

Two Pilot Studies on Functional Family Therapy Early Intervention: Adapting Functional Family Therapy for Younger Children

Kellie Armey, LISW-S¹

Cheryl Hills, PgD, MCACP²

Elsa Campos, MSW, RSW¹

Helen Midouhas, Ph.D.¹

Siobahn McMecahn, Msc.²

Michael Robbins, Ph.D.¹

¹ Functional Family Therapy LLC

² Action for Children (Scotland)

Address correspondence to Kellie Armey at Kellie@fftlc.com.

Two Pilot Studies on Functional Family Therapy Early Intervention: Adapting Functional Family Therapy for Younger Children

Functional Family Therapy (FFT) (Alexander & Parsons, 1982; Alexander et al., 2013) is an evidence-based, intensive family therapy intervention that addresses adolescent emotional and behavioral problems through a phasic, family systems approach. The FFT model was developed specifically for 11–18-year-old youth with behavior problems (i.e., delinquency, substance use) who are referred by multiple systems such as juvenile justice, child welfare, mental health, and school settings. Based on extensive research conducted over five decades, the FFT model has received endorsements as an efficacious intervention from multiple entities, such as the Office of Juvenile Justice and Delinquency Prevention, the US Department of Justice, the California Clearinghouse for Child Welfare, the American Youth Policy Forum, and the National Gang Center.

The FFT model has been adapted and successfully implemented in a child welfare context (FFT-Child Welfare; FFT-CW) (Alexander et al., 2011; Turner, Robbins, Rowlands, & Weaver, 2017). The FFT-CW model serves a population of youth from birth through 17 years of age and is relevant for families in which a child is at risk of becoming accommodated by social services due to child abuse and neglect. In this paper, the focus is on examining whether FFT, can also be successfully adapted and implemented with a younger population of children (Functional Family Therapy-Early Intervention; FFT-EI), ages 6 to 10, where the focus is on the youth's behavior problems rather than a family-based child welfare concern, such as abuse and neglect. Information about developmental and clinical adaptations is presented. In addition, the process and outcomes of two pilot projects are presented to demonstrate the feasibility, intervention quality, and outcomes of these adaptations.

Based on requests from two community-based agencies, FFT LLC, the organization responsible for disseminating the evidence-based FFT and FFT-CW models worldwide (www.fftllc.com), agreed to adapt the FFT and FFT-CW models further to address the referral and risk factors for a younger population of 6- to 10-year-old children exhibiting behavior problems. This population was unique from prior research and implementation based on the age of youth and the referral pathway into services. For example, standard FFT addresses referral issues for 11–18-year-old youth, while the pathway into FFT-CW involves an issue of parent/caregiver/family abuse or neglect. In this adaptation, the impetus for referral is youth-based, like standard FFT. However, the developmental characteristics and clinical issues were similar to working with younger populations in FFT-CW.

The term “evidence-based program” promotes the perception that such programs are rigid, inflexible, and too narrowly focused to address the multi-faceted nature of issues in real-world settings. In addition, quality assurance in the implementation process is often viewed as difficult to sustain in community settings. Nonetheless, programs like FFT and the FFT-CW adaptation have been successfully transported into community settings. Every year, FFT LLC (www.fftllc.com) supports the implementation of these models with tens of thousands of youths and families in the United States and internationally.

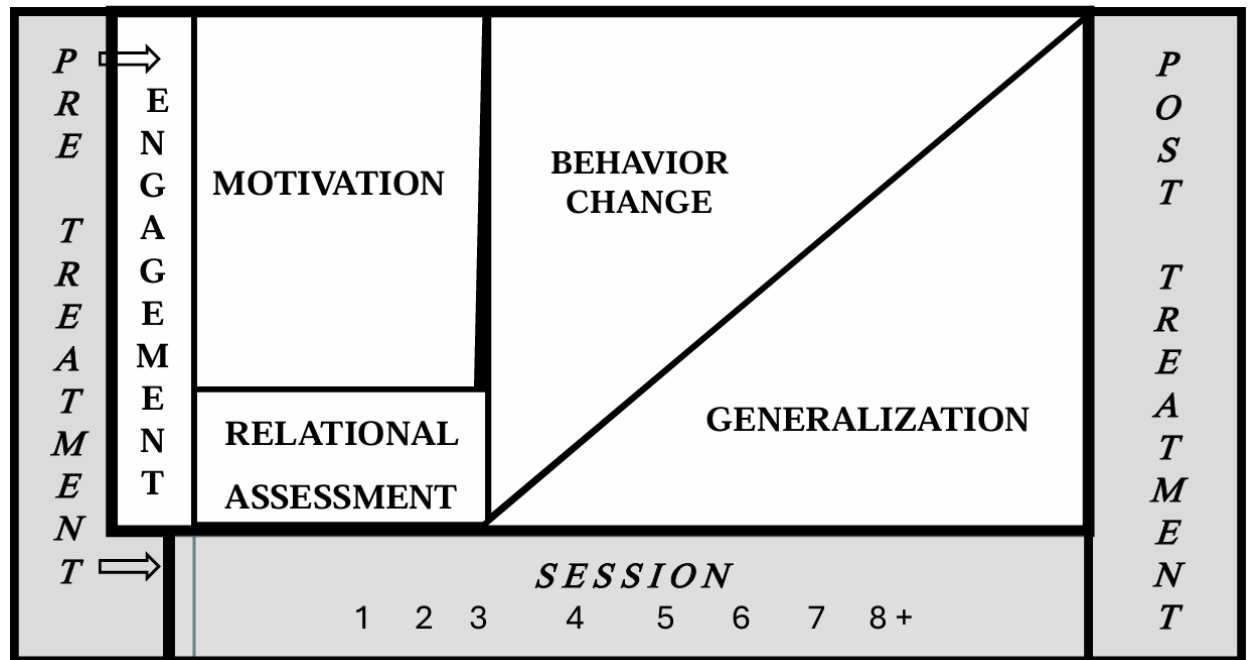
The focus of implementation is to ensure that the interventions demonstrated to work in peer-reviewed, rigorous evaluations are put on the ground with the same integrity, quality, and outcomes observed in the research studies. This rigor likely drives some perceptions that programs like FFT are rigid and inflexible. However, FFT LLC has a rich history of working with communities and leaders to accommodate and expand services to include new groups of youth and families, both in child welfare settings (Turner et al., 2017) as well as with gang-

involved (at-risk) adolescents (Gottredson et al., 2018; Thornberry et al., 2018). In doing so, the process of evolution is driven by core values on clinical integrity, accountability, and effectiveness. The process includes (i) a careful and systematic review of the literature to identify unique characteristics of the clinical population to ensure that interventions are matched to the needs of the new group, (ii) rigorous monitoring and support of clinical delivery through training and consultation, and (iii) systematic data collection and analysis to ensure safety and effectiveness. In this paper, we describe this process with two community-based groups. Both agencies highlighted the challenges they faced in addressing a group of younger children falling through the cracks in the service system and showing up in the system years later. Given the high-risk nature of these referrals and their age, we viewed this in part as a prevention project; however, these children showed up with serious referral issues that required complex clinical interventions; as such, we refer to this adaptation as FFT-Early Intervention.

Clinical Features of the Standard FFT Model for Adolescents with Behavior Problems

FFT's clinical model is grounded in core beliefs or principles of hope, strength, and resilience that recognize that each person and family are unique with respect to culture, community, family definition, and norms. Families who receive the model are actively involved in all aspects of treatment, including the definition of family.

