

Utilizing Family Strengths and Resilience: Integrative Family and Systems Treatment with Children and Adolescents with Severe Emotional and Behavioral Problems

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Community mental health agencies are consistently challenged to provide realistic and effective home-based family-centered treatment that meets local needs and can realistically fit within available budget and resource capabilities. Integrated Family and Systems Treatment (I-FAST) is developed based on existing evidence-based approaches for working with at-risk children, adolescents, and families and a strengths perspective. I-FAST identified 3 evidence-based, core treatment components and integrated them into a coherent treatment protocol; this is done in a way that builds on and is integrated with mental health agencies' existing expertise in home-based treatment. This is an intervention development study in which we conducted an initial feasibility trial of I-FAST for treating families with children at risk of out-of-home placement. The outcomes of the study provide initial empirical evidence that supports the effectiveness of I-FAST. Findings indicate that there were significant improvements in child behavior, significant increases in parental competency, and significant increases in the level of cohesion and adaptability in these families. All observed changes were significant from pre- to posttreatment with the families able to maintain these positive changes at 6-month follow-up. A more rigorous and robust research design, however, will be needed to establish definitive evidence of the effectiveness of I-FAST.

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When parents have a child with a severe emotional and/or behavioral problem that they have not been able to resolve on their own, they are often directed to take the child for mental health treatment. If the child's problems persist, the child can be at risk of out-of-home placement including but not limited to psychiatric hospitals, residential treatment facilities, detention centers, foster homes, and so on. Home-based treatment has been increasingly used for treating families with a child or adolescent who is at risk of out-of-home placement. Although home-based treatment is widely used for treating families with a child or adolescent who is at risk of out-of-home placement, mental health agencies are consistently challenged to develop and provide realistic home-based family-centered treatment that meets local needs, can realistically fit within available budget and resource capabilities, and is effective in accomplishing the following goals: (1) preventing out-of-home placement or residential placement of the symptomatic child; (2) empowering the families to develop competence and confidence in addressing emotional and/or behavioral problems of children; (3) supporting the development and continuity of expertise in home-based treatment for case managers and therapists at the agency level; (4) collaborating with institutions that determine placement, including, but not limited to, Juvenile Courts and Children Services; and (5) improving cost-effectiveness in attaining the goals of home-based treatment.

Funding sources of mental health services are increasingly requiring mental health agencies to use evidence-based approaches when providing treatment to at-risk families. There are several well-established evidence-based approaches to family therapy: Brief Strategic Family Therapy (BSFT; Horigian, Suarez-Morales, Robbins, Zarate, Mayorga, Mitrani & Szapocznik, 2005; Szapocznik, Robbins, Mitrani, Santisteban, Hervis, & Williams, 2002), Multisystemic Therapy (MST; Henggeler, Schoenwald, Rowland, & Cunningham, 2002; Schoenwald & Henggeler, 2005), Multidimensional Family Therapy (MDFT; Hogue, Liddle, Becker, & Johnson-Leckrone, 2002; Hogue, Liddle, & Becker, 2002; Liddle, Rodriguez, Dakof, Kanzki & Marvel, 2005), Functional Family Therapy (FFT; Sexton & Alexander, 2005), and Problem Centered Systems Therapy (Ryan, Epstein, Keitner, Miller, & Bishop, 2005). An evidence-based approach that is not as well established is Ecosystemic Structural Family Therapy (ESFT; Jones & Lindblad-Goldberg, 2002). All of these treatment approaches operate from a systems theory perspective and to varying degrees are based on strategic family therapy (Fisch, Weakland, & Segal, 1982; Grove & Haley, 1993; Haley, 1987; Madanes, 1981) and structural family therapy (Minuchin & Fishman, 1981). For the most part, these current home-based treatment approaches were initially developed outside mental health agencies. As such, for a mental health agency to use one of these approaches it must adopt it in its entirety, which requires substantial investment of time and resources in reorganizing service delivery, training, supervision, and consultation.

Given that these home-based family therapy approaches have been found to be effective with at-risk populations and they all have a common base of structural and strategic family therapy, there should be factors in common that could be integrated

into a systematic framework and transported to community agencies and effectively applied within its existing resources. Integrated Family and Systems Treatment (I-FAST) is developed based on evidence-based common factors to intervening with at-risk families and their children and adolescents.

