U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

OJJDP
December 2000
JUVENILE JUSTICE BULLETIN

Functional Family Therapy

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The Office of Juvenile Justice and Delinquency Prevention (OJJDP) is dedicated to preventing and reversing trends of increased delinquency and violence among adolescents. These trends have alarmed the public during the past decade and challenged the juvenile justice system. It is widely accepted that increases in delinquency and violence over the past decade are rooted in a number of interrelated social problems—child abuse and neglect, alcohol and drug abuse, youth conflict and aggression, and early sexual involvement—that may originate within the family structure. The focus of OJJDP's Family Strengthening Series is to provide assistance to ongoing efforts across the country to strengthen the family unit by discussing the effectiveness of family intervention programs and providing resources to families and communities.

Problems arising from juvenile crime are a serious concern for many local communities. Expressions of adolescent behavior problems range from minor offenses (e.g., curfew violations and trespassing) to serious crimes (e.g., drug abuse, theft, and violence) and result in staggering personal, economic, and social costs. Until recently, most communities were left on their own to determine how to address juvenile crime, and many communities turned to exclusively punitive approaches such as incarceration. Mounting evidence, however, indicates that such approaches are ineffective and costly. By removing adolescents from their families and communities, punitive programs inadvertently make adolescents' problems more difficult to solve in the long run. Regardless of how adolescents' problems manifest themselves, they are complex behavioral problems embedded in adolescents' psychosocial systems (primarily family and community). Thus, family-based interventions that adopt a multisystemic perspective are well suited to treating the broad range of problems found in juveniles who engage in delinquent and criminal behavior.

Functional Family Therapy (FFT) is a family-based prevention and intervention program that has been applied successfully in a variety of contexts to treat a range of these high-risk youth and their families. As such, FFT is a good example of the current generation of family-based treatments for adolescent behavior problems (Mendel, 2000; Sexton and Alexander, 1999). It combines and integrates the following elements into a clear and comprehensive clinical model: established clinical theory, empirically supported principles, and extensive clinical experience. The FFT model allows for successful intervention in complex and multidimensional problems through clinical practice that is flexibly structured and culturally sensitive—and also accountable to youth, their families, and the community.

From the Administrator

While a number of States and communities are turning to punitive approaches to addressing juvenile crime, research indicates that such approaches, despite their high cost, are largely ineffective. Juvenile offenders removed from their families and communities eventually return, and unless their underlying behavioral problems have been treated effectively, these problems are likely to contribute to further delinquency.

Functional Family Therapy (FFT) draws on a multisystemic perspective in its family-based prevention and intervention efforts. The program applies a comprehensive model, proven theory, empirically tested principles, and a wealth of experience to the treatment of at-risk and delinquent youth.

This Bulletin chronicles FFT's evolution over more than three decades; sets forth the program's core principles, goals, and techniques; and reviews its research foundations. Community implementation of FFT is described, and an example of effective replication is provided.

Thirty years of clinical research indicate that FFT can prevent the onset of delinquency and reduce recidivism at a financial and human cost well below that exacted by the punitive approaches noted earlier. I believe this Bulletin will help you to consider the program's merits for your community.

John J. Wilson
Acting Administrator

Although commonly used as an intervention program, FFT is also an effective prevention program for at-risk adolescents and their families. Whether implemented as an intervention or a prevention program, FFT may include diversion, probation, alternatives to incarceration, and/or reentry programs for youth returning to the community following release from a high-security, severely restrictive institutional setting.

Based on the results of extensive independent reviews, FFT has been designated variously as a "blueprint program" (Alexander et al., 2000), an "exemplary model" program (Alexander, Robbins, and Sexton, 1999), and a "family based empirically supported treatment" (Alexander, Sexton, and Robbins, 2000). These designations reflect FFT's 30 years of clinical and research experience and its use at a wide range of intervention sites in the United States and other countries.

FFT targets youth between the ages of 11 and 18 from a variety of ethnic and cultural groups. It also provides treatment to the younger siblings of referred adolescents. FFT is a short-term intervention—including, on average, 8 to 12 sessions for mild cases and up to 30 hours of direct service (e.g., clinical sessions, telephone calls, and meetings involving community resources) for more difficult cases. In most cases, sessions are spread over a 3-month period. Regardless of the target population, FFT emphasizes the importance of respecting all family members on their own terms (i.e., as they experience the intervention process).