FFT systematically integrates family systems, cognitive-behavioral theory, and intervention strategies to coherently address adolescent behavioral and emotional issues. Family-respect and strength-based interventions are delivered in five distinct, sometimes overlapping treatment phases (see Figure 1). Each phase includes specific goals, assessment foci, specific techniques of intervention, and clinician skills necessary for movement forward.

Figure 1. Phases of the FFT Model.

The first phase, Engagement, is focused on ensuring that youth and family members attend the first treatment sessions. Therapists work relentlessly to identify and connect with key players in the family to ensure that all relevant individuals view the therapist as credible and see therapy as something that will benefit them by participating. Contacts often involve multiple phone calls to key players and home- or community- visits. In the second phase, Motivation, the focus shifts from “What does this family member need to hear from me to see that they have something to gain?” to “What do they need to hear about each other to be willing to consider change?” The goals are to reduce conflictual family interactions (blame, negativity), create a relational focus, increase hope, and develop a collaborative and balanced relationship with family members.

During the first two phases, the therapist observes family members' interactions in the session and encourages them to report patterns of interaction outside of the sessions. The

information they are processing is critical to help them assess family members' "functions" in the third Phase, Relational Assessment. As such, the activities of the Relational Assessment Phase overlap with the earlier phases. The focus of this phase is to identify the relational functions, or payoffs, for an individual's behaviors in the family. FFT focuses on two aspects of family relationships: Contact and Hierarchy. Functions are not considered to be a trait but rather are unique to each relationship. That is, the function of the same behavior (i.e., youth screams) can lead to distance in the relationship with one family member and contact with another. In FFT, functions are considered neither good nor bad. They are critically important for understanding family members' natural style and tendencies. The strategies in the final phases incorporate the understanding of relational payoffs to ensure that interventions are matched to each family member and family relationship. This ensures that interventions are immediately acceptable to the family and that the family can sustain change over time.

The fourth phase, Behavior Change, focuses on directly addressing the youth's referral reason(s) and associated risk and protective factors. Interventions focus primarily on within-family, including systemic (i.e., communication, conflict, parenting) and individual (i.e., coping skills, emotional regulation, decision-making) features of the families. Strategies are practical and focused and are delivered in the context of conjoint sessions with the family. All interventions are matched to relational functions, developmental level, and individual style.

In the final phase, Generalization, the focus is on maintaining the changes made during Behavior Change, extending changes into multiple systems, and developing plans for sustaining all changes post-treatment. Therapists add a case-manager focus to the mix to connect families to informal and formal networks, which helps to ensure that changes are sustained over time.

The FFT model is typically delivered over three to 6 months, with sessions matched to the risk and protective factors present in the youth and family, 12-16 sessions for moderate cases, and up to 30 for more severe cases. FFT is provided where it is convenient for the youth and family, in the home or community settings.

Adaptations of the FFT model of change for an Early Intervention Age Group

The unique risk factors associated with a population of 6–to 10-year-old children who exhibited problematic behaviors necessitated a training and consultation focus that matched the developmental needs of this group. These adaptations impacted all phases of the FFT clinical model and included a unique focus on child development milestones, attachment theory, sensory regulation, and overall brain development.

Developmental Milestones for Younger Children

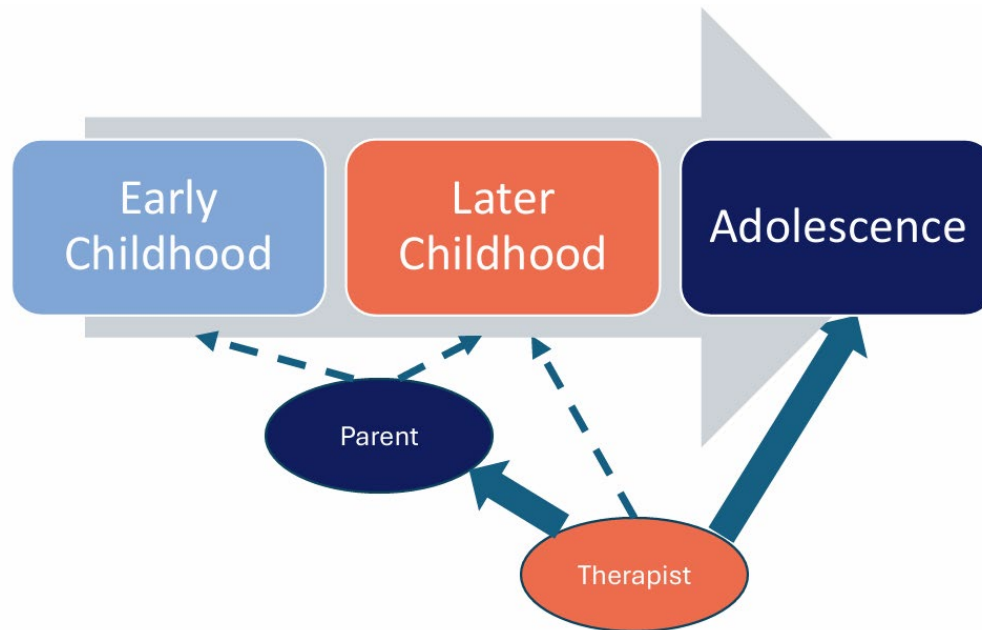
Understanding the developmental milestones in younger children was critical to adapting the FFT model for this population. This included theory and practice models of “typical” and “non-typical” behaviors as identified by Erikson’s Psychosocial Development Stages (1950) and understanding brain development (Haartsen, Jones, & Johnson, 2016), along with possible causes for those behaviors. Understanding developmental milestones allowed the FFT therapist to identify and target skill deficiencies better. Incorporating the understanding of developmental milestones happens throughout all phases of the FFT model in general, but this is heightened for FFT EI.

FFT is a talk therapy that requires participation, comprehension, and expression. Although adolescents might be difficult to engage and get involved in sessions, there is a direct communication channel with them. In fact, a key difference between FFT and FFT-CW and

FFT-EI is that therapists are expected to connect with adolescents during the Engagement Phase, prior to the first session, to enhance the adolescent's view of the credibility of the therapist and the potential benefits they might receive from treatment; whereas, this level of direct contact and engagement is not necessary in clinical work with younger children. With younger children, engagement moves through parent figures. Similarly, in the Motivation Phase, therapist interventions are directed to all family members; however, the content of complex change meaning interventions, like reframing, is directed towards parents. The content often includes a new way to look at other family members, including the youth. However, the recipient is often parents locked into conflict with each other, other family members, or the referred child. These interventions can have a profound impact on reducing parent and older family members' expressions of negativity and blame, and this reduction in expressed emotion can have a profound impact on the referred youth, who is usually highly tuned into and affected by this negative climate. It is common to observe younger children calm down or "become less noisy" when parents stop fighting or expressing hostility.

Communication channels become more difficult in the early intervention age group given the variability in the cognitive capacity of children developmentally. Therapists tailor their speaking tone and content based on the developmental differences in abilities to express oneself and comprehend. However, as noted, the burden of change is increasingly on parental figures as one moves across developmental phases (see Figure 2). This requires the therapist to respond to the phase by facilitating participation in treatment using games and activities. One way to match developmentally with younger children is to use motivators, coloring activities, or games. Additionally, therapists often need to adjust the session length to match to lower tolerance to attention and talking of children in the younger years.