Integrating common elements shared across evidence-based approaches is consistent with the way the separate approaches were developed. In fact, each of these evidence-based approaches to high-risk youth and families represent integration in them as they all have a common base of systemic, structural, and strategic family therapy. Regarding integration, Sprenkle, Blow, and Dickey (1999) and Lebow (1997) have made a strong case for integration in family therapy across all major approaches. Sprenkle et al. (1999) note that the influence of relationship and alliance, expectancy, and extra-therapeutic factors exert the same powerful influence across systems-based approaches as they do in individual treatments. The more unique elements in systemic approaches tend to include the idea of offering a relational conceptualization, expanding the direct treatment system beyond the individual to multiple embedded systems, and expanding the therapeutic alliance across numerous individuals and systems. Nevertheless, all of these factors converge with the general literature to affirm that there is much more in common across therapies that work than there is difference. The key questions that remain regard how and why these treatments work, and how they might be integrated (Wampold, 2001). Applied theorists have struggled for decades with the question of how psychotherapies are connected with one another. They have synthesized a number of useful schemes to integrate approaches, including technical eclecticism (i.e., using the most effective techniques without adapting the theories that underlie them), theoretical integration (or synthesizing different theories underlying different approaches within a superordinate unifying theory), and a common factors approach (or identifying the core elements shared by all effective psychotherapies) (cf. Norcross & Goldfried, 2005). I-FAST represents a combined approach of theoretical integration while emphasizing common factors across these evidence-based approaches to high-risk youth and families. The purpose of this paper is to provide an overview of I-FAST and report findings of an initial feasibility trial of its effectiveness.

I-FAST

I-FAST is a home-based treatment model that has been developed and implemented within the community mental health system. I-FAST assumes that: (1) effective treatment of a child or adolescent with a severe emotional or behavioral problem necessitates treatment of the family system, (2) families are resilient and have strengths and resources that can be used in building solutions and achieving client change, (3) effective treatment must include coordination and collaboration among the diverse organizations providing services to the child and the family, and (4) effective treatment is built upon training and retaining excellent staff with expertise in providing home-based family services.

The I-FAST Model

I-FAST consists of three major *common factors* we identified from the evidence-based literature on family treatment with at-risk children, youth, and families. These common factors are: (1) develop and maintain a *positive therapeutic alliance* with the

family members, (2) intervene to bring about *second-order change* in problematic patterns by having the parents be the ones to solve the presenting problem (*pattern change*), and (3) work with the various systems involved with the family so they collaborate in supporting the parents as the ones solving the presenting problem (*systems collaboration*). An important position of I-FAST is to intervene no more than is necessary to get a small but necessary and lasting shift in the interactional patterns between the child and parents and the other systems involved with them. I-FAST further holds that intervention is most effective when provided within the context of a positive therapeutic alliance with all the parties involved. The three major treatment components of I-FAST are as follows.

Therapeutic alliance

The literature has repeatedly described the important role of the therapeutic alliance in facilitating positive outcomes in working with clients and families (Asay & Lambert, 1999). Based on Bordin's (1979) work, I-FAST views the therapeutic alliance as consisting of three dimensions: (1) development of bonds (Johnson, Wright, & Ketring, 2002), (2) agreement on goals (Bordin, 1979; Johnson et al., 2002; Pinosof, 1994), and (3) agreement on tasks (Johnson et al., 2002). In addition, I-FAST is influenced by the strengths perspective and solution-focused therapy in viewing a focus on a family's strengths, competencies, and resources as important in successfully developing a therapeutic alliance and effecting positive change (outcomes) with clients (Berg, 1994; Lee, Sebold, & Uken, 2003).