Data from numerous studies of FFT outcomes suggest that when applied as intended, FFT reduces recidivism and/or the onset of offending between 25 and 60 percent more effectively than other programs (Alexander et al., 2000). Other studies indicate that FFT reduces treatment costs to levels well below those of traditional services and other interventions (Alexander et al., 2000). As FFT has evolved, it has adopted a set of guiding principles, goals, and techniques that can be used even when resources are limited—for example, in managed care and similar contexts that restrict open-ended and non-outcome-based resource funding.

The Evolution of Functional Family Therapy

More than 30 years ago, it became apparent to FFT progenitors that although the rate and severity of juvenile delinquency, violence, and drug abuse were growing at a frightening pace, intervention programs remained seriously underdeveloped (Alexander and Parsons, 1973). In 1969, researchers at the University of Utah's Psychology Department Family Clinic developed FFT to serve diverse populations of underserved and at-risk adolescents and their families. These populations lacked resources, were difficult to treat, and often were perceived by helping professionals as not motivated to change. Although these underserved populations were diverse in terms of family organization, relational dynamics, presenting problems, and cultures, they often shared a common factor: They had entered the school counseling, mental health, or juvenile justice systems angry, hopeless, and/or resistant to treatment.

The developers of FFT recognized that successful treatment of these populations required service providers who were sensitive to the needs of these diverse families and competent to work with them, and who understood why the families had traditionally resisted treatment. Over the past 30 years, FFT providers have learned that they must do more than simply stop bad behaviors; they must motivate families to change by uncovering family members' unique strengths, helping families build on these strengths in ways that enhance self-respect, and offering families specific ways to improve.

Since its development, FFT has been a dynamic clinical system. It has retained its core principles while adding clinical features that improve successful outcomes in the diverse communities in which it has been implemented. More than two decades ago, FFT began focusing on therapist characteristics and in-session processes from an integrated perspective that combines research and practice. This perspective, in turn, has contributed to the training of therapists for subsequent interventions by identifying specific step-by-step interventions and their impact on youth and other family members.

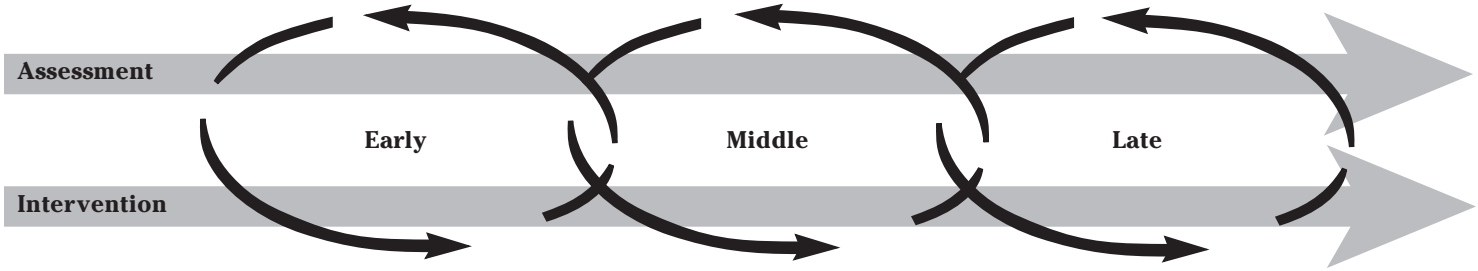
In the late 1990's, FFT further articulated its clinical change model by refining the phases of intervention (Sexton and Alexander, 1999; see table), developing a systematic approach to training and program implementation, and adding a comprehensive system of client, process, and outcome assessment. The system is implemented through a computer-based client tracking and monitoring system known as the Functional Family Therapy–Clinical Services System (FFT–CSS). This most recent iteration of FFT helps clinicians identify and implement goals for therapeutic change in a way that promotes accountability through process and outcome evaluation. As a result, FFT has matured into a clinical intervention model that includes systematic training, supervision, process, and outcome assessment components—all directed at improving the delivery of FFT in local communities.