Figure 2. Developmental Status and the Focus of Treatment.



Identifying areas where skills have been compromised for the child, based on developmental markers, then understanding those challenges and risks in the context of the family to create a relational focus in the Motivation Phase, helped to develop a skill-building plan for those areas in the Behavior Change Phase. Establishing good skills leads to developing relapse planning and practicing generalizing skills in the Generalization Phase. Developmental areas that may be compromised can include attention, impulsiveness, cognitive development, language and communication skills, and sensory integration. The FFT-EI adaptation requires therapists to specifically teach skills to the child and caregiver to support ongoing development in these key areas. Examples may include using sensory tools or changes to the environment (noise and light) to support decreased input into the child's brain system to help with regulation skills. In the Generalization Phase, it is recommended that additional therapeutic interventions

from outside professionals, including Occupational Therapists and Speech and Language Pathologists, be provided.

Attachment Theory Considerations

The foundation for understanding relationships and the dynamics within family systems comes from observing how caregivers “show up” in relationships with children and the response children have to those attachment figures. Identifying situations that interfere with the relationship and attachment between caregiver and child was critical in working with the younger population to identify ongoing relational patterns and support skill-building through the FFT approach.

Bowlby’s (1960, 1988) evolutionary theory of attachment suggests that children come into the world biologically pre-programmed to form attachments with others, which will help them survive. He notes there is a critical/sensitive period for developing attachment of up to 5 years. Bowlby’s maternal deprivation hypothesis suggests that continual attachment disruption between the infant and primary caregiver could result in long-term cognitive, social, and emotional difficulties for that child.

Additionally, according to Bowlby, an internal working model is a cognitive framework comprising mental representations for understanding the world, self, and others. It is based on the relationship with a primary caregiver. When the attachment patterns (Bowlby, 1988) are identified as a risk factor for cognitive, social, and emotional challenges, skills to support connection and space needs for both caregiver and child are developed in the Behavior Change Phase to mitigate escalating behaviors. This can include helping caregivers learn attachment “cues” and “miscues” their child is showing through their behaviors and addressing those more

productively. A cue is identified as a signal/request (direct or indirect) from the child or caregiver for a specific need to be met (Zanetti, Powell, Cooper, & Hoffman, 2011). A miscue is a misleading or contradictory cue used to protect the child from the pain of having a specific need exposed and/or unmet (Zanetti et al., 2011). Using and understanding attachment theory and strategies to support skills around behaviors as cues and miscues helps decrease negativity and blame towards the child and caregiver. An example of a skill would include supporting assertive communication for the caregiver to identify the child's behavior as a need and giving choices for how that need can be met. By teaching skills that promote attunement to a child's attachment needs, the caregiver can more effectively reduce disruptive behaviors and make strong connections with their child (Zanetti et al., 2011).

Sensory Regulation Needs for At-Risk Children

Children with behavioral problems exhibit high rates of mental health concerns, which often have implications related to their sensory and regulatory needs (Askelund, Ask, Ystrom, Havdahl, & Hannigan, 2023). For example, in one of the pilots, the most common concern was behavior related to the diagnoses of ADD or ADHD, and sometimes autism spectrum disorders masked by other diagnoses. According to the National Institutes of Health, approximately 10% of children aged 6 to 11 years have an ADD or ADHD diagnosis (Habdank-Kolaczowski, Akahara, Ishola, Salawu, Augustine, Ezeamii, David, Okobi, & Okobi, 2023). Children aged 6 to 11 represent the largest age group receiving medication and behavioral treatment, with 59.6% of children diagnosed on medication and 60% of these children receiving treatment (CDC, 2024). The prevalence of Autism Spectrum diagnosis has risen in the U.S., from 6.7 cases per 1000 (1 in 150) in the year 200 to 27.6 per 1000 in 2020, or 1 in 36 (Grosvenor, Croen, Lynch, Marafino, Maye, Penfold, Simon, & Ames, 2024). In response to the prevalence of ADD or

ADHD and Autism Spectrum Disorder diagnoses, interventions required to address regulation and sensory adaptation skills are necessary for supporting developmental needs and parenting skills within families. Interventions, specifically during the Behavior Change Phase of the FFT model, focused on meeting the sensory and regulation needs of at-risk children to reduce to reduce risks associated with dysregulation and sensory overwhelm, which can create high level of conflict within the family structure. Supporting parent understanding and strategies for sensory and regulation needs is a strong component of the FFT-EI adaptation. Some skills identified and used regularly in the Behavior Change Phase include identifying when there is a need for either sensory input or withdrawal. Based on the child's sensory needs, interventions can be identified and used to include all senses. This can include removing stimulation or adding more stimulation, depending on the child's needs. FFT-EI therapists use strategies for touch (hugs, giving space, touch), sound (noise-canceling headphones, soothing sounds), sight (removing clutter, making visible schedules), and smell (essential oils) as intervention options.

Brain Development in Younger Children

A fundamental understanding of cognitive (Piaget, 1971) and brain development (Perry, 2006) and the implications and impact of that development is necessary for addressing the behaviors and challenges experienced by the children and families referred to FFT-EI. As the target risk factors for FFT-EI adaptation lie in risks related to child mental health and/or behavior, knowledge about the sequential nature of brain development and disruption to key areas of development and cognitive processing helps to develop strategies and interventions that match to where youth are currently functioning. Skills and strategies for supporting brain development during the Behavior Change and Generalization Phases often include addressing the need for ongoing support (both informal and formal) to facilitate and sustain changes as

children respond to treatment and continue to develop. For example, with families where the child has a diagnosis of ADD/ADHD, strategies may be used to support regulation (targeting the diencephalon and cerebellum) by reducing sensory input and working on ways for the caregiver to connect first before trying to introduce skills for decision making. Given cognitive and brain development, the FFT-EI adaptation would focus more on skill building related to play (social interactions), language development (communication), connection (attachment and co-regulation), and giving choices as opposed to some of the strategies in standard FFT where the focus may be more on decision making, self-regulation, supporting independence and life skills. Like understanding developmental milestones, identifying compromised areas of brain development allowed the therapist to further develop skills for the child and the family to support ongoing development. It is recommended that the therapist follows the sequential nature of brain development, from bottom regions of the brain to more complex and top regions of the brain, in their skill building plans so that families are more successful in implementing skills to mitigate risks (Perry, 2006).

In the following sections, preliminary evidence regarding the effectiveness of the FFT-EI approach is provided by examining the impact of the model on youth and family processes and outcomes in two implementation contexts. It is important to note that although the pilot projects were conducted in different countries, both agencies had extensive experience working with FFT LLC to provide FFT and/or FFT-CW. Also, both sets of therapists received extensive training and oversight from expert Consultants from FFT LLC, which includes a rigorous approach used for systematically monitoring practice, collecting data, and examining implementation processes and clinical outcomes on an ongoing basis. The outcomes of the two pilot projects are presented

to demonstrate the feasibility, intervention quality, and outcomes of the FFT-EI approach. The outcomes of each pilot are independent and should not be interpreted as a comparison.

Rationales for Pilot Studies

Pilot Study One: Action for Children, Scotland

Action for Children (AfC) is a U.K. charity delivering diverse services across Scotland for the most vulnerable children, young people, and families. AfC has operated for 65+ years in Scotland and delivers 90+ services across 31 local authorities to 20,000 youth and families annually. AfC has been delivering Family Functional Therapy (FFT) services in Scotland since 2012. AfC currently has four teams working in partnership with 10 local authorities. The pilot team covers six of these local authorities.

