measure (Barnowski, 2002). On both measures, outcome is rated on a 6-point

scale, where 0=worse, 1=no different, 2=only a little better, 3=some better, 4=a lot better, and 5=very much better. The COM-P contains 8 additional items, which ask parents to respond about adolescent criminal charges, detention, running away, school attendance, school expulsion, alcohol use, and substance use. All families in the FFT treatment condition completed the COM-A and COM-P and families in the dropout condition were contacted after dropout to complete the COM-P. A higher score on both the COM-A and COM-P indicates a positive progression over the course of therapy. It is expected that the families in the FFT treatment condition, as compared to families in the dropout condition, will show more of an improvement in adolescent behavior and family functioning.

Therapist Adherence Measure (TAM). As therapists who met with families in the FFT treatment condition presented their cases during supervision meetings, supervisors were responsible for rating the case presentation on the degree to which the therapist adhered to the FFT model on a 6-point Likert scale ranging from low (0) to high (5) model adherence. This degree of adherence was based on how much the therapist could demonstrate the ability to understand the case in regards to the FFT core principles (Sexton, Alexander, & Gilman, 2004). Supervisors were trained in using the adherence rating system and were monitored in supervision by an FFT expert. Therapists were supervised on weekly basis by a supervisor who demonstrated adherence in her own cases and received specific supervision experience and training on the adherence rating process. The supervisor of the FFT therapists is a Caucasian female with a background in mental health. An FFT expert made site visits 3-4 times per year to monitor the supervisor's supervision of therapists and the same FFT expert would join supervision meetings via video conferencing to provide supervision and monitor the supervisor.

Therapist adherence ratings were gathered over a three year period (from 2007-2010). These multiple measures of adherence reflect the therapist over multiple families and sessions, but do not describe therapist adherence with individual families. Over the course of three years, 9 therapists had a total of 145 adherence ratings (ranging from 13 to 26 times per therapist during three years). For each year of the project (2007-2011), each therapist was given an average TAM score for that year, based on the TAM ratings they received in supervision meetings that year. This average TAM rating was then linked to each family the therapist treated for that specific year. TAM scores could only be analyzed to reflect adherence in the FFT treatment condition, since the nature of therapist adherence is measured during treatment. Thus, adherence as a moderator was evaluated in relation to outcomes of one treatment condition and not as part of a comparison of treatment conditions.

Chapter IV

Results

This study utilized a between-subjects design to investigate whether or not the implementation of Functional Family Therapy (FFT) in an Irish setting has an effect on adolescent and family functioning when compared to non-completion of treatment. The study also examines how therapist adherence to the FFT model predicts outcome. Finally, the study considers the variables that may be necessary to measure therapist adherence, including therapist case experience, therapist dropout rate, and clients' perception of therapist adherence. The primary dependent variables were overall adolescent functioning and family functioning. The study compares a group of families that completed FFT treatment to a comparison group of families that did not complete treatment. Additionally, this study examined therapist model adherence (using the TAM score) as a moderator of client outcomes, hypothesizing that as therapist model adherence increases, there will be more of an improvement in adolescent and family functioning. Finally, this study sought to improve measures of therapist adherence by identifying how other variables that may also contribute to adherence, can better predict outcomes of adolescent and family functioning. Using archival data for the analysis, the valid data set for all analyses included 60 families that completed FFT treatment and 20 families that dropped out of treatment before completing. The results of the data analyses for this study are summarized in this chapter. Each analysis was conducted at $\alpha=.05$. First, results of analyses for the specific research questions and hypotheses are presented. Next, additional findings from follow-up analyses are also explained. Finally, information on the power analysis and benchmarking method are provided.

The mean and standard deviation of age of adolescents by group in the total sample are summarized in Table 1. Table 2 includes information pertaining to the distribution for demographic variables that were explored, including gender, age, ethnicity, race, living situation, and location. Frequency distributions of referral data, as well as means and standard deviations of treatment duration and amount of sessions spent in each FFT phase were also examined (see Tables 3, 4, and 5, respectively). All inter-correlations were tested using an adjusted alpha of .001 in order to avoid Type I Errors. Inter-correlations among the independent and dependent variables for the total sample are contained in Table 6.

In comparison of the two groups, analyses showed that the average age of adolescents in each group was similar. The mean age of adolescents in the FFT group was 14.25 (SD=2.0) and the age of adolescents in the dropout condition was 15 (SD=1.65). Additionally, there were more male than female adolescents in both groups, but the range was greater in the FFT group (Male=65%, Female=35%) as compared to the dropout group (Male=55%, Female=45%). Both groups were comprised of predominantly White, Irish participants (FFT, White=98.3%, Irish=96.7%; Dropout, White=95%, Irish=95%) and in both groups, a majority of participants were from Clondalkin, Ireland (FFT=55%, Dropout=60%). Moreover, 50% of participants in both groups were referred to counseling for family relationship problems, with school-related problems being the next prevalent for both groups (FFT=36.7%; Dropout=20%). Finally, the two groups seemed to vary significantly on the total number of sessions completed by each family. The mean number of sessions completed in the FFT condition was 17.48 (SD=8.0), while the mean number of sessions completed in the dropout condition was 5.55 (SD=4.0), which makes sense given the use of a non-completer group as a comparison.

Two two-sample t-tests were created to determine if there was a significant difference between means of group in age and number of sessions completed. Based on the results of the first t-test, the mean ages between the FFT condition ($M=14.25$, $SD=2.0$) and the dropout condition (15.0 , $SD=1.65$) are not significantly different; $t(38.98)=-1.67$, $p=0.104$. The results of the second t-test indicate that there was a significant difference between the FFT condition ($M=17.48$, $SD=8.0$) and the dropout condition ($M=5.55$, $SD=4.0$) on number of sessions completed; $t(78)=6.37$, $p=.000$. Further, a Chi-square analysis was utilized to examine differences between the groups on the variables of gender, place of residence, and referral problem. Three separate chi-square analyses were conducted for each variable and were compared between the two groups (FFT and Dropout). Results indicated the FFT group and Dropout group did not significantly differ on gender ($\chi^2(1, N =80) = .640$, $p =.424$) or place of residence ($\chi^2(1, N= 80) =.152$, $p=.696$). However, the groups did differ significantly on referral problems ($\chi^2(1, N=80) = 14.84$, $p=.038$).

Missing Values. One (1.3%) participant had missing data for the Adolescent COM Total variable only. This participant was included in all analyses because they provided data for all other response variables.

Test of Hypotheses

Research Question 1a. When FFT is implemented in an Irish context, compared to non-completion of treatment, is there a significant difference in outcomes of adolescent functioning?

An ANCOVA was created to investigate if there was a statistical difference between the FFT treatment group and dropout group on the variable of overall adolescent functioning, measured by the total score of the SDQ parent measure (SDQ-P) (Table 10). It was hypothesized that FFT would be more effective in improving adolescent functioning than the

dropout condition. Results indicated that there was a significant difference in the scores for the FFT treatment condition ($M=3.70$, $SD=5.35$) and the dropout condition ($M=2.05$, $SD=5.75$); $F(1, 79)= 4.963$, $p=.029$, $\eta^2p=.061$. Consistent with hypothesis, a significant difference between the FFT group and the dropout group on measures of overall adolescent functioning was detected.

An analysis of the individual subscale scores of the SDQ did identify significant differences between the two groups. Two-sample t-tests were created to investigate differences on the individual SDQ subscales (i.e. Emotional Problems, Conduct, Hyperactivity, Peer Relationships, and Prosocial Behaviors) (Table 11). Results of these t-tests reveal that there was a significant difference between the FFT condition and the dropout condition on the subscales of conduct problems, hyperactivity and prosocial behaviors. In particular, results indicate that the FFT condition shows more improvement than the dropout condition. Specifically, there was a significant difference between the FFT condition ($M=-1.28$, $SD=2.04$) and the dropout condition ($M=0.95$, $SD=2.37$) on the Conduct subscale; $t(78)=-4.07$, $p=.000$, $d=-3.76$; there was a significant difference between the FFT condition ($M=-0.83$, $SD=1.98$) and the dropout condition ($M=.80$, $SD=1.80$) on the Hyperactivity subscale; $t(78)=-3.27$, $p=.002$, $d=3.43$; and there was a significant difference between the FFT condition ($M=1.08$, $SD=2.60$) and the dropout condition ($M=0.92$, $SD=2.16$) on the Prosocial Behaviors subscale; $t(78)=2.45$, $p=.017$, $d=2.29$. While a significant difference was not detected between groups in outcomes of overall adolescent functioning, differences in adolescent conduct-related behavior, as an aspect of adolescent functioning, was examined. This particular subscale of the SDQ measure is a critical target of this study because of FFT's main aim in reducing adolescent delinquency. Thus, analysis of this particular subscale provides more of a relevant picture of adolescent functioning as it pertains to this study.