Core Principles, Goals, and Techniques

Functional Family Therapy is so named to identify the primary focus of intervention (the family) and reflect an understanding that positive and negative behaviors both influence and are influenced by multiple relational systems (i.e., are functional). FFT is a multisystemic prevention program, meaning that it focuses on the multiple domains and systems within which adolescents and their families live. FFT is also multisystemic and multilevel as an intervention in that it focuses on the treatment system, family and individual functioning, and the therapist as major components. Within this context, FFT works first to develop family members' inner strengths and sense of being able to improve their situations—even if modestly at first. These characteristics provide the family with a platform for change and future functioning that extends beyond the direct support of the therapist and other social systems. In the long run, the FFT philosophy leads to greater self-sufficiency, fewer total treatment needs, and considerably lower costs.

At the level of clinical practice, FFT includes a systematic and multiphase intervention map—Phase Task Analysis—that forms the basis for responsive clinical decisions. This map gives FFT a flexible structure by identifying treatment strategies with a high probability of success and facilitating therapists' clinical options. FFT's flexibility extends to all family members and thereby results in effective moment-by-moment decisions in

Functional Family Therapy Clinical Model: Intervention Phases Across Time



	Engagement and Motivation	Behavior Change	Generalization
Phase goals	Develop alliances. Reduce negativity, resistance. Improve communication. Minimize hopelessness. Reduce dropout potential. Develop family focus. Increase motivation for change.	Develop and implement individualized change plans. Change presenting delinquency behavior. Build relational skills (e.g., communication and parenting).	Maintain/generalize change. Prevent relapses. Provide community resources necessary to support change.
Risk and protective factors addressed	Negativity and blaming (risk). Hopelessness (risk). Lack of motivation (risk). Credibility (protective). Alliance (protective). Treatment availability (protective).	Poor parenting skills (risk). Negativity and blaming (risk). Poor communication (risk). Positive parenting skills (protective). Supportive communication (protective). Interpersonal needs (depends on context). Parental pathology (depends on context). Developmental level (depends on context).	Poor relationships with school/community (risk). Low level of social support (risk). Positive relationships with school/community (protective).
Assessment focus	Behavior (e.g., presenting problem and risk and protective factors). Relational problems sequence (e.g., needs/functions). Context (risk and protective factors).	Quality of relational skills (communication, parenting). Compliance with behavior change plan. Relational problem sequence.	Identification of community resources needed. Maintenance of change.
Therapist/ Interventionist skills	Interpersonal skills (validation, positive interpretation, reattribution, reframing, and sequencing). High availability to provide services.	Structure (session focusing). Change plan implementation. Modeling/focusing/directing/training.	Family case manager. Resource help. Relapse prevention interventions.

Source: Sexton and Alexander, 1999.

the intervention setting. Thus, FFT practice is both systematic and individualized.

The following sections describe the intervention phases and the model of FFT clinical assessment. As the clinical map presented in the table on page 3 reflects, FFT is a multiphase, goal-directed, and systematic program.

Intervention Phases

FFT's three specific intervention phases—engagement and motivation, behavior change, and generalization—are interdependent and sequentially linked. Each has distinct goals and assessment objectives, each addresses different risk and protective factors, and each calls for particular skills from the interventionist or therapist providing treatment. The interventions in each phase are organized coherently, which allows clinicians to maintain focus in contexts that often involve considerable family and individual disruption. The three intervention phases are described in the sections that follow.

Phase 1: Engagement and Motivation. This phase places primary emphasis on maximizing factors that enhance intervention credibility (i.e., the perception that positive change might occur) and minimizing factors likely to decrease that perception (e.g., poor program image, difficult location, insensitive referrals, personal and/or cultural insensitivity, and inadequate resources). In particular, therapists apply reattribution (e.g., reframing, developing positive themes) and related techniques to address maladaptive perceptions, beliefs, and emotions. Use of such techniques establishes a family-focused perception of the presenting problem that serves to increase families' hope and expectation of change, decrease resistance, improve alliance and trust between family and therapist, reduce oppressive negativity within families and between families and the community, and help build respect for individual differences and values.