In January 2018, concerns were raised within local authorities about a rise in the number of younger children between the ages of 8 and 10 years old who were being taken into residential care settings. Local authorities faced the dilemma of young children being placed outside the home in an environment unsuited to their developmental needs and away from their family of origin. Therefore, solutions were sought to provide family-based, developmentally appropriate interventions to support young people and their families, with the overall goal of children remaining within the family home.

Initially, FFT Child Welfare (FFT-CW) was considered. However, referrals for FFT-CW are primarily for families in which a child is at risk of becoming accommodated by social services due to behaviors related to parenting concerns rather than risks related to a child's behavior. Neglect and abuse were not concerns with the cohort of children who had been identified for this pilot. The children identified for this project were exhibiting high-risk

behaviors, including verbal aggression, physical violence, substance misuse, and delinquency within the community. Therefore, the children's externalizing behaviors put them at risk of becoming accommodated by social services. FFT-CW was not considered to be a viable option for this cohort. It was decided that an adaptation of standard FFT, FFT-EI, which focused on younger children who were displaying FFT referral behaviors similar to adolescents, would be more sustainable and appropriate to meet the needs of risk-related behaviors for this cohort.

Pilot Study Two: Start Corporation, Louisiana

Start Corporation, a 501(c)(3) non-profit organization founded in 1984, provides holistic care to individuals and families in 6 clinic locations in Louisiana. They began providing FFT services in 2014, and their FFT-CW team launched 3 years later in 2017. In reviewing data trends for the FFT-CW program, it was found that 40% of cases referred to FFT-CW were due to referral behaviors associated with children aged 6-10, with 92% of these families reporting a youth mental health concern. Like the population in the Scottish pilot, behaviors associated with referral reasons included school truancy, aggression towards others, significant disruption to relationships (including family relationships), and other risks. Like AfC, the Start Corporation recognized that this population had characteristics similar to adolescents seen in FFT, but needed interventions tailored to the needs of younger children, such as FFT-EI.

Methodology

Participants

The Scottish pilot included 20 families referred from social services. The children were primarily male (65%), and the average age was 9.45. Seventeen of these families completed the intervention (85%). Of the three families who did not complete the intervention, all had a

treatment conflict, resulting in unsuitability to complete the intervention at that time. Families with at least one caregiver were eligible for the service. Services were delivered in the home and community.

The Louisiana Pilot included 93 families that self-referred for the treatment of 6-10-year-old youth with mental health problems. The children were primarily male (67%), and the average age was 8.61. Thirty-nine of these families completed the intervention (80%). Of the 19 that did not complete, seven families did not start, resulting in an engagement rate of the whole pilot of 88%. This percentage demonstrates the relentless engagement of the EI model with families. The remaining 12 families were closed due to the family not participating in the service (8) or the child being placed (2). Two families had services disrupted by the referral source, thus not being able to complete treatment. At the close of the evaluation period, 31 cases were still active in treatment.

Materials

In both performance locations, therapists used assessments endorsed by or provided for by FFT LLC. These case-level assessments included pre- and post-treatment questionnaire assessments, outcome and alliance measures, and outcome measures. Table 1 outlines case-level assessments used in the FFT EI adaptation and is featured in this paper.

Table 1.*Case-Level Assessments Featured in FFT Early Intervention*

Domain	Assessment	Description
<u>Pre-Post Assessments</u>		
	OQ®-45.2 Outcome Questionnaire & Risk Levels (UK only)	The OQ® 45.2 provides a quick but comprehensive snapshot of the parent/caregiver's (18 and older) current functioning across various disorders.
	Y-OQ® 2.01 Youth Outcome Questionnaire	The Y-OQ® 2.01 provides a quick but comprehensive snapshot of the parents'/caregivers' perceptions of their 4-17-year-old's current functioning.
	Strengths and Difficulties Questionnaire (parents, teachers, & self-report, UK Only)	The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioral screening questionnaire about 2-17-year-olds. It exists in several versions to meet the needs of researchers, clinicians, and educationalists.
	Accommodation Risk of Youth (UK Only)	The social worker assesses the likelihood of a young person needing to be accommodated before and after the FFT intervention.
<u>Outcome Measures</u>		
	Client Outcome Measure (COM caregiver (US and UK) and youth (UK Only)	The COM assesses the caregiver's or youth's perspective of family functioning and youth behavior change at closing.
	Therapist Outcome Measure (TOM)	The TOM assesses the FFT therapist's perspective of family functioning and youth behavior change at closing.
	Final Ratings	Provided for completed cases and based on the aggregated ratings of the COM(s) and TOM.
	Ultimate Outcomes	Global outcomes across several domains of risk are provided for both completed and non-completed cases.

Case tracking and service delivery data were also collected in the Louisiana pilot and will be reported where available below.

Data from assessments, including therapist fidelity and quality assurance measures, and service delivery data are housed in FFT LLC's Client Services System (CSS). This web-based system supports and guides therapists in organizing and adhering to the model. For the Scottish pilot only, the therapists and the FFT Consultant provided additional qualitative information about their experiences delivering and supervising the pilot program in a semi-structured interview. Questions included "What adaptations did you have to make with these families (what was different from standard FFT)? What went well? What were the more difficult parts of delivering the model? What may be helpful to implement moving forward?" This pilot study, consistent with Braun and Clarke (2006), used thematic analysis in an open-ended way to investigate therapists' experiences of engaging families in the adapted FFT model.

Procedure

In both pilots, FFT teams were trained to deliver the standard FFT model (Alexander & Robbins, 2023), which inherently provides a trauma-informed approach, along with enhancements for the adaptations of the EI model. For the Scottish pilot, the existing team of seven therapists was provided with an additional two days of training and extra consultation. In contrast, the new team of 5 therapists in the Louisiana project received the usual FFT training protocol, which included 10 days of clinical training (Five 2-day trainings) that included the EI areas of focus. For this team, two therapists had previously practiced the FFT CW model, and the remainder were new to FFT services. Both teams received weekly consultations, quality assurance, and improvements related to the ongoing assessment of therapist practice, reflecting fidelity to the clinical model. The same FFT Consultant was used for both performance locations.

Data

Pre- and Post-Assessments of Change. The first set of reported outcomes includes pre- and post-assessment data and focuses on reliable change indices between baseline and post-intervention measures. The section will briefly describe what was measured, the target of the assessment, and the findings.

OQ®-45.2 Outcome Questionnaire

The OQ® 45.2 measures caregiver progress in therapy by examining three dimensions: subjective (intrapsychic functioning), interpersonal relationships, and social role (Lambert, Kahler, Harmon, Burlingame, Shimokawa, White, 2013). The measure is for adults, 18 and older, and asks about agreement with statements from the three dimensions over the past 7 days. The measure is completed by each caregiver (up to two) pre- and post-intervention, so it is only used when the intervention was delivered successfully (all five phases). Table 2 describes the OQ measures for the caregivers in both projects.