Pattern change (second-order change)

Influenced by a systems perspective and the concept of feedback mechanisms (Hoffman, 1981; Keeney & Ross, 1985), I-FAST postulates that a change in the problem-maintaining pattern at the family interactional level is required for the change process (second-order change) (Fisch et al., 1982; Fraser & Solovey, 2007; Greene, 2002; Grove & Haley, 1993). Approaches to change behavioral patterns include but are not limited to a strategic view of using behavioral prescriptions for disrupting the problem-maintaining patterns and changing the family system (Fisch et al., 1982; Grove & Haley, 1993; Haley, 1990; Nardone & Watzlawick, 1993), a solution-focused view of identifying and amplifying patterns in which the problem does not occur, is less frequent, or the problem is being handled in a more satisfactory manner (solution-building) (De Jong & Berg, 2007; Lee, Greene, Solovey, Grove, & Fraser, 2003), or a structural view of changing family relational patterns and organization primarily by interventions made in the session with the family (Minuchin & Fishman, 1981). Regardless of the approach to creating pattern change in the family, I-FAST emphasizes that the practitioner intervenes in a way that empowers the parents to be the ones to successfully solve the child or adolescent's presenting problem(s) and rather than the professionals.

Systems collaboration

Many, if not most, of the families with a child or adolescent with a severe emotional or behavioral problem are concurrently involved with practitioners from several different agencies, that is, mental health, social services, juvenile courts, schools, psychiatric hospitals, and so on. When practitioners from different agencies are involved with these family systems a new system is temporarily created which can help

or hinder the resolution of the presenting problem (Anderson, Goolishian, & Winderman, 1986; Boyd-Franklin & Bry, 2000; Schwartzman, 1985). Practitioners from these agencies can involve themselves with families in ways that “can sometimes perpetuate the very problems they were intended to solve” (Imber-Black, 1991, p. 584). Frequently, practitioners from these agencies get involved with these families by restraining the out-of-control child and placing her or him outside the home in various settings such as residential care, foster care, juvenile detention, or a hospital. In those situations, the family’s interactional pattern with the problematic child may not change for several reasons two of which may be: (1) the goal of the intervention is safety and not changes in how parents deal with the problems the child has, and (2) the child is settled down by professionals outside the family rather than empowering the parents as the primary solver of the child’s problem. For home-based services to be a cost-effective alternative to out-of-home placement home-based staff must be able to influence practitioners from the institutions in charge of placing children outside the home and empower parents to be the ones to regain control over their out-of-control child (Imber-Black, 1988, 1991). Consequently, collaboration between and among practitioners from the different systems involved with these families is integral to achieving positive outcomes.

The perspective of I-FAST is that just as interventions should focus on changing the problem maintaining patterns within families, they should also focus on changing the problem maintaining interactions between practitioners from outside agencies and the family. To make these changes I-FAST practitioners need to develop and maintain collaborative relationships with these other practitioners similar to how they do with the families in treatment (Fraenkel, 2006; Koch, Egbert, & Coeling, 2005; Madsen, 2007; Selekman, 2005; Sells, 1998). Such relationships can and should be developed and maintained whether or not there are formal agreements between the mental health system and the other involved systems (Darlington & Feeney, 2008; Horwath & Morrison, 2007).

Programmatic Structure of I-FAST

In addition to identifying effective treatment components in working with families, I-FAST takes a systems perspective in viewing I-FAST, not as an isolated treatment program, but as an integrated program supported and embedded within the administrative structure of the agency. The model entails a parallel process of empowerment at the client level, agency level, and interagency level (Figure 1). The programmatic structure of home-based treatment using I-FAST involves administrative and clinical support to the home-based treatment staff. With respect to administrative support, the home-based staff is assigned no more than 10–12 cases at one time. In addition, Emergency Services and other agencies involved with these families provide services to them at nights and on weekends. A crisis plan is developed with each family receiving I-FAST and this plan is readily available in the client records and emergency service staff members are informed of the plan. This approach frees up case managers from having to be on call all the time. Being on call all the time is a major drawback to any approach that requires it because it can be a contributing factor to burnout and turnover of competent community-based staff.