Phase 2: Behavior Change. During this phase, FFT clinicians develop and implement intermediate and, ultimately, long-term behavior change plans that are culturally appropriate, context sensitive, and tailored to the unique characteristics of each family member. The assessment focus in this phase includes cognitive (e.g., attributional processes and coping strategies), interactive (e.g., reciprocity of positive rather than negative behaviors, competent parenting, and understanding of behavior sequences involved in delinquency), and emotional components (e.g., blaming and negativity). Clinicians provide concrete behavioral intervention to guide and model specific behavior changes (e.g., parenting, communication, and conflict management). Particular emphasis is placed on using individualized and developmentally appropriate techniques that fit the family relational system.

Phase 3: Generalization. This FFT phase is guided by the need to apply (i.e., generalize) positive family change to other problem areas and/or situations. FFT clinicians help families maintain change and prevent relapses. To ensure long-term support of changes, FFT links families with available community resources. The primary goal of the generalization phase is to improve a family's ability to affect the multiple systems in which it is embedded (e.g., school, juvenile justice system, community), thereby allowing the family to mobilize community support systems and modify deteriorated family-system relationships. If necessary, FFT clinicians intervene directly with the systems in which a family is embedded until the family develops the ability to do so itself.

Assessment

Assessment is an ongoing, multifaceted process that is part of each phase of the FFT clinical model. In FFT, assessment focuses on understanding the ways in which behavioral problems function within family relationship systems. The focus of assessment depends on the phase of treatment (see table, page 3).

In general, assessment in FFT is based on the following principles:

- FFT assessment should focus on the ways that family relational systems are related to the presenting behavior problems—in both adaptive and maladaptive ways.
- FFT should identify risk and protective factors through clinical and formal assessment. In doing so, FFT helps identify family, individual, and contextual issues that might become the targets of treatment.
- Assessment should be multilevel, multidimensional, and multimethod. Individual factors include the adolescent's cognitive and developmental level and any psychological conditions that he or she may have (e.g., depression/anxiety, thought disorders). Assessment should also consider the adolescent's family because the family is the psychosocial context in which the adolescent lives. Family factors considered in an FFT assessment include what goes on during daily family life (e.g., parenting, teaching, supporting, providing, and relating). Behavioral and contextual factors include external and social factors that influence the adolescent (e.g., the presence or absence of risk and protective factors and the availability of community resources).
- Assessment of family functioning—rather than completion of a diagnostic assessment—is the most helpful way to identify appropriate treatment options and approaches. The goal of assessment is to plan the most appropriate treatment.
- Clinical, outcome, and adherence assessment are critical to successful implementation of the FFT model.

FFT has identified formal and clinical tools for model, adherence, and outcome assessment. These tools are incorporated into the Functional Family Assessment Protocol—a systematic approach to understanding families—and the Clinical Services System (CSS)—an implementation tool that allows therapists to track the activities (i.e., session process goals, comprehensive client assessments, and clinical outcomes) essential to successful implementation.

CSS seeks to improve therapists' competence and skill by keeping them focused on the goals, skills, and interventions needed for each phase of FFT. CSS's computer-based format gives therapists easy access to a variety of process and assessment information which, in turn, allows them to make good clinical decisions and provides them with the complete outcome information needed to evaluate case success.

Research Foundations

Throughout its development, FFT has required step-by-step descriptions of the clinical change process and rigorous evaluation of outcomes. FFT also has insisted on integrating science (as it applies to evaluation and research), clinical and cultural sensitivity, sound clinical judgment and experience, and comprehensive theoretical principles. From 1973 to the present, published data have reflected the positive outcomes of FFT. Data show, for instance, that when compared with