Table 2

Outcome Questionnaire Pre- and Post-Comparisons for Total Scores and Subscales

Time	<i>Pre avg</i>					<i>Post avg</i>				
	<u>Subscales</u>	<u><i>n</i></u>	<u>SD</u>	<u>IR</u>	<u>SR</u>	<u>Total</u>	<u>SD</u>	<u>IR</u>	<u>SR</u>	<u>Total</u>
Scotland		15	43	16	9	68	36	12	7	54
Louisiana		44	30	10	9	49	32	11	9	52

** Total Cutoff Score 0 to 180 ≥ 64 , Symptom Distress (SD) 0 to 100 ≥ 37 , Interpersonal Relations (IR) 0 to 44 ≥ 16 , Social Role (SR) 0 to 36 ≥ 13*

For the Scottish project, symptom distress met the clinical cutoff ($43 \geq 37$), as did the pre-total ($68 \geq 64$), suggesting that the caregivers in this pilot were experiencing high levels of symptoms related to anxiety and affective disorders (Lambert et al., 2013). For Scotland, the

Interpersonal Relations cut-off was met (16=16), but Social Role did not reach the cutoff (9<13). A difference of 14 or more points between the pre- and post is required for reliable change. Only the Scottish pilot achieved a reliable change from pre- to post-test. For the Louisiana pilot, reliable change was not met, and while scores went up pre- to post-test, the change was not significant, nor were the scores above the normative cutoff. However, when examining the OQ outcomes, it is noteworthy that approximately 30% of the caregivers demonstrated significant changes from pre to post, reaching the cutoff of 64. For these caregivers, the pre- to post-change significantly decreased by 29 points. It should be noted that the sample was not selected for caregiver distress or functioning. Rather than adult distress, child behavior led to the referral, hence the lower pre-scores for Louisiana. As such, it is challenging to demonstrate reliable change with the caregiver when the level of functioning is below the clinical cutoff at baseline. For Scotland, the sample did reach the cutoff. However, it was small, and caregivers involved admitted to high levels of symptom distress (anxiety, depression, and possible somatic issues along with stress), as well as issues related to interpersonal relationships and social role (usually work) (Lambert et al., 2013).

Y-OQ® 2.01 Youth Outcome Questionnaire

The Youth Outcome Questionnaire was only used in the Louisiana Pilot, as the Scotland Pilot used the Strengths and Difficulties Questionnaire (SDQ). Caregivers complete the Y-OQ® 2.01 as a measure of treatment progress for children and adolescents aged 4 to 17. It was “constructed to assess the occurrence of observed behavior change” from the caregiver’s perspective (Burlingame, Cox, Wells, Latkowski, Justice, Carter, & Lambert, 2005, p. 1). Like the OQ® 45.2, the Y-OQ® 2.01 asks the caregiver about behaviors observed over the last 7 days and is done at baseline and post-intervention. There is a Total Score and seven subscales. The

subscales are Intrapersonal Distress (ID), which captures emotional distress; Somatic (S), which includes physical and somatic concerns; Interpersonal Relations (IR), which involves interpersonal difficulty with caregivers, other adults, and/or peers; Social Problems (SP), which involves aggressive or delinquent behaviors, Behavioral Dysfunction (BD), which includes difficulty with attention, concentration, impulsivity, organizing and dealing frustration, and Critical Items (CI), which includes behaviors that suggest the child would benefit from more psychiatric care. Finally, the Total Score reflects the total distress in a child's life. Table 3 provides a breakdown of subscales and total pre- and post-scores for the Louisiana pilot.

Table 3

Youth Outcome Questionnaire Pre and Post-Comparisons for Total Scores and Subscales

Time	<i>Pre avg</i>								<i>Post avg</i>							
	<i>n=39</i>	ID	S	IR	SP	BD	CI	Total	ID	S	IR	SP	BD	CI	Total	
Louisiana		26	6	11	7	23	9	82	20	6	7	7	18	8	66	

** Total Cutoff Score -16 to 240 ≥ 47 , Critical Items (CI) 0 to 36 ≥ 6 , Intrapersonal Distress (ID) -4 to 68 ≥ 17 , Somatic (S) 0 to 32 ≥ 6 , Interpersonal Relations (IR) -6 to 34 ≥ 5 , Social Problems (SP) -2 to 30 ≥ 4 , Behavioral Dysfunction (BD) -4 to 40 ≥ 13*

The 39 assessments demonstrate significant change in behavior pre- to post, exceeding the reliable change index of 13, with a difference of 16. A pre-score of 82 is considered moderately high by the test developers (Burlingame et al., 2005) and is close to the scoring of a residential sample in general and for age ranges (Mean of 89.74 vs. Outpatient Mean of 75.35). The Behavioral Dysfunction pre-score matches that of a clinical sample of 9-11-year-olds in an inpatient day treatment facility (Burlingame et al., 2005). Critical Items pre- and post-score were notably higher than an outpatient clinical sample of the same age. The significant change from pre- to post for Interpersonal Relationships is notable (11-7, *RCI of* >4).

Strengths and Difficulties Questionnaire

The Scotland Pilot utilized the Strengths and Difficulties Questionnaire, or the SDQ. This is the preferred measure in the U.K. by both funders and agencies. The SDQ was developed as a behavioral screening questionnaire for 2 to 17-year-olds (Goodman, 1997). There is a youth version (4-17), a caregiver version, and a teacher version. The SDQ measures positive attributes and risk symptoms regarding the child or adolescent's behavior in the past 6 months by examining the scores on five subscales: Emotional Symptoms, Conduct Problems, Hyperactivity, Relationship Problems, and Prosocial Behavior. Table 4 provides the pre- and post-scores for risks only (excluding the prosocial subscale), with the analyses following.

Table 4

SDQ Pre and Post Scores (Youth n=10, Caregiver n=17, and Teacher n=10 perspectives)

Version

	<u>Subscale</u>	<u>Pre Avg</u>	<u>Post Avg</u>
Youth			
	Emotional Symptoms	5.67	6.60
	Conduct Problems	4.67	4.40
	Hyperactivity	6.17	7.00
	Peer Relationships Problems	4.00	5.40
	Total	20.51	23.4
Caregiver			
	Emotional Symptoms	6.24	4.29
	Conduct Problems	7.00	5.18
	Hyperactivity	8.06	6.18
	Peer Relationships Problems	4.06	3.82
	Total	25.36	19.47
Teacher			
	Emotional Difficulties	5.50	2.50
	Conduct Problems	5.64	4.40
	Hyperactivity	7.00	5.20
	Peer Relationships Problems	3.50	2.90
	Total	21.64	15

** Means and Standard Deviations(SD) are available for Youth. Emotional 2.8 (2.1), Conduct 2.2 (1.7), Hyperactivity 3.8 (2.2), Peer 1.5 (1.4), Total 10.3 (5.2). Means and Standard Deviations(SD) are available for the Caregiver. Emotional 1.9 (2.0), Conduct 1.6 (1.7), Hyperactivity 3.5 (2.6), Peer 1.5 (1.7), Total 8.4 (5.8). *Means and Standard Deviation for Teachers (SD) Emotional 1.4 (1.9), Conduct 0.9 (1.6), Hyperactivity 2.9 (2.8), Peer 1.4 (1.8), Total 6.6 (6.0)*

Table 4 pre- and post-scores show that the 10 youth had Means above the normative population on the SDQ self-report, with most considered “Slightly Raised” to “High” in terms of level of risk (Youthinmind, 2024). The total scores fall under the “Very High” category. This

matches the risk and distress the families and therapists reported for these referrals. While the post scores did not decrease, they reflect a small number of youth who were eligible to complete the measures. For those that did, the scores suggest more awareness of difficulties.