The services of a consultant are used to provide ongoing clinical support and training to home-based treatment teams. Through the process of consulting with the

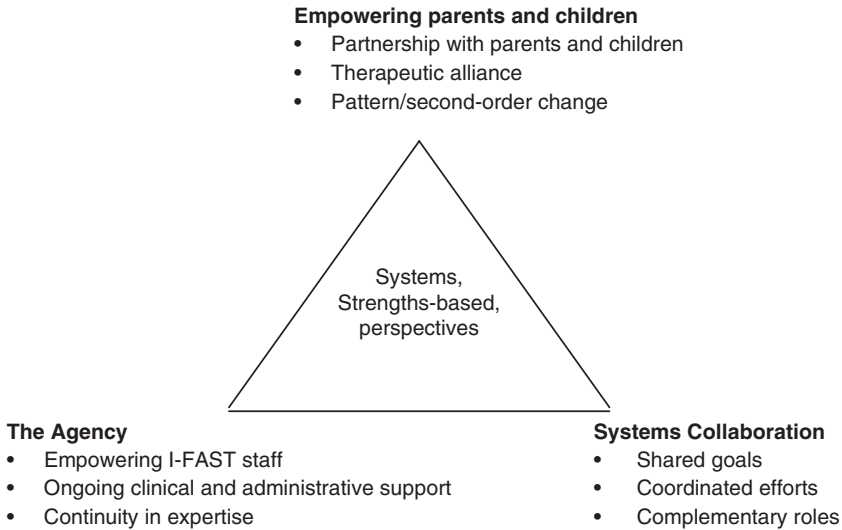


FIGURE 1. Integrative Family and Systems Treatment (I-FAST): A Parallel Process of Empowerment.

team on their cases, the consultant teaches home-based staff and other professionals, including center directors and supervisors, in how to use the core I-FAST treatment components and how these treatment principles could be generalized to other cases. Because clinical consultation is offered to the home-based staff as well as other treatment professionals at the agency, home-based treatment services can become an integral part of the other services the agency provides. When families terminate from intense community-based services they frequently continue to receive treatment from other professionals employed at the agency thus providing continuity of care. An expectation is that eventually key staff at the agency will develop enough expertise in I-FAST home-based treatment that outside consultants will no longer be needed. The ultimate training goal is to influence the treatment culture within the agency instead of creating a special area of knowledge or expertise that is known only by a limited number of specialists in one program at the agency.

THE OUTCOME STUDY

This initial feasibility study used a one-group pre- and posttest design with a 6-month follow-up to explore the effectiveness of I-FAST in treating families with children at risk of out-of-home placement and receiving home-based treatment. We hypothesized that effective I-FAST treatment would lead to improved functioning, reduced problem severity in the child, reduce out-of-home placement of the child, improve family functioning, increase parental competency in addressing their child's problems, and increase family participation in the treatment process.

Research Participants

Findings of the outcome evaluation were based on the 77 families who completed the program and provided data at pre- and posttreatment. Participants of the research included families with children or adolescents at risk of out-of-home placement and

who had received home-based services from two mental health agencies in a Midwestern state; one agency serves five counties and another serves six counties. Participating families were mostly low-income families and approximately 98% of the treatment costs were paid by Medicaid and other public funds. The Court, Children's Services, hospitals, or other mental health agencies referred families to the programs. Both parents and the child(ren) who were at risk of placement and were 12 years old or older were invited to participate in the study. Other than qualifying for intensive home-based family treatment no other selection (inclusion-exclusion) criteria were used. Participation in the study was voluntary and formal written consent was obtained from all participants. Families participating in the study received home-based services up to a 6-week period with additional 6-week increments negotiated based upon the family's needs and progress. Families completing intake, posttreatment, and 6-month follow-up received 40 dollars in compensation.

Among the 77 children, 64.9% were males (50) and 35.1% females (27). The majority of child participants were students at middle school (41.9%) and elementary schools (32.3) while 14.5% were high school students and 11.3% were in kindergartens or preschools. Child participants were predominantly Caucasian (93.2%), with 2.6% African Americans, and 5.2% biracial. The ages of the children ranged from 4 to 17 (mean: 11.8, *SD* 3.3) with 2.6% age 4, 19.5% between 5 and 8, 29.9% between 9 and 12, 31.2% between 13 and 14, and 16.9% between 15 and 17. Mental status examination was conducted by licensed mental health professionals. Using DSM: IV criteria, almost half of the child participants had a diagnosis of Hyperactive Attention Deficit Disorder (48.4%), 12.9% Adjustment Disorder, 11.3% Mood Disorder, 8.1% Depression Disorder NOS, 4.8% Oppositional Defiant Disorder, 3.2% Bipolar, 3.2% Disruptive Disorder, 1.6% Impulse-Control Disorder, 1.6% Dysthymic Disorder, 1.6% Anxiety Disorder, 1.6% Posttraumatic Stress Disorder, and 1.6% Trichotillomania. Regarding child participants' placement status, 41.3% had been in out-of-home placement before receiving I-FAST. Children who were in placement were most frequently placed in psychiatric hospitals (40%) and juvenile detention centers (32%), which was followed by foster care (16%), other youth facilities (8%), and residential treatment facilities (4%).