A within group paired-samples t-test was created to analyze whether or not there was a significant difference between the pre and post scores on a measure of overall adolescent functioning from the parent (SDQ-P) perspective for the FFT group only (Table 10). In terms of overall adolescent functioning from the parent perspective, results indicate that there was more of improvement in the FFT condition than dropout condition in the scores from the beginning of treatment to end of treatment ($M=3.70$, $SD=5.35$); $t(59)= 5.35$, $p=.000$, $d=1.47$. In further examination of the relevant Conduct subscale, a within-group, paired samples t-test was also created to analyze whether or not there was a significant difference between the pre and post scores on a measure of adolescent conduct-related behavior from both the parent (SDQ-P Conduct subscale) perspective for the FFT group only (Table 10). In terms of adolescent conduct from the parent perspective, results indicate that there was more of an improvement in the FFT condition than dropout condition in the scores from the beginning of treatment to end of treatment ($M=1.28$, $SD=2.04$); $t(59)= 4.87$, $p=.000$, $d=0.90$.

Specifically, in examination of the actual interpretation of the overall adolescent functioning scores, a significant change was noted between pre and post scores in terms of clinical impact. The mean of scores for overall adolescent functioning pre-treatment is 19.58 ($SD=6.25$), which is considered to be at high substantial risk of clinically significant problems. The mean of scores for overall adolescent functioning post-treatment is 15.88 ($SD=6.66$), which is considered only to be slightly raised and may reflect some clinically significant problems (see Table 10). Thus, results show that FFT had a clinical impact on adolescent functioning.

Further, interpretation data was evaluated for the conduct aspect of adolescent functioning, using the SDQ-P Conduct subscale. The mean of scores for conduct problems pre-treatment is 5.23 ($SD=1.99$), which is considered to be at high substantial risk of clinically

significant problems, whereas the mean of scores for conduct problems post-treatment is 3.95 (SD=2.16), which is considered to be slightly raised, reflecting some clinically significant problems (see Table 10). Again, findings reveal FFT's statistical significance and clinical significance on the improvement of adolescent conduct problems (Goodman, Meltzer & Bailey, 1998).

Research Question 1b. When FFT is implemented in an Irish context, compared to non-completion of treatment, is there a significant difference in family functioning?

An additional ANOVA was performed to test any difference between the treatment and dropout condition on general family functioning since beginning treatment, using Item 1 on the COM-Parent measure (*In general, how much has the family changed since you began counseling?*) (Table 9) The COM-P is an outcome measure and thus, was not given pre-treatment. Therefore, this analysis was not able to capture differences between pre- and post-scores, but focused on the difference between groups on the outcome of family functioning. Item 1 of the COM-P was the item used for comparison as this was the one item response collected in the dropout group. It was hypothesized that the FFT treatment condition would show significantly larger improvements in family functioning from the beginning to end of treatment than within the dropout group. Results indicate more of an improvement in family functioning between the FFT treatment condition (M=3.80, SD=0.86) and the dropout condition (M=2.10, SD=1.57); $F(1, 79) = 37.0, p < .001, \eta^2 p = .322$. These results support the hypothesis that the FFT treatment condition would be more effective in improving family functioning over time than the dropout group.

Research Question 2. How does FFT therapist model adherence predict client outcomes?

Multiple regression analysis was used to examine if treatment adherence (TAM score) significantly predicted adolescent functioning post-treatment from both the parent and adolescent perspective while controlling for pre-treatment functioning for families in the FFT condition (Table 14 and Table 15). It was hypothesized that the level of adherence of an FFT therapist would predict adolescent behavior from the beginning to end of treatment. The results of the regression analysis indicated that therapist adherence explained 14% of the variance ($R^2=.14$, $F(1, 59)=9.206$, $p=.004$). It was found that the TAM score did not significantly predict adolescent functioning from the adolescent perspective, while controlling for pre-adolescent functioning ($\beta=-.410$, $p=.642$). Additionally, a regression analysis indicated that therapist adherence explained 31% of the variance ($R^2=.309$, $F(1, 59)=10.44$, $p=.002$). It was found that the TAM score significantly predicted adolescent functioning from the parent perspective, while controlling for pre-adolescent functioning ($\beta= -.2.87$, $p=.000$).

Research Question 3. Do other variables, added to the measure of treatment adherence, predict client outcomes?

In order to test the final hypothesis, multiple regressions were analyzed. For each regression analysis, the dependent variables (adolescent and family functioning post-treatment from both the parent and adolescent perspective, change in adolescent functioning from beginning to end of therapy from both the parent and adolescent perspective, and the perceived family change due to therapy) were regressed on the independent variables (years of therapist case experience, dropout rate per therapist, and z-scores of phase-specific CPQ scores for adolescents and parents) (Table 16,17,18,19,20). It was hypothesized that additional variables would better predict therapist adherence to the FFT model. Instead of using the TAM score alone to predict therapist model adherence, the hypothesis suggests that additional variables

would be able to better explain therapist model adherence. Results indicate that dropout rate is found to be a significant predictor of client-rated general change from the parent perspective (COM-P). Additionally, the perception of the counseling process in phase one and phase three from the adolescent perspective were both found to be a significant predictor of the change in adolescent functioning from the beginning to end of therapy from the Adolescent perspective (SDQ-A). Finally, the perception of the counseling process in phase three from the parent perspective is found to be a significant predictor of perceived change in counseling (CPQ).

Power Analysis and Benchmarking Comparison. According to the results of the paired sample t-tests conducted in order to determine differences in pre and post scores of adolescent functioning for the FFT treatment condition only, an effect size of 1.469 with an associated power of .999 (99.9%) was detected for hypothesis 1a. The effect size was calculated using the Cohen's d statistic. The effect size of this main hypothesis was analyzed because of its inclusion of both pre-and post-treatment data for use as comparison against the benchmark. While treatment effect size could provide information on treatment effectiveness, an external indicator is required in order to interpret the absolute magnitude of the effect size. In the current study, the dropout group includes participants that did not complete treatment and dropped out of treatment during the first or second phase. There could be an inherent difference between participants who complete treatment and those that do not, thus, this comparison group may not be the best indicator of absolute magnitude of the study effect size. For example, participants who did not complete treatment may be less motivated than participants who completed treatment, may have more inherent problems within their family, or may have fewer resources available to complete treatment. Therefore, a comparison group allows interpretation of the relative magnitude of the

observed treatment effects between groups, but provides no insight into how the absolute magnitude should be interpreted (Minami, et al., 2009).

A method that allows for interpretability of the treatment effect size is benchmarking (Weersing & Weisz, 2002). Through this method, researchers can “use the magnitude of change obtained in efficacy studies as a benchmark against which to judge the magnitude of change in service clinic settings” (Wade et al., 1998, p. 231). Following a benchmarking procedure adapted from Minami and colleagues (Minami, Serlin, et al., 2008; Minami, Wampold, et al., 2008; Minami et al., 2007), this study uses a strategy that involves three steps: a) selecting a benchmark, b) calculating an effect size found in a large-scale, community effectiveness study, and c) statistically comparing the effect sizes detected in this study against the selected benchmark from the literature. In an effort to select benchmarks that utilize similar FFT outcome measures, a recent FFT meta-analysis conducted by Baldwin et al. (2012) was selected. The meta-analysis combined outcomes from randomized trials of FFT for outcomes of adolescent functioning. As does the current study, this study examines outcomes of adolescent functioning from pre-treatment to post-treatment from four different FFT clinical trials. It was hypothesized that the magnitude of the treatment effect for pre to post treatment for the FFT condition would be clinically equivalent to treatment effectiveness in the FFT meta-analysis and effectiveness study.

It becomes necessary to determine a priori magnitude of difference between the benchmark and effect size estimate that could be clinically trivial (Minami et al., 2009). Based on Cohen’s (1988) suggestion that an effect size of $\Delta = 0.2$ is small, Minami et al. (2000) defined any difference between the benchmark and the population represented by the sample that is under $\Delta = 0.2$ to be clinically trivial. Given the fact that Cohen does not speak directly to social

sciences in his effect size suggestions, the $\Delta=0.2$ cut-off is a conservative measure for the present study. Nonetheless, the analyses utilized should not reject the null hypothesis if the difference is under $\Delta=0.2$, while maintaining a Type I error of $\alpha=.05$.

The FFT meta-analysis by Baldwin, et al. (2012) detected an effect size of 0.29 using the Cohen's *d* statistic. The effect size of 0.29 does not fall within 0.2 of the calculated effect size for the main hypothesis. The magnitude of the FFT meta-analysis's effect size was considerably smaller than the effect size found for the individual t-test in this study. Specifically, the effect size estimate exceeded the critical value on the basis of the efficacy benchmark, demonstrating that the magnitude of the treatment effects were larger as the treatment efficacy observed in other FFT studies. Thus, a power analysis was recalculated and with an effect size of 0.49 (0.2 within the FFT study effect size) using a paired sample t-test with a sample size of 60 and alpha of .05, a power of .982 (98.2%) was calculated for the main hypothesis. As the purpose of the benchmarking method is to give absolute comparison, the fact that the effect size of the current study was significantly larger than the FFT meta-analysis effect size demonstrates that FFT was, indeed, effective in an Irish context.