Table 4 displays scores above average and improvements pre- to post for caregivers. Emotional Symptoms, Hyperactivity, and Peer Relationship Problems all fell from “High” to “Slightly Raised.” Conduct Problems were under the “Very High” category and dropped to “High,” and the total score fell from “Very High” to the “High” category (Youthinmind, 2024).

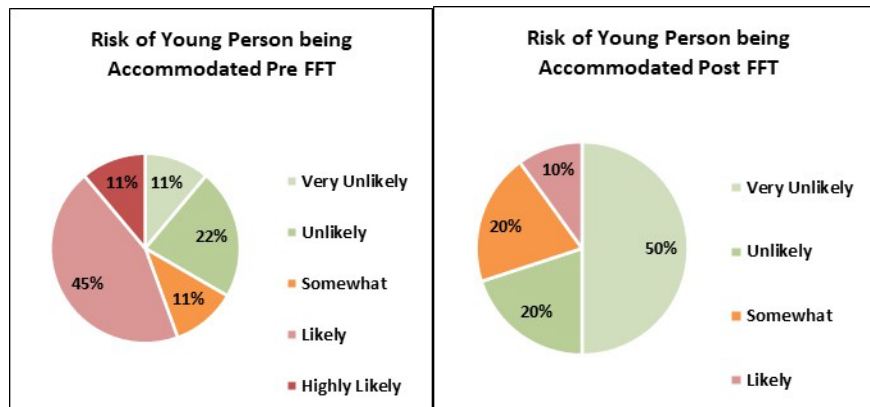
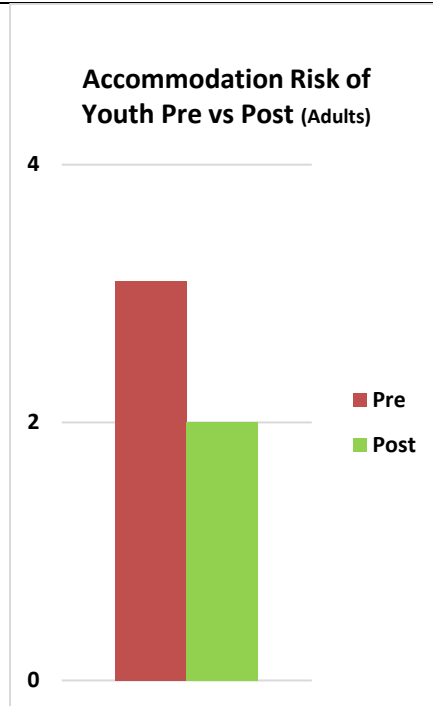
Last, Table 4 displays what is known as the “Teacher SDQ” (YouthinMind, 2024); however, this was completed by the social workers who referred the youth. Emotional Difficulties had the most significant categorial change, from “Very High” to “Close to Average.” Hyperactivity and Peer Relationship Problems all fell from “Slightly Raised” to “Close to Average,” and Conduct Problems fell from “Very High” to “High.” The total score fell from “Very High” to the “Slightly Raised” category. It is highly recommended that practitioners use psychometrically comparable measures when gathering reports, and most look at school and home (Murray, Speyer, Hall, Valdebenito, Hughes, 2021). Caregiver versions often “score higher,” possibly due to the less structured environment of the home versus the school.

Accommodation of Risk

The Scotland pilot furnished a final pre- and post-assessment that asked the social worker who referred the case what the likelihood was of the young person becoming accommodated in the immediate future. Using a Likert Scale, they chose responses that ranged from “Very Unlikely” to “Highly Likely”. Figure 3 provides Social Worker feedback on 10 young people and shows a reduction in accommodation from 3.10 pre-FFT EI to 2.00 post-FFT EI.

Figure 3.

Accommodation Risk of Youth Pre vs. Post by Social Workers



**Ratings: Highly Likely (4), Likely (3), Somewhat (2), Unlikely (1), Very Unlikely (0)*

FFT LLC Measures of Outcome. The second set of outcome measures is collected routinely for all cases that complete FFT services. FFT LLC developed these measures. The section will briefly describe what was measured, the target of the assessment, and the findings.

Client Outcome Measure (COM)

FFT LLC developed the Client Outcome Measure (COM) to assess the caregivers' and youth's perspectives of family functioning and youth behavior change. There are two versions, one for the youth and one for the caregiver. For both pilots, only family functioning scores are displayed. Youth behavior was excluded, given that the questions fall under adolescent delinquency-type behaviors. For the Louisiana pilot, the COM-C was only given as most youth were 10 and under, and the COM-Y is intended for 11 and older. The COM-Caregiver (COM-C) and a small sample of COM-Y's (n=7) were given for the Scotland pilot. This is due to the recommendation that the COM-Youth version be given to youth 11 and older. The COM-C utilizes a 6-point Likert scale that ranges from 0 "Worse" to 5 "Very Much Better." The goal is to receive a 3, or "Some Better" or higher, from the caregivers. For both pilots, caregivers, youth (U.K.), and therapists consistently scored a rating of 3 or higher.

Therapist Outcome Measure (TOM)

FFT LLC simultaneously developed the Therapist Outcome Measure (TOM) to assess the therapist's perspective of family functioning and youth behavior change. The TOM utilizes a 6-point Likert scale that ranges from 0 "Worse" to 5 "Very Much Better". The goal is to achieve a 3, or "Some Better," or higher. The average ratings for both pilots are displayed in Table 5.

Table 5

Client and Therapist Outcomes on Completed Cases for Scotland and Louisiana Pilots

<i>Outcome Measures (goal ≥3)</i>	<i>COM-C</i>	<i>Scotland</i>		<i>Louisiana</i>	
		<i>COM-Y</i>	<i>TOM</i>	<i>COM-C</i>	<i>TOM</i>
Family relationships improved	3.38	4.00	3.44	3.95	3.76
Communication improved	3.50	4.33	3.56	3.92	3.73
Youth behavior improved	3.00	4.00	3.22	3.67	3.64
Parenting improved	4.25	4.00	3.67	4.00	3.76
Youth supervision improved	3.13	3.67	3.56	3.97	3.70

Reduction of conflict	3.50	4.33	3.44	3.84	3.64
-----------------------	------	------	------	------	------

**COM-C, COM-Y, and TOM ratings for Scotland Youth (n=7), Caregiver (n=19), Therapists (n=17), Louisiana Caregiver (n=40), Therapists (n=39)*

Ultimate Outcomes

When a case closes, global outcomes are given by therapists across several risk domains. Before 2020, there were three ultimate outcomes: youth remained at home or in the community, youth were in school, and youth had no new law violations. In 2020, four more ultimate outcomes were added to capture the full range of referral types the FFT programs and their adaptations address. These added whether siblings and caregivers remained in the home or community, whether there was no intensity of the referral problem, and the absence of new safety incidents. Because the two pilots occurred at different times, only the Louisiana pilot features new ultimate outcomes (see Table 6).

Table 6

Ultimate Outcomes for Scotland and Louisiana Pilots on Completed Cases

Variable	Louisiana Pilot %	Scotland Pilot %
<u>Original Outcomes</u>		
Youth Remains in the Home/Community	100%	100%
GED/working	100%	94%
Youth with no new law violations	100%	100%
<u>Additional Outcomes Added 2020:</u>		
Sibling(s) Remain in the Home/Community	100%	
Caregiver(s) Remain in the Home/Community	100%	
No Intensification of the Referral Problem	100%	
No New Safety Incidents for the Family	97%	

**Percentages are based on agreement with the statement*

Service Delivery and FFT Program Comparison Data.