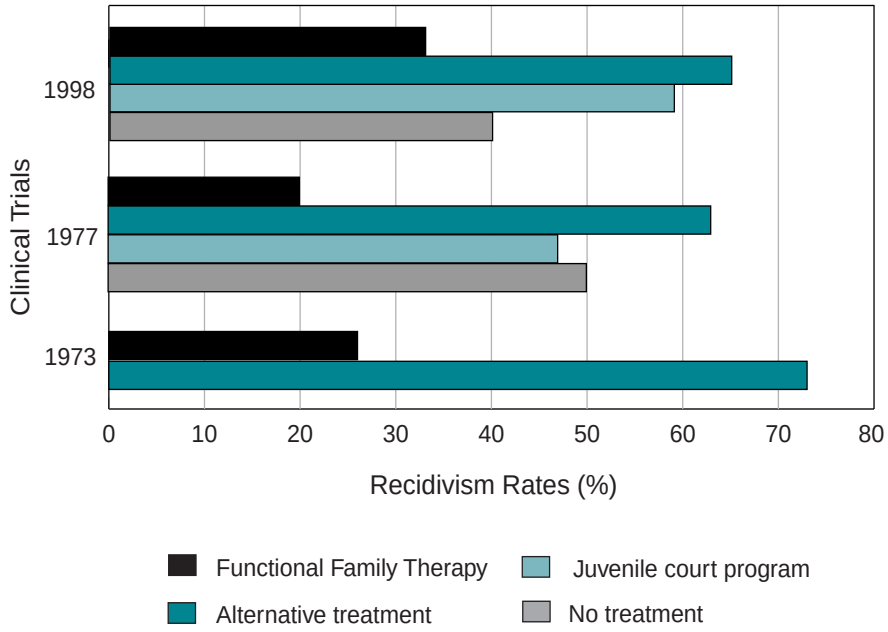
standard juvenile probation services, residential treatment, and alternative therapeutic approaches, FFT is highly successful. Both randomized trials and nonrandomized comparison group studies (Alexander et al., 2000) show that FFT significantly reduces recidivism for a wide range of juvenile offense patterns. In addition, studies have found that FFT dramatically reduces the cost of treatment. A recent Washington State study, for example, shows savings of up to $14,000 per family (Aos, Barnoski, and Lieb, 1998). FFT also significantly reduces potential new offending for siblings of treated adolescents (Klein, Alexander, and Parsons, 1977). Figures 1 (randomized clinical trials) and 2 (comparison studies) summarize the outcome findings of FFT studies conducted during the past 30 years. These studies show that when compared with no treatment, other family therapy interventions, and traditional juvenile court services (e.g., probation), FFT can reduce adolescent rearrests by 20–60 percent.

Community Implementation of Functional Family Therapy

Successful FFT programs, whether home based, clinic based, or school based, include programs grounded in diversion, probation, alternatives to incarceration, and reentry from high-security, severely restrictive institutional settings.

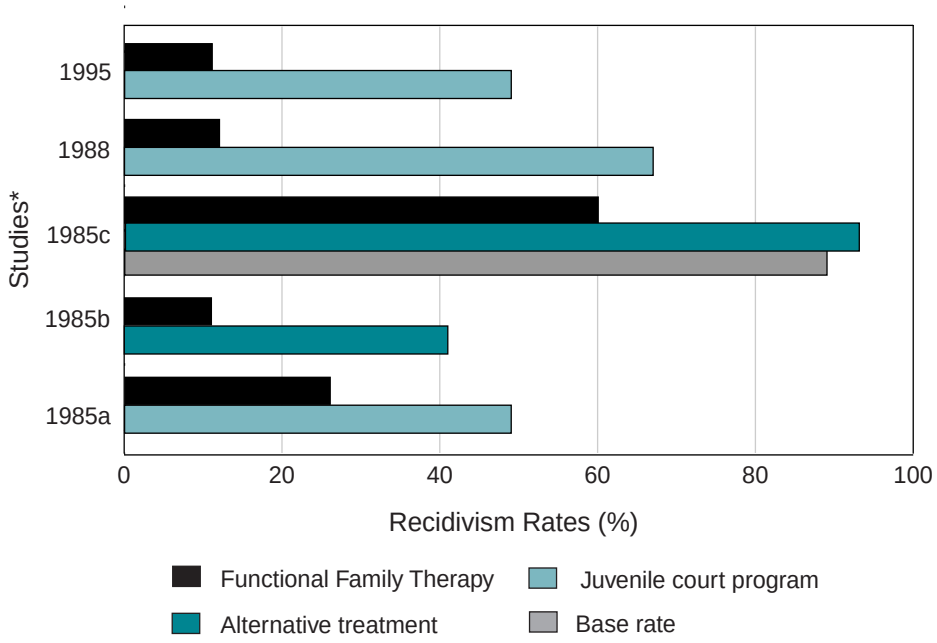
FFT currently has 50 active certified service sites in 15 States. These sites serve thousands of adolescents and their families each year. The ability to replicate FFT with fidelity has been achieved through a specific training model and a sophisticated client assessment, tracking, and monitoring system (FFT–CCS) that provides for clinical assessment, outcome accountability, and supervision. In addition, the FFT Practice Research Network (FFT–PRN) allows clinical sites to develop and disseminate information on the FFT model. Clinicians who have successfully implemented FFT include trained professionals with master's degrees and, on occasion, staff with bachelor's degrees from fields such as public health nursing, social work, marriage and family therapy, clinical psychology, licensed mental health counseling, probation services, criminology, psychiatry, and recreation therapy.