Summary

In conclusion, the overall results indicate that FFT significantly improves adolescent and family functioning to non-completion of treatment. Specifically, FFT was found to be more effective than the dropout group in improving overall adolescent functioning and client-rated change in therapy. In addition, when the subscales of adolescent functioning from the parent perspective (SDQ-P) were analyzed, there was more of an improvement in the FFT condition than the dropout condition on the Conduct, Hyperactivity, and Prosocial Behaviors subscales. Further, when pre and post-scores were examined on the measures of both overall adolescent

functioning and the conduct aspect of adolescent functioning for the FFT treatment condition, results revealed both a statistically significant and clinically significant impact from beginning to end of treatment. Additionally, a multiple regression analysis examining therapist model adherence as a predictor of adolescent functioning from both the adolescent and parent perspective revealed that therapist adherence was a significant predictor of adolescent functioning from both the parent and adolescent perspective while controlling for pre-functioning scores. Thus, analyses revealed that as therapist model adherence increases, adolescent functioning should also improve. Finally, a multiple regression analysis was used to examine the hypothesis that additional variables representing therapist adherence (i.e. years of therapist clinical experience, therapist dropout rate, and both adolescent and parent perception of therapist adherence) would better predict the dependent variables of adolescent functioning, client-rated general change, and perceived change in counseling. Results indicate that therapist dropout rate is found to be a significant predictor of client-rated general change from the parent perspective. In addition the first-phase and the third-phase adolescent perception of counseling process is found to be a significant predictor of the change in adolescent functioning from the beginning to end of therapy from the adolescent perspective. Finally, the third-phase parent perception of counseling process was found to be a significant predictor of perceived change in counseling. Thus, additional variables were able to better predict client outcomes than using the TAM score alone. From the results of this study, it is clear that FFT is effective at improving adolescent and family functioning in an Irish setting and the best outcomes are found when the variable of adherence is included. Importantly, adherence is best measured by multiple measures and when adherence is considered, FFT is effective for outcomes of adolescent functioning and family functioning.

Chapter V

Discussion

The current study sought to investigate the effectiveness of Functional Family Therapy (FFT) in an Irish youth justice context. The desire to implement an evidence-based practice for adolescents and their families in Ireland stemmed from the need to confront a rising problem with youth crime in the country. FFT was well-suited as a part of this research design in Ireland because one of its core principles is ‘matching to’ the unique family system (Breuk et al.,2006). Within this principle is the idea that each individual should be viewed as unique and part of a larger family context, which has its own particular values, traditions, and norms. This allows the therapists to adhere to the goals and principles of the FFT clinical model, but do so in a flexible way that meets the family where they are and fits within individual and family norms. The overall objective of this study was to determine if a viable treatment for youth behavior problems (FFT) may also be effective in an international setting where juvenile crime is now a major problem. More specifically, one goal of this study was to examine differences in adolescent functioning and family functioning between families who completed FFT treatment and families that did not complete treatment. A second goal of this study was to examine the effects of a moderating variable (treatment adherence) on client outcomes, using the Therapist Adherence Measure (TAM). Finally, this study examined whether or not additional variables representing therapist adherence (therapist dropout rate, years of therapist clinical experience, adolescents’ and parents’ views of their therapist’s adherence) could improve the already established metric of supervisor-judged adherence (Sexton & Turner, 2010) and predict client outcomes more than just this measure alone. This chapter includes a review of the findings related to each of the hypotheses, a discussion of the implications of those findings, an examination of the limitations of the study, and recommendations for future research.

Adolescent Functioning and Family Functioning

The first set of hypotheses investigated the impact of the treatment (FFT vs. non-completing group) on measures of adolescent functioning and family functioning over a three year period. Results indicated a significant difference between the FFT and dropout groups in overall adolescent functioning, as measured by pre and post scores on the Strengths and Difficulties Questionnaire—Parent Measure (SDQ-P), which is an overall measure of adolescent mental health functioning. Additionally, there was more of an improvement in the FFT condition on the Conduct, Hyperactivity, and Prosocial Behaviors subscales of the SDQ-P. Of particular interest to this study because of FFT's main goal to reduce criminal behavior and because of Ireland's increasing problem with youth crime, is the finding from the analysis of the individual SDQ subscales that indicates a significant improvement in the FFT condition in adolescent conduct problems, as measured by the SDQ-P Conduct subscale. A significant difference was also noted between the groups in family functioning, as measured by the Counseling Outcome Measure—Parent version (COM-P), supporting the hypothesis that the FFT treatment condition would be more effective in improving family functioning over time than the dropout group.

Findings reveal that FFT is more effective in improving overall adolescent functioning, family functioning, and the conduct-related aspect of adolescent functioning than non-completion of treatment. Specifically, parents from both groups (FFT treatment and dropout) completed a post-measure and were asked *In general, how much do you think your family has changed since you began counseling?* and there was a significant difference in the amount of perceived change in the FFT group than in the group that did not complete treatment. Additionally, parents were asked to rate their adolescents' conduct on pre and post measures,

responding to statements such as *usually does what adults request, often fights with other youth or bullies them, and steals from home, school, or elsewhere*. Results indicated a significant decrease in conduct problems in the FFT group than in the non-completion group. Conduct is a critical component of adolescent functioning as it pertains to this study since one of FFT's main aims is to improve conduct-related behavior. Taken together, the results of the current study are extremely encouraging and provide evidence that FFT holds promise as an effective intervention for youth in Ireland.

In addition, the current findings also suggest that delinquent adolescents and their families in Ireland respond well to family-based treatments. It also appears that these families respond to FFT in a way that is more effective than non-completion of treatment. While many professionals in the field of juvenile justice have emphasized the importance of family-based treatment for this population (Kazdin & Weisz, 2003; Pinsof & Wynne, 1995; Stanton & Shadish, 1997; Waldron, 1997), these treatments have yet to be implemented in an Irish setting with this population. The current study results add support for the usefulness of family-based approaches when working with youth in Ireland and it appears that FFT may be a viable treatment for this population.

It is important to note that while there was a significant difference detected between groups on outcomes of overall adolescent functioning, there was also a significant difference in reduction of conduct problems, which is the most relevant aspect of adolescent functioning as it pertains to this study. The measure of overall adolescent functioning includes additional subscales that capture aspects perhaps not as relevant or important to the main goals of FFT. Thus, the change in adolescent functioning from a conduct problems standpoint is most notable of the results found.

Effect of Therapist Adherence on Outcomes

The second hypothesis investigated the moderating effect of FFT therapist model adherence on client outcomes (adolescent and family functioning post-treatment from the parent and adolescent perspectives, change in adolescent functioning from beginning to end of therapy from both the parent and adolescent perspective, and the perceived family change due to therapy). The examination of therapist adherence was limited, however, to the FFT treatment condition only as therapist adherence could not be accurately measured in the dropout condition since families did not complete treatment. Results indicated that therapist adherence, as measured by the TAM, was found to be a significant predictor of the change in adolescent functioning from the beginning to end of therapy from the parent perspective. These findings suggest that when practiced with model adherence, FFT resulted in an improvement (decrease in SDQ-P score) in parents' perception of their adolescents' functioning from the beginning to end of therapy.

The role that model adherence has on parents' view of adolescent functioning is supported by previous studies. Similar effects for therapist model adherence on client outcomes have been identified in other evidence-based treatment models (Heneggeler et al., 2007; Hogue et al., 2008). It could be possible that therapist adherence was only found to be a significant predictor of the parents' view of change in adolescent functioning because perhaps adherent therapists were able to have a strong alliance with parents and thus, impact the way these parents view their adolescents. In addition, it is likely that therapist adherence was not found to be a significant predictor of the adolescents' view of change in adolescent functioning because it is common that adolescents are not always the best reporters of their own functioning. That is, compared to adults, adolescents are likely not always able to accurately assess their functioning

and thus underreport the severity of their problems. Results showing that therapist adherence is not a significant predictor of family functioning, adolescents' view of adolescent functioning, and perceived family change in therapy, could be a result of this study's realistic community setting. In this study, FFT therapists were trained and consistently supervised in a real-world, community setting in Ireland, unlike the controlled settings of efficacy trials. As a result, therapists may be susceptible to competing demands, and organizational influences that could hinder their ability to consistently provide high quality of care (Hoagwood, Hibbs, Brent, & Jensen, 1995). Additionally, validity and reliability of the ratings rely on supervision by an FFT expert and are dependent on supervisors' clinical judgments of adherence to the FFT model. Thus, some therapists may be able to present cases during supervision in a way that is consistent with the FFT model, but cannot as skillfully implement the model during sessions (Sexton & Turner, 2010). In theory, the TAM is meant to capture what the therapist actually does in the room with families. However, unless the FFT supervisor or expert has actually been in the session or watched a video of it, it becomes nearly impossible to measure exactly what level of adherence the therapist demonstrated. Supervisors may also have a difficult time providing precise adherence ratings. It is also possible that therapists received TAM scores from multiple supervisors, further complicating the results.

Moreover, the fact that TAM was not a significant predictor of the change in adolescent functioning from the adolescent perspective may reflect the inability of supervisors to apply the TAM ratings as intended. Specifically, FFT supervisors may have difficulty discriminating between therapists of varying adherence levels due to lack of knowledge of the FFT clinical model or an unwillingness to be critical of therapists. This could certainly impact the TAM's ability to reflect the impact of therapist adherence on outcomes. Nonetheless, the final research

question in this study sought to determine whether or not additional variables, other than the TAM score, could better predict client outcomes.