Method of Data Collection

Treatment fidelity

I-FAST checklist. The I-FAST Checklist is a 31-item measure that assesses core treatment components of I-FAST: therapeutic alliance (item 1–20), second-order change strategies (item 21–25), and systems collaboration (item 26–31). A list of items was first generated based on the identified core treatment components of I-FAST. The list was reviewed by a panel of seven experienced professionals who developed I-FAST and professionals currently working with home-based populations. The checklist was further refined based on their feedback and pilot-tested by five clinical supervisors for usability before actual implementation. I-FAST Case managers were invited to videotape or audiotape 1 family session at the beginning of treatment and another session at week 6 with formal consent obtained from participating families. Two clinical consultants of the program also videotaped their consultation sessions with treatment teams for fidelity purposes.

In order to ensure reliability across raters, independent raters who were not involved in the delivery of the intervention but were well-trained in I-FAST viewed and

scored four videotapes of family sessions (two for the initial family sessions and two for the week 6 family session) and discussed disagreements until overall consensus was reached. The raters used the I-FAST Checklist to rate the adherence and competence of specific interventions of each core treatment component used by case managers and the clinical consultants in the treatment process or the consultation process; I-FAST fidelity evaluation resembles procedures used by Knutson, Forgatch, & Rains (2003) in their study. The focus of rating with the initial family session was on the development of the therapeutic alliance. The focus of rating of the week 6 family session was on second-order change strategies and systems collaboration. The focus of rating of the consultation sessions was on all three core treatment components as suggested by I-FAST. Two independent raters, who had received the fidelity training, rated the adherence and competence of the interventions of each core treatment component on a 3-point Likert scale: (0) absence, (1) some, (2) excellent. The I-FAST Checklist was scored by summing individual items and ranges from 0 to 62 with higher scores indicating greater adherence to and competence of implementing I-FAST in the treatment process by clinicians or in the consultation process by clinical consultants.

We had tapes from 35 initial family sessions and 17-week 6 family sessions. The study used intraclass correlation (ICC) to assess interrater reliability of I-FAST. Findings of ICC showed a satisfactory level of interrater reliability. The intraclass coefficient for therapeutic alliance was .84, for second-order change was .86, and for systems collaboration was .88. We had tapes on nine consultation sessions. Findings of ICC showed a satisfactory level of interrater reliability. The intraclass coefficient for therapeutic alliance was .82, for second-order change was .88, and for systems collaboration was .80. The intraclass coefficient for the overall I-FAST was .88.

Outcome variables

Child's functioning. Child's functioning referred to the level of emotional and behavioral functioning of the child and was operationally defined as the scores the child had on the Problem Severity and Functioning subscales of The Ohio Scale-Short Form. The Ohio Scales were developed to provide multisource, multicontent measures of clinical outcomes of youth ages 5–18 (Ogles, Lambert, & Masters, 1996). Multiple reporting sources are included in the process of data collection: the youth (if age 12 and older), parents or primary caretakers, and I-FAST case managers. The Problem Severity Scale is comprised of 20 items covering common problems associated with children who receive mental health services. Raters are asked to rate the degree to which the child has experienced the problem in the past 30 days on a 6-point scale (0 = *not at all* to 5 = *all the time*). The scores range from 0 to 100 with a higher score indicating a more severe problem. The Functioning Scale is comprised of 20 items designed to rate the child's level of functioning in a variety of areas of daily activity. Raters are asked to rate the current level of functioning of the youth using a 5-point scale (0 = "*extreme troubles*" to 4 = "*doing very well*"). The scores range from 0 to 80 with a higher score indicating a higher level of functioning in the youth. Ogles, Melendez, Davis, and Lunnen (2001) report satisfactory reliability coefficients of The Ohio Scales across multiple reporting sources that range from .65 to .97 (Cronbach's α) with the test-retest reliabilities ranging from .43 to .88. In addition, The Ohio Scale ratings have been found to be significantly correlated with several other well-established related measures.