Figure 1: Outcome Findings for Recidivism in Randomized Clinical Trials, 1973–1998



Source: Alexander and Parsons, 1973; Klein, Alexander, and Parsons, 1977; Hansson, 1998.

Figure 2: Outcome Findings for Recidivism in Comparison Studies, 1985–1995



* The three 1985 comparison studies (1985a, b, and c) appear in Barton et al., 1985.

Source: Barton et al., 1985; Gordon et al., 1988; Gordon, Graves, and Arbuthnot, 1995.

Communities have implemented FFT with success because its training program is multisystemic, meaning that it focuses on the therapist, community, and clinical delivery system. At any given site (e.g., agency, intervention team, contracting intervention program), FFT's four major goals are to:

- Replicate the program as it has been used in previous sites (to increase the probability that the site will have the same success), yet tailor the program to the unique needs of the community.
- Develop a self-sufficient site (i.e., one that will be able to provide FFT over time in a way that remains true to the therapy's core principles).
- Develop competent therapists and supportive clinical and administrative structures.
- Initiate and use the FFT clinical system to promote adherence to the FFT model.

Implementation of FFT focuses, in particular, on developing therapist competence rather than simply teaching skills. A competent therapist is able to:

- Implement a treatment model's core elements.
- Treat each family member with clinical and cultural sensitivity.
- Enhance the treatment's effectiveness by making treatment decisions based on core principles of the model.

The Family Project: A Recent FFT Replication

The Family Project is a unique partnership between a university (the University of Nevada, Las Vegas) and a community service provider (the Clark County Department of Family and Youth Services (DFYS)). The Family Project is currently the largest FFT research and practice site in the Nation. Through this partnership, located in one of the Nation's fastest growing and most multiculturally and ethnically diverse urban areas, FFT services are provided to at-risk youth and their families referred by juvenile probation. As the data below reflect, the effectiveness of this true community project results from its use of marriage and family therapists in an established community clinic.

During a 2-year period, clinic-based therapists successfully contacted 231 families referred to the Family Project by probation officers. Because the Family Project was the only counseling service used by the juvenile court during that period, this group represented the entire population of adolescents referred for counseling services. Of the group, 80 percent completed FFT treatment services, a high rate of completion compared with the rate for standard juvenile justice-based interventions. Thus, even though its services were delivered in a university training center to which clients had to travel for each session, the Family Project successfully engaged and retained a high percentage of a diverse population of at-risk adolescents, all of whom were on probation. This success was a function of both the FFT clinical model and the clinic's extensive outreach procedures.[1]

Figure 3 shows 1-year recidivism rates for those who completed the Family Project's program and those who were part of a treatment-as-usual comparison group (a group that received probation services as usual). The figure also provides the districtwide 3-year recidivism rate and the 3-year recidivism rate for those who received other available court services. Of those who completed the program, only 19.8 percent committed an offense during the year following completion, compared with 36 percent of the treatment-as-usual comparison group. These data suggest that FFT reduced recidivism by roughly 50 percent, a figure consistent with previous FFT randomized clinical trials and replication studies.