Effect of Additional Variables as measure of Therapist Adherence on Client Outcomes

The final hypothesis investigated the effect of additional variables as a measure of therapist adherence (therapist dropout rate, years of therapist clinical experience, and clients' perception of therapists' adherence) on client outcomes. It was hypothesized that using additional variables, aside from the TAM score alone, could better predict client outcomes (adolescent and family functioning post-treatment from the parent and adolescent perspectives, change in adolescent functioning from beginning to end of therapy from both the parent and adolescent perspective, and the perceived family change due to therapy). The examination of these variables was also limited to the FFT treatment condition only as clients' perception of therapist adherence could not be accurately measured in the dropout condition since families did not complete treatment. Additionally, therapist dropout rate could be measured for each therapist in the dropout condition, but since the families in this condition did drop out of treatment themselves, therapists working with clients in this condition could all be considered less adherent. Findings suggest that therapist dropout rate was a significant predictor of family functioning from the parent perspective (COM-P), first and third-phase adolescent perception of the counseling process (CPQ scores) was a significant predictor of adolescents' view of change in adolescent functioning from beginning to end of therapy (SDQ-A), and third-phase parent perception of the counseling process was a significant predictor of family perceived change in counseling (CPQ). This suggests that the more adherent a therapist is perceived to be by an adolescent and parent in specific phases of FFT and the more therapists are able to increase

retention amongst their clients, the more this could benefit adolescent functioning and family functioning on average.

Therapist dropout rate, calculated by the number of clients that drop out of treatment per therapist divided by the overall number of clients seen by each therapist, was found to predict family functioning from the parent perspective, using the COM-P measure. This suggests that the more the therapist is able to retain their clients in FFT treatment, the more likely the parents receiving FFT treatment are going to perceive their family as functioning well after treatment. This finding sheds light on the importance of treatment adherence as a way of keeping clients engaged in the therapeutic process. Dropout is a reflection of adherence and competence as FFT therapists. In regards to international implementation, this finding can particularly lend insight into the important ingredients, like engagement and retention, which lead to positive client outcomes like family functioning.

Interestingly enough, findings revealed that the third-phase adolescent and parent rating of therapist adherence was a significant predictor of adolescents' view of change in adolescent functioning and perceived change in counseling, respectively. The items on the CPQ that pertain to the Generalization phase model adherence include *My therapist is giving me and my family ideas and referrals for different services in the community*, *My therapist is helping me and my family plan for handling possible problems we may have in the future*, *I think my therapist is helping me and my family know how to continue the changes we made in counseling*, and *I am learning new skills that I can apply to situations other than the problems we came to counseling for*. It seems as though the further along a family is in the duration of their FFT treatment, the more they are going to believe that their therapist understands them, is helping them, and is teaching them tools that they can use in the future. More importantly, the longer an adolescent

or parent remains in treatment and participates in the third-phase of FFT, the more likely they are going to have a family-focused understanding of their problems, learn skills to improve their functioning, and maintain their improvements over time. Therefore, it is no surprise that particularly third-phase adolescent and parent rating of therapist adherence was a significant predictor of client outcomes.

Moreover, years of therapist clinical experience was not found to be a significant predictor of any client outcomes. This is consistent with a fair amount of research that examines whether years of experience as a therapist correlates with psychotherapy outcomes. Multiple studies suggest that experience plays a minimal to non-existent role in psychotherapy outcome (Smith, Glass, & Miller, 1980; Shapiro & Shapiro, 1982). The range of clinical experience of therapists who participated in this study ranged from 2 years to 11 years (see Table 7). Given the range of time that the therapists were providing FFT treatment to clients for this study, the quality of their clinical experience could improve significantly from the beginning of the study time period (2007) to the end of the study time period (2010). Thus, although a level of clinical experience was assigned to each therapist based on their experience at the onset of the study, they most likely became more competent in the FFT model over time, which could allow for a therapist who began with a low level of experience to be considered as competent as a therapist who began with a high level of experience. It is also possible that the variable of therapist clinical experience was not a significant predictor of outcomes because although some therapists began this study with more experience than others, it was not specific experience in the FFT model. All therapists received specific training and supervision according to the current FFT training manual (Sexton & Alexander, 2004; Sexton, 2010), which includes clinical training, follow-up training, and ongoing supervision. Therefore, although therapists with more clinical

experience may have started providing FFT with more of a basis and understanding of general counseling techniques, it is likely that all therapists were on the same level in terms of competence in the FFT treatment program.

Limitations

There are a number of limitations of the present study that must be considered when interpreting the results. Many of the limitations are due to the nature of the study as a community-based effectiveness study where treatments are being investigated under “real-world” conditions. Unlike a clinical trial where rigorous controls can work to ensure validity, this type of study can enhance external validity, but can also lend itself to a number of potential problems and threats to internal validity, which will be discussed here.

A primary limitation of this study is the use of a dropout group as a comparison and the lack of a “no treatment” control group. This makes it nearly impossible to determine whether the client outcomes were a direct result of the treatment. Both groups completed some FFT treatment, while some of the families in the dropout group (40%) dropped out during the second phase of therapy. While the results revealed that FFT shows more of an improvement on variables than the non-completer comparison group, it is unclear whether FFT actually had a positive effect on these outcomes that would not have been obtained without treatment at all. It may be that similar outcomes would have been found regardless of whether or not the youth received treatment. This limitation seems largely unavoidable due to inability to find delinquent adolescents who are not receiving treatment of some kind, even if it is typical probation services. However, traditional probation services may be considered “no treatment” if the youth are not receiving therapeutic services of some kind. Using drop-outs as a comparison group, as in the present study, is not an adequate no-treatment control group because again, there may be

something unique about drop-outs that could make them more likely to offend in the first place, reoffend, have more risk factors, less resources, or certain personality characteristics that do not allow them to be a true comparison (Edwards et al., 2005; Worling & Curwen, 2000).

For this reason, a benchmark comparison was used to utilize an effect size from a recent FFT meta-analysis in the literature with similar variables so that absolute comparison could be achieved. The effect size of the present study was significantly larger than the effect size in the FFT meta-analysis and was not within 0.2, which has been considered by Minami et al. (2000) to be the range of difference between the two effect sizes that is clinically trivial. The difference between the present study and the previous study was 1.179, and thus, a power analysis was recalculated with a higher effect size (within the 0.2 range). Once recalculated, the power of the present study changed from 99.9 (99.9%) to .982 (98.2%). Therefore, the power decreased slightly when the effect size was changed to one with clinically trivial difference from an effect size in the FFT literature. A significant strength of this study is its significantly larger effect size than the effect size from a recent FFT meta-analysis as well as the most recent FFT community-based trial (Sexton & Turner, 2010).

While the use of a dropout group can be considered a limitation of this study, it could also be deemed a significant strength as well. Studies are often criticized in the literature for evaluating treatments compared to absolutely nothing at all. However, in this study, the dropout group did, indeed, complete some treatment so that the FFT treatment is compared to an average of five sessions of the same treatment. Through this comparison, effective outcomes were revealed, allowing perhaps even more robust and relevant outcomes.

Furthermore, a main aim of this study was to address the need for an evidence-based intervention in Ireland due to the rising problem of youth crime. While the findings of this study

shed light on the conduct problems in the adolescents between the two conditions, it does not analyze data on specific criminal activity and whether or not FFT was able to reduce actual crimes committed by adolescents. Initial data from the FFT treatment condition was collected post-treatment on the number of crimes the adolescents' committed since beginning therapy. Of the 60 adolescents in this FFT group, three adolescents (15%) reportedly committed crimes since beginning FFT treatment. Unfortunately, data was not collected about crimes committed from the families in the dropout condition. However, with the delayed follow-up time to administer post-treatment measures to the dropout group, crimes could be committed at any point up to four years after beginning treatment. While measuring conduct problems using the SDQ conduct subscale can provide information about behavior related to criminal activity, it does not allow for interpretation about the effect of treatment on actual crimes amongst this population.

Another limitation associated with the size and variation of sample sizes may limit applicability of the results to other adolescents and their families in Ireland, as well as the conclusions that can be made about the effectiveness of evidence-based treatments with this population. Specifically, while all the families in the dropout group did, indeed, drop out of treatment, some (40%) did so during the second phase of therapy, which could be several sessions into treatment. Because there were well-intended efforts to increase sample size, particularly for the dropout group, there is not a clear cut-off for considering families "drop out", which causes there to be less of a clear comparison between the two groups. Also, the difference in sample size between the FFT treatment group (N=60) and dropout group (N=20) is another reason why the current study cannot be considered a true comparison. While there were sufficient participants to attain acceptable power to test overall group differences, differences among groups were not sufficiently explored due to inadequate numbers. Therefore, it is

possible that differences between groups may have been even larger than the current results suggest. Inherent in a group with a larger sample size is the affordability to have a larger variability across variables and thus, the dropout group again, fundamentally, is not able to be a true comparison for the FFT treatment data.