The Louisiana project was uniquely positioned to examine service delivery data and compare this data with the two existing FFT and FFT CW programs offered at Start Corporation from July 1, 2023, to July 1, 2024. This allowed the authors to examine the hypothesis that the model could be adapted to target the reduction of behavioral risk factors present in children 6-10 years of age and that through the adaptation of clinical focus, FFT EI could meet the same model standards associated with service delivery and outcomes of FFT and FFT CW. The results of this comparison are in Table 7.

Table 7

Comparison of Service Delivery of FFT, FFT CW, and FFT EI

Model	FFT		FFT CW		FFT EI	
Variable	#	%	#	%	#	%
Average Number of Sessions	15.24		15.23		15.38	
Length of Stay	137.73		143.48		132.23	
Assignment to First Contact (days)	0.6		1.36		1.35	
Assignment to first Session (days)	10.04		9.42		7.84	
First to Second Session (days)	9.18		8.72		10.18	
Second to Third Session (days)	8.99		10.18		8.74	
Completion Rates	81%		80%		80%	
Final Ratings						
Very Much Improved	14%		35%		23%	
A Lot of Improvement	43%		30%		46%	
Some Improvement	34%		32%		31%	
Little Improvement	8%		2%		0%	
No Change or Worse	1%		1%		0%	

Ultimate Outcomes			
Youth Remains at Home or Community	99%	97%	100%
No Intensification of Referral Problem	95%	95%	100%
No New Safety Incidents in the Home	96%	95%	100%
Youth Attending School	97%	96%	100%

**Percents are based on agreement with the statement.*

with 46% of the caregivers and therapists rating the outcomes as “A lot of Improvement,” 31% noting “Some Improvement,” and 23% noting “Very Much Improved.” Nineteen families did not complete the service (20%).

Discussion and Considerations for FFT EI Implementation

Outcomes

The results of quantitative analyses demonstrated positive findings from multiple perspectives, measures, and performance locations. For example, parents, teachers, and social workers report significant improvements in youth behavior. This is particularly important because it shows the robustness of change across contexts (home and school), including the potential avoidance of costly outplacements that have devastating long-term consequences on young people and their families. Across both pilot project studies (Action for Children, Scotland, and START, Louisiana), it was hypothesized that referral behaviors would decrease, children would remain within the family home, children would be involved in education, and family relations would improve while maintaining fidelity to the FFT model. Quantitative data indicate a reduction in the overall combined risk level for the young people involved. Additionally, clinical outcome measures highlight improved skills among family members and enhanced family relationships.

Although the youth reports were not significant, the fact that key adults that experienced the youth’s disruptive behavior prior to treatment suggests that either a) the youth experienced the

treatment differently, b) the measures failed to meet the youth's developmental needs, or c) this population of younger children is not as reliable reporters as other individuals.

The FFT-EI model also seems to have a positive impact on caregiver distress. Given that this sample was not referred to treatment to address problems in caregivers' functioning, it was not surprising that the impact was only observed in a sub-sample of caregivers who presented with higher levels of distress at baseline. Thus, although the focus of treatment was primarily on youth behavior problems, interventions included elements, such as trauma-based strategies, that indirectly or directly helped caregivers experience change.

Adaptation

The development of FFT-EI underscores the importance of flexibility, responsiveness, and collaboration as key elements in the evolution of the delivery of evidence-based programs like FFT. Although younger children fall outside the target range for whom traditional FFT is effective, it was impossible to ignore the significant challenge that community-based agencies faced with younger children. One of the messages from a leader in Scotland was that these children of a latent age were being missed by local and national efforts to meet children's needs. Very young children (infants and toddlers) were being served by parenting programs, and adolescents were receiving services because their extreme behaviors were being recognized by formal systems (e.g., police, social care, schools). Latent age children, however, were slipping through the cracks, falling somewhere outside of the prevention initiatives for very young children and the treatment programs for adolescents.

Working with this group of young people was not as simple as just implementing FFT and hoping for the best. Prior to doing any training or serving cases, the clinical leaders at FFT LLC, including the developer of the FFT model (James Alexander) and Clinical Director

(Michael Robbins), began to identify key features of the population and to match the principles and strategies of FFT to the unique developmental and clinical needs of the population.

However, this dynamic process started before training but spanned the entire implementation.

Therapists, site supervisors, and consultants have provided examples of the types of themes and strategies that evolved from this work. The types of themes identified earlier in this paper include understanding the theoretical and practical implications of attachment theory, child and brain development, and the presentation of sensory needs for clinicians in their work with families of younger children. It is their voices that have brought this adaptation to life and made it relevant and meaningful to families and the therapeutic community. Their commitment to being accountable to families is evident in their attempts to systematically gather information about clinical processes and outcomes. This interplay between clinical theory, clinical practice, and evaluation is critical in the evolutionary process for clinical models.

Implications for Training and Supervision

The clinical framework provided by the FFT model has proven to be remarkably relevant across clinical populations (children, adolescents, and young adults), clinical settings (juvenile justice, social welfare, schools), and implementation contexts (US, Canada, Europe, Australia, New Zealand, Singapore). Across these areas, the core principles of being family-based, respect-based, and strength-based have been consistently applied. In addition, the overarching 5-phase structure of intervention has been the same, which makes sense given that the Anatomy of Intervention Model (Barton et al., 1983) on which FFT is based was intended to provide a generic framework that applied to the universe of treatment models. Thus, across models, including FFT-EI, the core features of training always start with an overview and then a deeper dive into the model's principles and the phases of treatment.

The uniqueness of FFT-EI, however, comes from the intensive attention that developers paid to understanding and matching interventions to the developmental needs of this group of children. From the outset, it was understood that delivering a talk-based model with strong cognitive-behavioral elements would look different because of younger children's different levels of communication abilities (both receptive and expressive). Interventions were adapted to be more relational in nature and focused on skills to support earlier stages of development. This includes focus on parental/caregiver skill development in supporting and scaffolding developmental skills for their child(ren) and the relationship between parent/caregiver and child. This focus was further enriched by experience and research into understanding how brain development, experience of trauma (etc.) were linked to youth and family member behavior problems, as well as communication and decision-making abilities.

Other key factors in the adaptation to the model include clinician training to support more in-depth knowledge and training in three specific areas: child and brain development, attachment, and trauma. These areas are discussed previously in this paper as significant when working with children within this age group and their families, given the reasons for referral. As indicated earlier, the referral reasons for both pilot projects were linked to child mental health and previous experience with trauma. As a result, clinician knowledge, experience, and understanding of child and brain development, attachment, and trauma are areas where the model focuses more attention on matching and skill development. The evolution of the adaptations in this paper was also influenced by the clinical work with the FFT-CW model, which has occurred with thousands of youths and families globally. The articulation of the therapist's position, the structure of sessions, and the nature of strategies have been specifically matched to the needs of families with younger children.

Functional Family Therapy (FFT) has a long-standing legacy of reducing risk factors associated with the primarily referred youth aged 11–18 through a family-centered change process. Families referred to FFT and FFT-CW are often involved in systems such as juvenile justice or child welfare, where mandated mental health interventions are required. In contrast, it was anticipated that families receiving FFT Early Intervention (FFT EI) would more frequently be referred voluntarily through mental health systems rather than formal mandates. It was also hypothesized that the referred concerns for children in FFT EI would more commonly reflect mental health issues rather than family risk factors or delinquent behaviors.