Child's placement status. Child's placement status was operationally defined by the location and frequency of out-of-home placement pretreatment, at posttreatment, and 6-month follow-up.

Family functioning. FACESII, which measures the level of cohesion and adaptability of a family, was used in this study to evaluate family functioning. FACESII is 30-item scale with 16 items measuring cohesion and 14 items measuring adaptability (Olson, Portner, & Bell, 1982). Respondents are requested to rate how frequently the described behavior occurs in his/her family on a 5-point Likert scale that ranges from 1 (*almost never*) to 5 (*almost always*). Scoring procedures are described in the Family Inventories Manual (Olson, 1992). Olson (1992) reported satisfactory Cronbach's α of .90 for the total scale, .87 for Cohesion, and .78 for Adaptability. Test-retest reliability was .83 for Cohesion and .80 for Adaptability. Good concurrent validity was also established for FACESII (Hampson, Hulgus, & Beavers, 1991).

Parental competence with children. Parental competence with children was operationally defined by the scores on the Parental Efficacy Scale which is a 10-item scale adapted and modified from the Parental Locus of Control Scale (Campis, Lyman, & Prentice-Dunn, 1986). Parents are asked to rate their responses on a 5-point Likert-type scale from "*strongly disagree*" (1), "*disagree*" (2), "*neither agree or disagree*" (3), "*agree*" (4), to "*strongly agree*" (5). The Parental Efficacy Scale is scored by summing individual items with the scores ranging from 5 to 50 with a higher score indicating greater parental competence in relation to children. Norms for the original Parental Efficacy Scale are not reported although means for parents who did not report difficulties in the parenting role (17.62) are distinguished from means of parents who had requested counseling services for parental problems (19.27) (Campis et al., 1986). Good internal consistency has been found for the Parental Efficacy Scale (Campis et al., 1986).

Family participation. Family participation was operationally defined as the scores on the Family Participation Measure as completed by the parents (Friesen, 2001; Friesen & Pullman, 2002). The Family Participation Scale consists of 7 items and is designed to measure a caregiver's impression of his or her level of participation in planning for a child's service and treatment. Respondents are asked to answer the questions on a 4-point Likert-type scale from "*not at all*" (1), "*a little*" (2), "*some*" (3), to "*a lot*" (4). Psychometric properties have not been reported by the authors because this is a relatively new scale. On the other hand, the scale was developed in a large-scale national study that investigates experiences of families whose children received services for severe emotional and behavioral disorders.

Data Analyses

Data collected from various instruments were checked and coded for data processing and statistical analyses. The Statistical Package for Social Sciences was used for this purpose. Regarding treatment fidelity, the study used intraclass correlation (ICC) to assess interrater reliability of I-FAST. The study used paired-sample *t* tests to examine the within-subject changes from pre- to posttreatment and repeated measures analysis of variance to assess the within-subjects changes during the three assessments of pretreatment, posttreatment, and 6-month follow-up. In addition, the study used the Wilcoxon signed-rank tests to assess the within-subjects changes during the three assessments of pretreatment, posttreatment, and 6-month follow-up for the categorical variable of child's placement status.

To address the problem of attrition, we had used multiple imputation method to simulate value for the missing assessments to reduce the adverse effect of missing observations in the data analyses. When there were a valid pretreatment assessment and at least one valid assessment at posttreatment or 6-month follow-up, we imputed the missing assessment with available valid results along with the age and gender of the client. Details for the imputation were attached at the footnote of Tables 1 and 2. We used PROC MI from SAS to create 5 imputed datasets and combined these results to simulate value with PROC MIANALYZE for the missing observations (Graham, Cumsille, & Elek-Fisk, 2003; Schafer & Olsen, 1998).