Additionally, participants in the current sample are from one counseling center (Families First) from a limited geographic location (Clondalkin and surrounding suburbs) with somewhat restricted demographics (e.g. predominantly White, of Irish ethnicity). These demographics are most likely representative of the general population in the Republic of Ireland, but it may be that results cannot be replicated with other samples of delinquent adolescents from other, or more diverse geographical areas of the country. Thus, future studies should utilize a larger and more diverse sample to suitably investigate possible differences and should sample from a wider geographical area to increase the generalizability of results.

Moreover, the time frame over which the assessments were given was also problematic due to the varying treatment start and treatment lengths of the two groups. First of all, some of the families in the FFT condition began treatment in 2007 (1.67%), some began in 2008(40%), some began in 2009(48.3%), while other families began treatment in 2010 (10%). This variation in start date could impact the treatment received by each family. For example, FFT therapists can gain skills, become more adherent to the FFT clinical model over the course of the three-year period and thus, predict client outcomes. While there is no specific data on the start dates of the dropout group families, they also began treatment across the three-year range of 2007-2010. However, the time frame of administration of the post-treatment assessments varied tremendously between the FFT treatment group and dropout group. The families in the FFT treatment condition were administered post-treatment measures as treatment was completed

(Number of sessions, $M=17.5$) within the three-year period. The parents in the dropout condition, however, were administered post-treatment measures over the telephone by a research assistant in 2011. As mentioned previously, this delayed follow-up period may not be remotely near the time of dropout. This could certainly affect how much the parents were able to recall about their adolescent and family functioning since the start of therapy, as well as the change that occur within their family and adolescent during this time independent of the effect of treatment. Additionally, the nature of the telephone conversation for administration of post measures to the dropout group can impact the accuracy of reporting. Again, since respondents are not able to read the measures, they may have a more difficult time accurately responding and they may feel less comfortable giving responses over the phone as compared to the more therapeutic and accepting environment that can come with an in-person interview. Finally, another problem with this response method is that parents were the only participants that provided information at the post-measure administration time. Parents can certainly provide information about their adolescents' functioning that is completely different from their adolescent perspective, giving limited information about the accuracy of the adolescents' functioning and behavior. This impacted not only the amount of data that was able to be collected for this group, but also resulted in limited post-treatment measures that were able to be compared to the FFT treatment data and analyzed for this study.

Conclusions and Areas for Future Research

As the present study is the first empirical investigation into the use of Functional family Therapy as a treatment for adolescents and their families in Ireland, the potential future areas of research are vast. While FFT was found to be effective for major aspects of adolescent functioning and family functioning in this population, replication of the results will be necessary

to establish the validity of FFT for this population. Additional effectiveness studies should be conducted with other samples of families and other treatment providers to determine if the results obtained in this study can be replicated. Another critical area of future research involves an effectiveness study of FFT in other areas of The Republic of Ireland, with families of different races and ethnicities. The findings of this study may only apply to a small sample of Irish youth from one counseling center in a small Dublin suburb. An increased sample size may uncover more reliable and stable effects of treatment outcome. Also, just conducting FFT in one site (Families First) could limit the generalizability of the findings. Perhaps expanding FFT to more than one site could be helpful.

While improving adolescent functioning and family functioning are typically the central goals of most FFT studies, research into the impact of FFT on other clinical goals is also a key area of future research. While the present study attempted to address this by examining the impact of treatment on three main variables, the usefulness of the results was limited and not as specific as it could be. Given the varying range of referral reasons for families in this study, future research should attempt to examine the impact of FFT on other outcome variables such as specific criminal behavior, parental supervision, truancy, individual symptomatology, and substance abuse. Further, future studies should also measure the impact of the treatment at multiple follow-up periods rather than at one, inconsistent follow-up time, as was used in the current study.

While this study provided insight into the effectiveness of FFT compared to some amount of treatment, future research is needed to examine FFT in an Irish context with a no-treatment comparison, or at least a treatment-as-usual comparison group. A no-treatment comparison group could be difficult to obtain with this population, especially given the ethical implications of not

providing treatment to this at-risk population. However, Since there has been recent initiative for Irish legislators to divert youth away from crime with the implementation of the Garda Youth Diversion Projects (GYDP), it would be interesting to compare outcomes of adolescents who participate in GYDP (treatment as usual, in this case) and adolescents who attend FFT with their families. Currently, GYDP occupies a pivotal position in the Irish juvenile justice system, as they are funded by the Irish Youth Justice Service. Although, the results of the current study will shed light on the service delivery transition of FFT in an Irish setting and the cultural considerations to which practitioners should attend, it is important to have a true comparison group in order to provide further evidence of FFT's effectiveness in this particular context.

This study utilized archival data in order to examine differences between groups on outcomes of adolescent functioning and family functioning. Future research could employ studies that involve the actual collection of data in order to avoid particular limitations of this study. For example, with the foresight of the data collection process, researchers could ascertain adequate sample sizes, implement consistent administration of follow-up measures across groups, and limit variability across participants. Researchers could also have the benefit of ensuring that all participants, including parents and adolescents, are able to complete necessary measures at the beginning and end of treatment in order to have a complete and balanced data set. Additionally, a comparison group could be selected that provides an adequate and absolute comparison to an FFT treatment group to ensure that client outcomes are a direct result of treatment.

There are many cultural considerations to take into account when implementing FFT, an American-based model of family therapy, in an international setting. The Families First staff and FFT therapists' experiences throughout the implementation could provide insight into the

difficulties and organizational issues that are associated with integrating the FFT model into their work with clients. Therefore, a qualitative approach, such as interviews, could be useful in determining the challenges and benefits of implementing FFT, any modifications necessary to ease the transition, factors that supported or hindered the implementation, and any other lessons learned. The information from interviews of staff and therapists could not only indicate necessary variations in FFT service delivery methods needed for its adoption in an Irish context, but it could also lend to crucial information necessary for the implementation of FFT in other international contexts.

Conclusion

In conclusion, the present study provides additional support for the effectiveness of Functional Family Therapy in the treatment of delinquent youth and their families in the Republic of Ireland. There is a clear need to empirically evaluate the effectiveness of treatment programs for this population given the recent increase in crime and the specific need for interventions that target parenting and prosocial behavior. The current study is an initial investigation attempting not only to examine the applicability and effectiveness of FFT to Irish youth, but also studies the interacting effect of therapist model adherence on client outcomes. Findings from this study reveal similar outcomes as previous studies conducted in settings in the U.S. Specifically, results indicate a significant difference between the FFT group and a dropout group on the measure of overall adolescent functioning. Additionally, there was a significant difference between the FFT group and dropout group on measures of family functioning and aspects of adolescent functioning, particularly conduct problems, the most relevant aspect of adolescent functioning, from the beginning to end of treatment. Additionally, therapist adherence to the FFT model as a moderating variable, using the Therapist Adherence Measure (TAM), was

found to be a significant predictor of change in adolescent functioning from beginning to end of therapy from the parent perspective. Finally, in examination of additional variables as treatment adherence, the variables of therapist dropout rate, adolescents' perception of the counseling process, and parents' perception of the counseling process during the first and third phase of FFT treatment were found to be significant predictors of family functioning from the parent perspective, change in adolescent functioning from the adolescent perspective, and perceived change in counseling, respectively. Thus, viewing treatment adherence with additional variables other than the TAM can help better moderate client outcomes and can help shed light on necessary factors to consider when transporting an evidence-based practice to international settings.

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Appendix A: Tables

Table 1

Age of Participants by Group

	<i>n</i>	<i>M (SD)</i>
FFT	60	14.25 (2.0)
Dropout	20	15 (1.65)

Table 2

Frequency Report of Demographics Data

Variable	FFT		Dropout	
	<i>n</i>	%	<i>n</i>	%
Age				
10	3	5.0	0	0
11	4	6.7	0	0
12	6	10.0	1	5.0
13	6	10.0	3	15.0
14	9	15.0	4	20.0
15	16	26.7	5	25.0
16	7	11.7	2	10.0
17	9	15.0	4	20.0
18	0	0	1	5.0
Gender				
Female	21	35.0	9	45.0
Male	39	65.0	11	55.0
Race				
White	59	98.3	19	95.0
Biracial	1	1.7	1	5.0
Ethnicity				
Irish	58	96.7	19	95.0
Romanian	1	1.7	0	0
Zimbabwean	1	1.7	0	0
Nigerian	0	0	1	5.0
Location				
Clondalkin	33	55.0	12	60.0
Tallaght	4	6.7	0	0
Palmerstown	2	3.3	1	5.0
Lucan	7	11.7	2	10.0
Leixlip	2	3.3	0	0
Ballyfermot	5	8.3	2	10.0
Firhouse	1	1.7	0	0
Bawnogue	1	1.7	0	0
Ballycullen	1	1.7	0	0
Cherry Orchard	1	1.7	0	0
Clonburris	1	1.7	0	0
Dublin	1	1.7	0	0

Ballymount	1	1.7	1	5.0
Rathcoole	0	0	1	5.0
Maynooth	0	0	1	5.0
<hr/>				
Living Situation				
<hr/>				
Both Parents	24	40.0	8	40.0
Mother	26	43.3	8	40.0
Father	2	3.3	2	10.0
Mother & Stepfather	6	10.0	0	0
Other Relatives	2	3.3	2	10.0