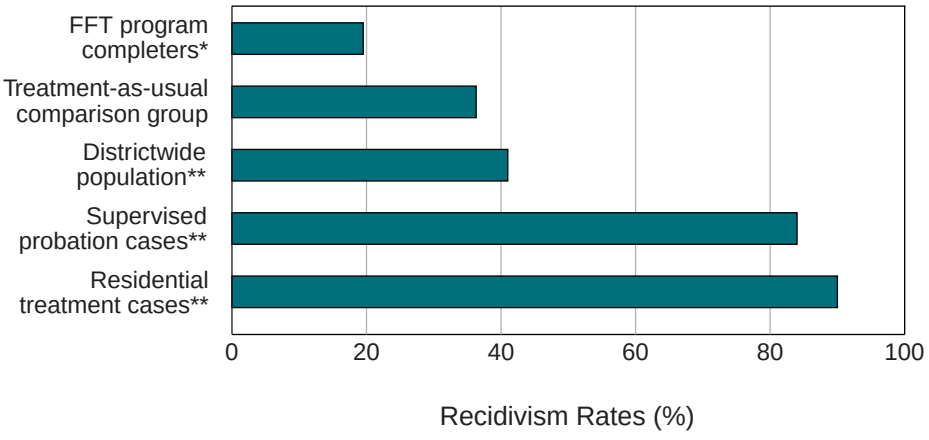
Another measure of outcome is a program's cost effectiveness. Figure 4 shows the costs of various services within the Clark County DFYS system during the 2-year study period. On average, FFT treatment costs during this time were between $700 and $1,000 per family. By contrast, the average cost of detention was at least $6,000 per adolescent and the average cost of the county residential program was at least $13,500 per adolescent. Considering that the county's residential program has a 3-year recidivism rate of more than 90 percent (i.e., 90 percent of those who complete the program commit a subsequent offense within 3 years), FFT is highly cost effective—resulting in a much lower rate of recidivism (19.8 percent for 1 year) at a much lower cost.

Conclusion

FFT is one of the current generation of family-based treatments for adolescent behavior problems. As both a prevention and an intervention program, FFT has been implemented in various treatment contexts and with culturally diverse client populations. The success of FFT is due to

[1] Initial sessions were accompanied by many phone contacts to enhance treatment participation.

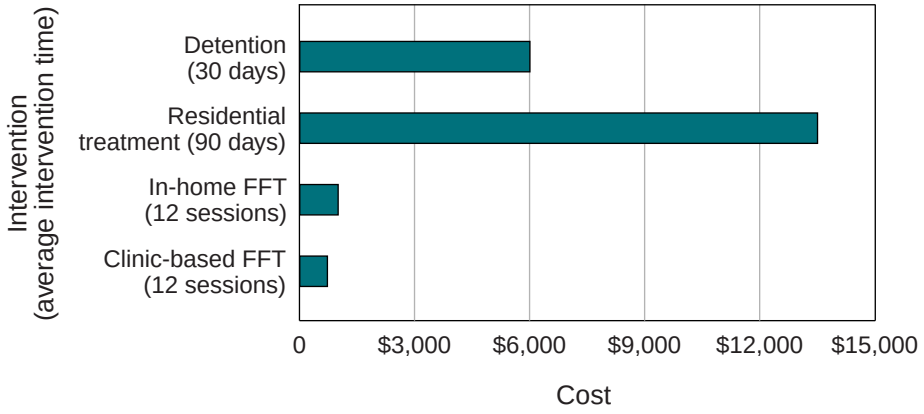
Figure 3: Recidivism Rates—Functional Family Therapy Versus Other Available Court Services



* 1-year recidivism totals.
**3-year recidivism totals.

Source: Sexton, in press.

Figure 4: Cost Effectiveness—Functional Family Therapy Versus Other Available Court Services



Source: Sexton, in press.

its integration of a clear, comprehensive, and multisystemic clinical model with ongoing research on clinical process and outcomes. FFT also includes a systematic training and community implementation program. The results of more than 30 years of clinical research suggest that by following these principles, FFT can reduce recidivism and/or prevent the onset of delinquency. These results can be accomplished with treatment costs well below those of traditional services and other interventions.

Unique to FFT is its systematic yet individualized family-focused approach to juvenile crime, violence, drug abuse, and other related problems. The phases of FFT provide therapists with specific goals for each family interaction. Although systematic, each phase is guided by core principles that help the therapist adjust and adapt the goals of the phase to the unique characteristics of the family. In this way, FFT ensures treatment fidelity while remaining respectful of individual families and cultures and unique community needs.

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U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Washington, DC 20531

Official Business
Penalty for Private Use $300

OJJDP Bulletin NCJ 184743

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The Office of Juvenile Justice and Delinquency Prevention is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, the Bureau of Justice Statistics, the National Institute of Justice, and the Office for Victims of Crime.