A comparison of the three FFT programs offered by START confirmed these assumptions regarding FFT EI. More significantly, the findings underscore the importance of tailoring family therapy to address the specific risk factors associated with children aged 6–10. This approach ensures families receive services designed to create immediate access to long-term, meaningful change.

Limitations and Future Considerations

A key limitation across both pilot studies was the difficulty in collecting comprehensive outcome data. Small sample sizes and inconsistent reporting from youth, caregivers, and referral agencies resulted in significant data gaps, particularly among younger children. This was most evident in the Scotland pilot, where only 6 out of 17 children completed pre- and post-treatment paperwork. Additionally, standardized measures were often not developmentally appropriate for younger participants, limiting the accuracy and completeness of feedback.

Unique to the Scotland pilot is how the cases were referred to FFT EI. A challenge arose with the referral pathway involving system-based social workers. Only 10 of 17 social workers returned complete data, often due to role transitions during the intervention. While the data

received did show promising results, these findings highlight the need for improved data collection strategies, including streamlined processes and enhanced communication with social work partners.

Despite these limitations, the second pilot (START) produced promising outcomes. Quantitative data indicated a reduction in overall risk levels, and improvements were noted in family functioning. Caregiver-reported outcomes using the OQ 45.2 measure showed that 13 caregivers reported decreased stress in domains such as social roles, interpersonal relationships, and symptom distress. While 29 caregivers showed no measurable change, qualitative feedback reflected increased confidence in the FFT process and its positive impact on children. It was also recognized that some caregiver stressors, such as employment, substance use, and depression, extended beyond the timeframes of FFT and were addressed through referrals during the Generalization Phase.

An early hypothesis for the START pilot study findings supported the initial assumption that FFT Early Intervention (FFT EI) families are more often referred voluntarily through mental health pathways, with presenting concerns centered more on child mental health than on delinquency or broader family risk factors.

Based on discussions and feedback from therapists and the FFT Consultant, it has been recommended that FFT EI implementation include developmentally appropriate assessment tools for children aged 6–10 and their caregivers. Alternative pre- and post-assessment tools specific to the risk and protective factors associated with children aged 6–10 and their caregivers should be implemented to measure change better. Additionally, feedback from therapists and the FFT National Consultant also emphasized the importance of integrating additional training content on developmental milestones, parent-child attachment, sensory regulation, and neurodiversity,

including conditions such as ADHD, ODD, and ASD. These enhancements will help ensure that FFT EI remains responsive to the distinct needs of younger children and their families.

References

Alexander, J. F. & Robbins, M.S. (2023). *Functional Family Therapy: Clinical training manual*. Functional Family Therapy (FFTLLC/): Atlanta, GA/Seattle, WA.

Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). *Functional family therapy for adolescent behavior problems*. Washington, DC: American Psychological Association.
<http://dx.doi.org/10.1037/14139-000>

Askelund, A. D., Ask, H., Ystrom, E., Havdahl, A., & Hannigan, L. J. (2023). Exploring the differentiation of behavioural and emotional problems across childhood: A prospective longitudinal cohort study. *JCPP advances*, 3(4), e12176. <https://doi.org/10.1002/jcv2.12176>

Bowlby, J. (1960). *Separation anxiety*. The International Journal of Psychoanalysis, 41, 89–113.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. Basic Books

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>

Burlingame, G., Cox, J., Wells, G., Latkowski, M., Justice, D., Carter, C., & Lambert, M. (2005). *The administration and scoring manual of the Youth Outcome Questionnaire*. Salt Lake City, Utah: OQ Measures.

Centers for Disease Control. (2024, November 19). Data and Statistics on ADHD. Retrieved on December 12, 2024, from [https://www.cdc.gov/adhd/data/index.html#:~:text=Nearly%202%20million%20U.S.%20children,to%202022%20\(2.8%20million\)](https://www.cdc.gov/adhd/data/index.html#:~:text=Nearly%202%20million%20U.S.%20children,to%202022%20(2.8%20million))

Erikson, E. H. (1950). *Childhood and Society*. New York: W. W. Norton & Co

Goodman R (1997). The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, **38**, 581–586.

Grosvenor, L.P., Croen, L.A., Lynch, F.L., Marafino, B.J., Maye, M., Penfold, R.B., Simon, G.E., Ames, J.L. (2024, October 1). *Autism Diagnosis Among US Children and Adults, 2011-2022*. JAMA Network Open;7(10):e2442218. doi: 10.1001/jamanetworkopen.2024.42218. PMID: 39476234; PMCID: PMC11525601

Haartsen, R., Jones, E. J. H., & Johnson, M. H. (2016). Human brain development over the early years. *Current Opinion in Behavioral Sciences*, *10*, 149-154.

<https://doi.org/10.1016/j.cobeha.2016.05.015>

Habdank-Kolaczowski, J.S., Akahara, P.C., Ishola, F., Salawu, M.A., Augustine, S.W., Ezeamii, V.C., David, A.B., Okobi, E., Okobi, O.E. (2023). *Attention-Deficit Hyperactivity Disorder Among American Youth: A Comprehensive 20-Year Analysis of National Center for Health Statistics (NCHS) Data*. Cureus,15(11):e48781. doi: 10.7759/cureus.48781. PMID: 38098925; PMCID: PMC10719878.

Lambert M.J., Kahler, M., Harmon, C., Burlingame G.M., Shimokawa, K., White, M.M. (2013). *The administration and scoring manual of the Outcome Questionnaire*. Salt Lake City, Utah: OQ Measures.

Murray, A.L., Speyer, L.G., Hall, H.A., Valdebenito S., Hughes C. (2021). *Teacher Versus Parent Informant Measurement Invariance of the Strengths and Difficulties Questionnaire*. Journal Pediatric Psychology, 46(10):1249-1257. doi: 10.1093/jpepsy/jsab062. PMID: 34333621; PMCID: PMC8561254.

Perry, B. D. (2006). Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children: The Neurosequential Model of Therapeutics. In N. B. Webb (Ed.), *Working with traumatized youth in child welfare* (pp. 27–52). The Guilford Press.

Piaget, J. (1971). *The Theory of Stages in Cognitive Development*. In D. Green, M. P. Ford, & G. B. Flamer (Eds.), *Measurement and Piaget* (pp. 1–11). New York, NY: McGraw-Hill.

Robbins, M. S., Alexander, J. F., Turner, C. W., & Holliman, A. (2016). *Evolution of functional family therapy as an evidence-based practice for adolescents with disruptive behavior problems*. *Family Process*, 55(33), 543–557. <http://dx.doi.org/10.1111/fam.12230>.

YouthinMind. (2022, August 16). *What is the SDQ?* Retrieved on February 24, 2025, from <https://www.sdqinfo.org/a0.html>

YouthinMind. (2022, August 16). *Scoring the SDQ?* Retrieved on February 24, 2025, from <https://www.sdqinfo.org/py/sdqinfo/c0.py>

Zanetti, C. A., Powell, B., Cooper, G., & Hoffman, K. (2011). The circle of security intervention: Using the therapeutic relationship to ameliorate attachment security in disorganized dyads. In J. Solomon & C. George (Eds.), *Disorganized attachment and caregiving* (pp. 318–342). The Guilford Press.