Table 3

Frequency Report of Referral Data by Group

	FFT		Dropout	
	<i>n</i>	%	<i>n</i>	%
Reason for Referral				
Family Relationship Problems	30	50.0	10	50.0
School-related Problems	22	36.7	4	20.0
Parenting Issues	3	5.0	0	0
Crisis	1	1.7	1	5.0
Mood Disorders	1	1.7	0	0
Anxiety Problems	1	1.7	0	0
Substance Abuse Problems	1	1.7	0	0
Youth Justice Referral	0	0	4	20.0
Other	1	1.7	1	5.0

Table 4

Number of Total Sessions by Group

	FFT	Dropout
	M (SD)	M (SD)
Total Number of Sessions	17.48(8.0)	5.55 (4.0)

Table 5

Frequency of FFT Dropout Phase for Dropout Group

FFT Phase	<i>n</i>	%
Engagement and Motivation	12	60.0
Behavior Change	8	40.0

Table 6

Intercorrelations Among the Independent and Dependent Variables for Total Sample

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Adolescent Problems (Parent)	-															
2. Adolescent Problems (Adol)	.187	-														
3. Change in Family Functioning	-.572	-.092	-													
4. Family Functioning (Parent)	.086	.038	.829	-												
5. Family Functioning (Adolescent)	-.017	.197	.538	-.508	-											
6. Perceived Change in Therapy	-.067	.034	-.011	-.012	.000	-										
7. Therapist Dropout Rate	-.250	.027	.201	.304*	.006	-.083	-									
8. Level of Therapist Adherence	.428*	-.033	.105	.036	.136	-.110	-.269*	-								
9. Level of Therapist Experience	-2.32*	.026	.032	.031	.027	.027	.025	-.141	-							
10. Adolescent Criminal Behavior	.076	.060	-.238*	-.084	.073	-.015	.177	-.245	-.039	-						
11. First-phase Adolescent perception of counseling process	.039	.098	.211	.174	.175	-.032	.254	.104	-.146	.181	-					
12. Second-phase Adolescent perception of counseling process	-.008	-.131	.229	.176	.185	.049	.304*	.060	-.167	.112	.593*	-				
13. Third-phase Adolescent perception of counseling process	-.111	-.304*	.229	.205	.081	.086	.374*	.037	-.082	.137	.635*	.819*	-			
14. First-phase Parent perception of counseling process	-.080	.197	.187	.227	.181	.163	.169	-.053	.021	.219	.499*	.286*	.286*	-		
15. Second-phase Parent perception of counseling process	.018	-.057	.312*	.263*	.213	.215	.234	.054	-.121	.050	.394*	.565*	.539*	.620	-	
16. Third-phase Parent perception of counseling process	.070	-.044	.285*	.275*	.213	.362*	.226	-.041	-.047	-.07	.412*	.503*	.538*	.564	.81	-

*Correlation is significant at the .05 level (2-tailed)

Table 7

Demographic Data of Therapists by Group

Variable	FFT (n=9)		Dropout (n=7)	
	<i>n</i>	%	<i>n</i>	%
Gender				
Male	3	33.3	4	57.1
Female	6	66.7	3	42.9
Ethnicity				
Irish	7	77.8	7	100.0
American	2	22.2	0	0
Years of Clinical Experience				
Low	1	11.1	2	28.6
Medium	2	22.2	1	14.3
High	6	66.7	4	57.1

Table 8

TAM Scores of FFT Therapists by Family in Treatment Condition

	<i>n</i>	<i>M (SD)</i>
TAM Score	60	3.3 (0.81)

Table 9

ANOVA: Comparing Groups on Family Functioning

Independent Variable	Sum of Squares	<i>Df</i>	<i>F</i>	η^2_p	<i>P</i>
Group	43.35	(1,79)	37.0	.322	.000*

* $p < .05$

Table 11

T-test Comparing Groups on Individual Subscales of Adolescent Problems

	<i>t</i>	<i>df</i>	<i>p</i>	Mean Difference	Std. Error Difference	95% CI of the Difference		Effect size
						Lower	Upper	<i>d</i>
Emotional Problems	-1.554	78	.124	-.967	.622	-2.205	.272	1.359
Conduct Problems	-4.065	78	.000*	-2.233	.549	-3.327	-1.140	3.763
Hyperactivity	-3.272	78	.002*	-1.633	.499	-2.627	-.640	3.427
Peer Relationships	-1.888	78	.063	-1.117	.592	-2.294	.061	1.677
Prosocial Behaviors	2.449	78	.017*	1.417	.579	.265	2.568	2.287

* $p < .05$

Table 12

ANCOVA: Differences between FFT completers and non-completers on post-adolescent problems while controlling for pre-therapy problems

Independent Variable	M(SD)	Sum of Squares	<i>Df</i>	<i>F</i>	η^2_p	<i>P</i>
Group		126.146	(1,79)	4.963	.061	.029*
Adolescent Functioning Pre-Score	19.58(6.25)	1.396	(1,79)	13.966	.155	.000*

* $p < .05$

Table 13

ANCOVA: Differences between FFT completers and non-completers on post-adolescent conduct problems while controlling for pre-therapy problems

Independent Variable	M(SD)	Sum of Squares	<i>df</i>	<i>F</i>	η^2_p	<i>P</i>
Group		9.984	(1,79)	2.648	.034	.108
Conduct Problems Pre-Score	5.23(1.99)	59.816	(1,79)	15.867	.173	.000*

* $p < .05$

Table 14

Regression: Pre-Scores and TAM scores on Change in Adolescent Functioning from the Adolescent Perspective (SDQ-A)

Independent Variable	Parameter Coefficient	Std. Error	<i>T</i>	<i>P</i>
TAM	-.410	.876	-.468	.642
SDQ-A Pre Score	-.404	.133	-3.03	.004*

* $p < .05$

Table 15

Regression: Pre-Scores and TAM scores on Change in Adolescent Functioning from the Parent Perspective (SDQ-P)

Independent Variable	Parameter Coefficient	<i>Std. Error</i>	<i>T</i>	<i>P</i>
TAM	-2.87	.729	-3.94	.000*
SDQ-P Pre Score	-.305	.094	-3.23	.002*

* $p < .05$

Table 16

Regression: Client-rated General Change from Parent Perspective (COM-P) on TAM Score and Therapist Adherence (Additional Variables)

Independent Variable	Parameter Coefficient	<i>Std.</i> <i>Error</i>	<i>T</i>	<i>P</i>
TAM	.396	.594	.667	.508
Therapist Experience	-1.033	1.205	-.857	.396
Therapist Dropout Rate	5.515	2.160	2.553	.014*
Perception of counseling process in Phase 1 (Adol)	-.153	.677	-.226	.822
Perception of counseling process in Phase 2(Adol)	-.196	.815	-.240	.811
Perception of counseling process in Phase 3 (Adol)	.145	.896	.162	.872
Perception of counseling process in Phase 1 (Parent)	.496	.668	.742	.461
Perception of counseling process in Phase 2 (Parent)	-.157	.893	-.176	.861
Perception of counseling process in Phase 3(Parent)	.813	.788	1.031	.307

Note. Adol=from adolescent perspective; Parent=from parent perspective

*p<.05

Table 17

Regression: Client-rated General Change from Adolescent Perspective (COM-A) on TAM Score and Therapist Adherence (Additional Variables)

Independent Variable	Parameter Coefficient	<i>Std.</i> <i>Error</i>	<i>T</i>	<i>P</i>
TAM	.728	.910	.800	.428
Therapist Experience	.450	1.882	.239	.812
Therapist Dropout Rate	.519	3.369	.154	.878
Perception of counseling process in Phase 1 (Adol)	.633	1.037	.610	.545
Perception of counseling process in Phase 2(Adol)	1.451	1.292	1.123	.267
Perception of counseling process in Phase 3 (Adol)	-1.806	1.390	-1.30	.200
Perception of counseling process in Phase 1 (Parent)	.160	1.023	.157	.876
Perception of counseling process in Phase 2 (Parent)	.232	1.401	.166	.869
Perception of counseling process in Phase 3(Parent)	.818	1.271	.644	.523

Note. Adol=from adolescent perspective; Parent=from parent perspective

*p<.05

Table 18

Regression: Change in Adolescent Functioning from Parent Perspective (SDQ-P) on TAM Score and Therapist Adherence (Additional Variables)

Independent Variable	Parameter Coefficient	<i>Std.</i> <i>Error</i>	<i>T</i>	<i>P</i>
TAM	2.583	.877	2.945	.005*
Therapist Experience	.080	1.779	.045	.964
Therapist Dropout Rate	-2.322	3.190	-.728	.470
Perception of counseling process in Phase 1 (Adol)	1.070	.999	1.070	.290
Perception of counseling process in Phase 2(Adol)	.880	1.203	.732	.468
Perception of counseling process in Phase 3 (Adol)	-2.446	1.322	-1.85	.070
Perception of counseling process in Phase 1 (Parent)	-1.216	.986	-1.23	.223
Perception of counseling process in Phase 2 (Parent)	-.340	1.318	-.258	.797
Perception of counseling process in Phase 3(Parent)	1.965	1.164	1.688	.098

Note. Adol=from adolescent perspective; Parent=from parent perspective
*p<.05

Table 19

Regression: Change in Adolescent Functioning from Adolescent Perspective (SDQ-A) on TAM Score and Therapist Adherence (Additional Variables)

Independent Variable	Parameter Coefficient	<i>Std.</i> <i>Error</i>	<i>T</i>	<i>P</i>
TAM	.304	.878	.346	.730
Therapist Experience	2.516	1.782	1.412	.164
Therapist Dropout Rate	1.422	3.196	.445	.658
Perception of counseling process in Phase 1 (Adol)	2.185	1.001	2.182	.034*
Perception of counseling process in Phase 2(Adol)	1.779	1.205	1.476	.146
Perception of counseling process in Phase 3 (Adol)	-5.211	1.325	-3.93	.000*
Perception of counseling process in Phase 1 (Parent)	.691	.988	.700	.487
Perception of counseling process in Phase 2 (Parent)	-.186	1.320	-.141	.889
Perception of counseling process in Phase 3(Parent)	.069	1.166	.060	.953

Note. Adol=from adolescent perspective; Parent=from parent perspective
*p<.05

Table 20

Regression: Perceived Change in Counseling (CPQ) on TAM Score and Therapist Adherence (Additional Variables)

Independent Variable	Parameter Coefficient	<i>Std.</i> <i>Error</i>	<i>T</i>	<i>P</i>
TAM	-1.79	.306	-.585	.561
Therapist Experience	.304	.620	.490	.626
Therapist Dropout Rate	-1.647	1.112	-1.48	.145
Perception of counseling process in Phase 1 (Adol)	-.345	.348	-.990	.327
Perception of counseling process in Phase 2(Adol)	-.082	.419	-.195	.846
Perception of counseling process in Phase 3 (Adol)	.167	.461	.363	.718
Perception of counseling process in Phase 1 (Parent)	.085	.344	.248	.806
Perception of counseling process in Phase 2 (Parent)	-.267	.459	-.581	.564
Perception of counseling process in Phase 3(Parent)	.941	.406	2.32	.025*

Note. Adol=from adolescent perspective; Parent=from parent perspective

*p<.05

Appendix B: Figures

Figure 1

Difference in Means of Pre and Post Scores of Overall Adolescent Problems and Adolescent Conduct Problems

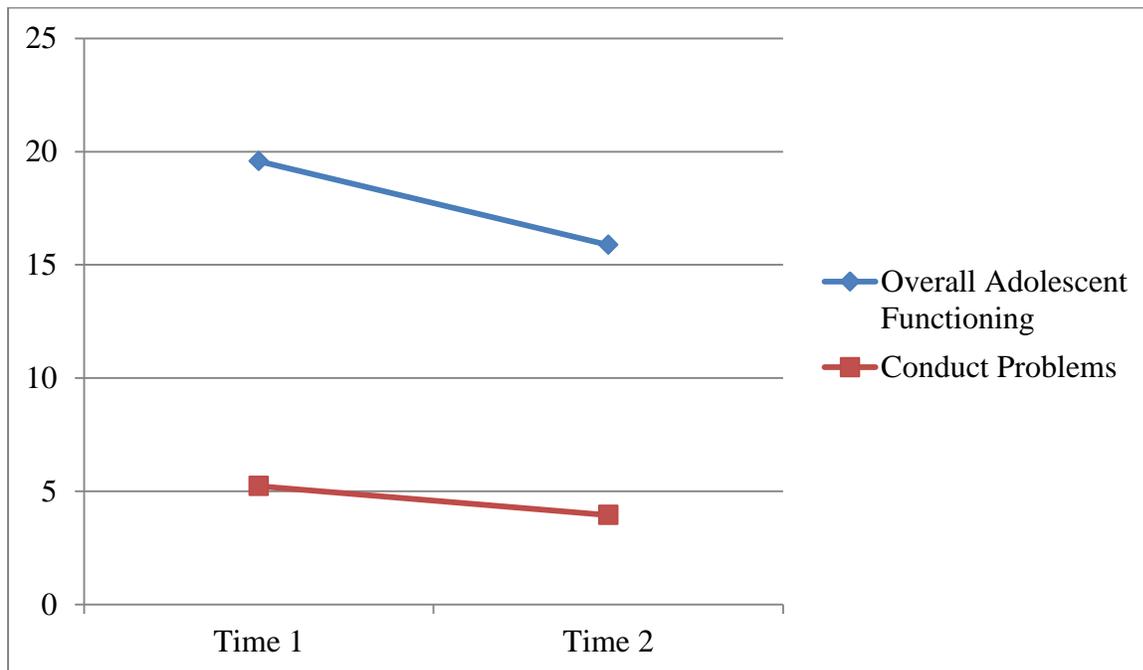
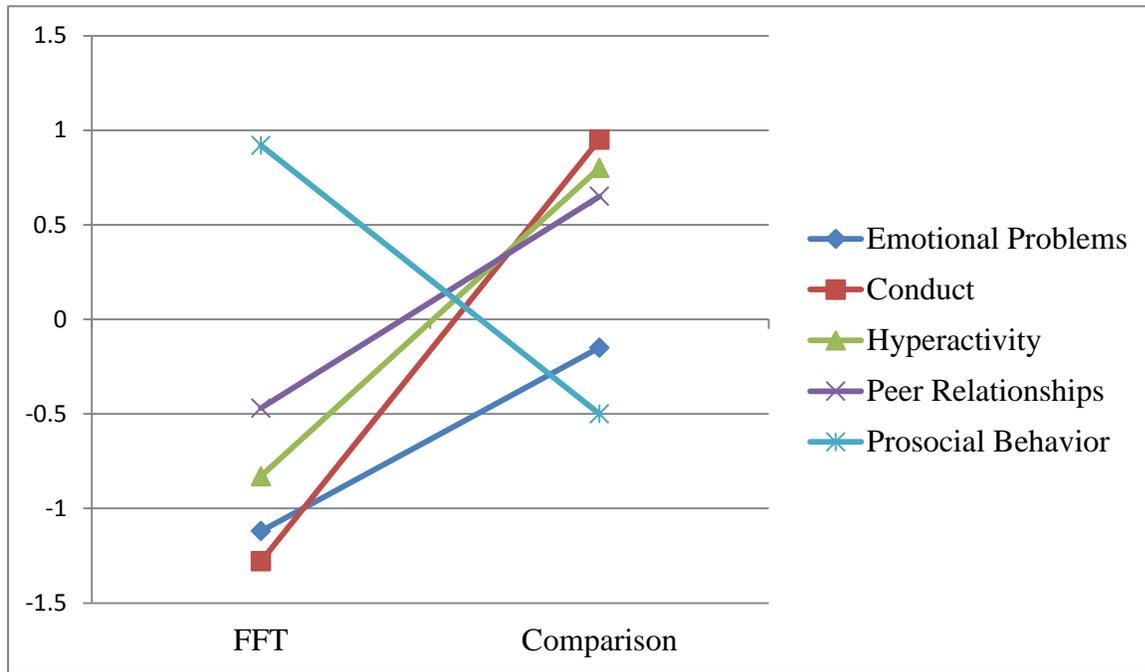


Figure 2

Difference in Change in Means between Groups on Individual Subscales of Adolescent Problems



LAURA W. SATTERFIELD

Name: Laura Wilson Satterfield
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Newton, MA 02465
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Education

Indiana University, Bloomington, IN

Ph.D.: Major: Counseling Psychology, Minor: Developmental Issues in Family Psychology,
December 2012

Dissertation: The Effectiveness of Functional Family Therapy in an Irish Context: An
Examination of International Implementation

The University of Georgia, Athens, GA

M.Ed.: Major: Guidance and Counseling, May 2006

B.S.: Major: Psychology, May 2003

Clinical Experience

Integrated Center for Child Development, Canton MA

Postdoctoral Fellow in Pediatric Neuropsychology, September 2012- Present
Supervisor: Rafael Castro, Ph.D.

- Administer range of Neuropsychological assessment batteries to children and adolescents
- Score, interpret, and write testing reports
- Facilitate feedback sessions for families to review results and discuss recommendations
- Consult with community agencies to plan treatment and coordinate care for clients

Riverbend Community Mental Health Center, Concord NH

Predoxal Intern, Child & Family Therapist, Trauma/Assessment rotation,
September 2011- August 2012

Supervisors: Cassie Yackley, Psy.D.& Amy Stultz, Psy.D.

- APA Accredited Predoxal Internship
- Provide individual and family therapy to children and adolescents, ages 3-17
- Provide school-based therapy to children in local elementary schools
- Facilitate two social skills groups for children with Autism Spectrum Disorders

FFT IN AN IRISH CONTEXT

- Administer, interpret, and write reports for range of psychological assessments for children and adolescents
- Attend two weekly consultation groups to discuss use of evidence-based interventions: *Child-Parent Psychotherapy (CPP)* and *Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)*
- Member of clinical team, comprised of multidisciplinary professionals
- Provided agency-wide presentation on *Functional Family Therapy* for APA CE credits

Centerstone, Bloomington, IN

Therapist, July 2010-June 2011

Supervisor: Matt Oliver, Ph.D.

- Provided individual, couple, and family therapy to children, adolescents, and adults in the community
- Conducted diagnostic evaluations for adults, children, and adolescents from community
- Administered and wrote reports for cognitive, personality, and neurological assessments with community clients
- Attended weekly staff meetings to collaborate with clinical treatment team members

Indiana Family Project, Bloomington, IN

Family Therapist, May 2009-May 2010

Supervisor: Corinne Datchi-Phillips, Ph.D.

- Provided Functional Family Therapy, an evidence-based intervention, to at-risk adolescents and their families.
- Attended weekly group supervisions to discuss cases and participated in live supervisions, gaining real-time feedback during family therapy sessions
- Typical caseload: 6-8 families per week

Center for Human Growth, Bloomington, IN

Therapist, August 2008-May 2009

Supervisor: Rex Stockton, Ph.D.

- Provided individual counseling to university and community members, mainly Indiana University students
- Involved in outreach activities, including screening for eating disorders, depression, and substance abuse
- Attended weekly staff meetings to discuss client cases and center activities
- Typical caseload: 4-6 individual hours per week

Project Safe, Inc., Athens, GA

Therapist and Children's Advocate, October 2006-July 2008

Supervisor: Donna Thomsen, LPC

- Provided advocacy case management and individual counseling to all children in domestic violence shelter
- Answered crisis hotline
- Facilitated support and psychoeducational groups for children and mothers in shelter

FFT IN AN IRISH CONTEXT

- Facilitated Emotional Abuse support group for non-resident women in the community
- Provided individual counseling to non-resident community women and children referred by hotline or law enforcement
- Conducted community presentations and in-service trainings to local agencies
- Taught domestic violence education programs in local elementary schools
- Development and facilitation of *Superheroes*, a 10-week domestic violence group therapy program for children and their parents in community.

Advantage Behavioral Health Systems, Athens, GA

Therapist, January 2005-May 2006

Supervisor: Laurie Wilburn, LPC

- Provided Individual counseling to adults in community mental health clinic
- Caseload consisted of adults of all ages with typically low-SES, who were often dually and sometimes triply diagnosed with Addictions and/or Developmental disabilities
- Established and facilitated support group for clients with Anxiety Disorders
- Typical caseload: 20-30 adult clients per week

Columbus Community Services, Atlanta, GA

Case Manager, July 2003-May 2005

Supervisor: Janell Young

- Provided case management to children and adults who had developmental disabilities and mentally retardation
- Conducted team meetings with family members, school personnel, medical staff, and clients to establish treatment plan
- Responsible for advocating needs of clients and helping to maintain personal and developmental goals

Athens Regional Medical Center, Athens, GA

Counseling Intern, January 2003-May 2003

Supervisor: Craig Sturges, LCSW

- Worked with patients in an acute residential unit
- Exposed to wide range of diagnoses and severe psychopathologies
- Observed individual and group counseling sessions
- Acquired a better understanding of different therapy techniques and dynamics of inpatient psychiatric care.

Research Experience

Center for Adolescent and Family Studies, Indiana University, Bloomington, IN

Research Assistant, January 2009-Present.

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- Assist in various research projects related to Functional Family Therapy, an evidence-based treatment for at-risk adolescents and their families
- Research Liaison between Center for Adolescent and Family Studies and University College Dublin, facilitating data collection and analysis for Functional Family Therapy effectiveness trial in Ireland
- Research Team Member for study developing blame rating system to examine role of blame in family therapy
- Research supervisor: Thomas L. Sexton, Ph.D.

Center for Family Research, The University of Georgia, Athens, GA

Research Assistant, September 2006-November 2007

- Assisted in recruitment and scheduling of participants for ProSAAM (Program for Strong African-American Marriages) project
- Facilitated weekly intervention workshops for selected couples with Prevention and Relationship Enhancement (PREP) curriculum
- Collected and analyzed follow-up data
- Research supervisor: Tera Hurt, Ph.D., under Steven Beach, Ph.D.

Mother/Infant Play Project, Child and Family Development Department, The University of Georgia, Athens, GA

Research Assistant, January 2002-May 2002

- Assisted in recording, coding, and analyzing video data in SPSS format of approximately 50 mother/infant dyads
- Worked with research supervisor to determine attachment style and behaviors of mothers and infants
- Research supervisor: Hui-Chin Hsu, Ph.D.

Department of Psychology Primate Lab, The University of Georgia, Athens, GA

Research Assistant, August 2001-January 2002

- Responsible for running discrimination tests on subjects, coding video, entering data into SPSS format, and analyzing data
- Participated in weekly team meetings and presented periodic findings to team members
- Research supervisor: Dorothy Fragaszy, Ph.D.

Teaching Experience

EDUC-X152, Right Start Seminar, Student Academic Center

Associate Instructor, Fall 2009, Fall 2010

- Instruct two sections of undergraduate freshman and transfer students who are self-referred or referred by academic advisor for additional introduction into college life
- Provide instruction and resources on campus life, study skills, time and stress management

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- Develop lesson plans, provide lectures, lead campus visits, and facilitate classroom discussions
- Lead free supplemental workshops for Student Academic Center on subjects related to college life and study skills

EDUC-X158 Culture of College, Student Academic Center
Associate Instructor, Spring 2010, Spring 2011

- Instructed two sections of undergraduate students who are placed on academic probation
- Developed lesson plans, provide lectures, facilitate classroom discussions
- Provided instruction on time and stress management, study skills, development of campus relationships, and self-knowing and motivation
- Lead free supplemental workshops for Student Academic Center on subjects related to college life and study skills

EDUC-X153 Critical Reading and Reasoning for the New College Student, IU Groups
Program

Associate Instructor, Summer 2009

- Instructed classroom of 16 incoming undergraduate freshman students in program for first-generation college students who are residents of Indiana
- Facilitated reading and discussion of *McDonalidization of Society* 5
- Provided daily lectures and discussion related to essentials of critical reading and reasoning
- Developed creative means of keeping students motivated and engaged

CJUS-P200 Theories of Crime and Deviance, Department of Criminal Justice
Associate Instructor, Fall 2008-Spring 2009

- Instructed three sections of undergraduate students in lower-level Criminal Justice course
- Facilitated discussion of text on weekly basis
- Provided supplemental instruction of lectures and preparation for exams

Publications/Presentations

Campbell, W. L., Wilson, L. R., & Mungro, J. L. (2010, April). *Examination of experiences and mental health needs of first-time fathers*. Poster session presented at the Great Lakes Conference, Akron, OH.

Graham, C., Satterfield, L.W., Carr, A. & Sexton, T.L. (2011). Evaluation of Functional Family Therapy in an Irish Context. Paper present at the XIX World Family Therapy Congress, NH Conference Centre, Noordwijkerhout, The Netherlands, 30th March – 2nd April 2011.

Graham C., Carr, A., Rooney, B., Sexton, T. & Satterfield, L. (Submitted). Evaluation of Functional Family Therapy in an Irish Context. *Journal of Family Therapy*.

FFT IN AN IRISH CONTEXT

Satterfield, L.W., Graham, C., Sexton, T.L., & Carr, A. (2011, August), *The Effectiveness of Functional Family Therapy in an Irish Setting*. Poster session presented at the 119th American Psychological Association Convention, Washington, DC.

Satterfield, L.W., Graham, C., Sexton, T.L., & Carr, A. (2011, April), *An Evaluation of Functional Family Therapy in an Irish Context*. Poster session presented at the Great Lakes Conference, Bloomington, IN.

Sexton, T. L., McEnery, A. M., & Wilson, L. R. (2011). Family research: Understanding families, family-based clinical interventions, and clinically useful outcomes. In J.C. Thomas & M. Hersen (Eds.), *Understanding research in clinical and counseling psychology*, Mahwah, NJ: Lawrence Erlbaum Associates.

Honors and Awards

Hope Scholar, 1999-2003

National Dean's List, 2000-2003

University of Georgia Presidential Scholar recipient (GPA of 4.0), Spring 2000, Fall 2000, Spring 2001, Spring 2002

National Society of Collegiate Scholars

Professional and Honor Societies

American Psychological Association; Member

Division 43 of APA: Society of Family Psychology; member

National Board of Certified Counselors; certified member

Licensed Associate Professional Counselor (state of Georgia), June 2007

Licensed Professional Counselors Association of Georgia; member

American Counseling Association; member

Psi Chi, National Honors Society in Psychology: Undergraduate Secretary

Golden Key National Honors Society

Activities and Volunteer Work

Indiana University Counseling Psychology program Newsletter Editor

Indiana University Counseling Psychology program Competencies Committee; member

Camp Barney Medintz; camp counselor

Best Buddies Program; volunteer

Clarke County School District; Substitute teacher

The Leukemia and Lymphoma Society: Team in Training; fundraiser

AIDS Athens; Buddy program volunteer

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The University of Georgia Big Event Leadership Institute
Sigma Delta Tau Sorority; member
The University of Georgia Psychology Club; member
Athens Humane Society; volunteer

Other Skills/Training

Mental Health Emergency Response Training, September 2009 & February 2010
Proficiency with SPSS software
Reading and writing of Hebrew language
Infant/Child CPR Certification
Adult CPR/First Aid Certification