FINDINGS

Child's Outcomes: The Ohio Scales

Based on parents' assessment, the mean score of Problem Severity at pretreatment was 40.4 ($SD = 20.6$), meaning that the child, on average, on several occasions ex-

TABLE 1

Paired-Sample t tests of The Ohio Scales (Parents', Youths', and Case Managers' Assessment), Parental Competence, and Family Participation at Pretreatment and Posttreatment

	Pretreatment	Posttreatment	<i>t</i>	<i>df</i>	<i>p</i>
Ohio scales					
Parents' assessment					
Problem severity ($N = 76$)	40.4 ($SD = 20.6$)	22.3 ($SD = 16.2$)	8.557	75	.000
Functioning ($N = 73$)	35.0 ($SD = 17.3$)	48.5 ($SD = 15.5$)	-6.839	72	.000
Youths' assessment					
Problem severity ($N = 39$)	30.7 ($SD = 19.4$)	17.8 ($SD = 12.1$)	4.178	38	.000
Functioning ($N = 38$)	47.6 ($SD = 19.4$)	57.6 ($SD = 10.7$)	-3.275	37	.002
Case managers' assessment					
Problem severity ($N = 72$)	37.9 ($SD = 15.1$)	16.7 ($SD = 10.0$)	12.409	71	.000
Functioning ($N = 68$)	34.1 ($SD = 12.7$)	49.7 ($SD = 12.0$)	-9.056	67	.000
Parental competence with children ($N = 64$)	34.2 ($SD = 6.4$)	36.2 ($SD = 5.3$)	-2.509	63	.015
Family participation ($N = 70$)	25.9 ($SD = 3.0$)	25.4 ($SD = 3.7$)	1.089	69	.280

Note. Data were imputed for missing assessments:

Problem severity (parent rating): 57 completed all three assessments, 2 missing in posttreatment only, and 17 missing in 6-month follow-up only.

Problem severity (worker rating): 53 completed all three assessments, 4 missing in posttreatment only, and 15 missing in 6-month follow-up only.

Problem severity (youth rating): 29 completed all three assessments, 1 missing in posttreatment only, and 9 missing in 6-month follow-up only.

Functioning (parent rating): 54 completed all three assessments, 2 missing in posttreatment only, and 17 missing in 6-month follow-up only.

Functioning (worker rating): 51 completed all three assessments, 3 missing in posttreatment only, and 14 missing in 6-month follow-up only.

Functioning (youth rating): 28 completed all three assessments and 10 missing in 6-month follow-up only.

Parent competence with children: 44 completed all three assessments, 7 missing in posttreatment only, and 13 missing in 6-month follow-up only.

Family participation: 51 completed all three assessments, 3 missing in posttreatment only, and 16 missing in 6-month follow-up only.

TABLE 2
Pairwise Comparisons of the Ohio Scales (Parents', Youths', and Case Managers' Assessment), FACEII, Parental Competence, and Family Participation: Pretreatment (T1), Posttreatment (T2), and 6-Month Follow-Up (T3)

	T1-T2			T2-T3			T1-T3					
	Mean difference	Std. error	Significance	95% Confidence interval for difference	Mean difference	Std. error	Significance	95% Confidence interval for difference	Mean difference	Std. error	Significance	95% Confidence interval for difference
Ohio Scales—Parents' assessment												
Problem severity (N = 76)	-18.1	2.1	.000	-22.3 -13.9	1.2	1.9	.536	-2.5 4.8	-17.0	2.1	.000	-21.1 -12.8
Functioning (N = 73)	13.6	2.0	.000	9.6 17.5	-0.6	1.7	.730	-4.0 2.8	13.0	2.1	.000	8.9 17.1
Ohio scales—Youths' assessment												
Problem severity (N = 39)	-12.9	3.1	.000	-19.1 -6.7	3.9	3.0	.199	-2.2 10.0	-9.0	3.1	.006	-15.2 -2.7
Functioning (N = 68)	9.9	3.0	.002	3.8 16.1	1.0	1.9	.595	-2.9 5.0	11.0	3.6	.004	3.7 18.2
Ohio scales—Case managers' assessment												
Problem severity (N = 72)	-21.3	1.7	.000	-24.7 -17.8	2.1	1.3	.127	-0.6 4.7	-19.2	1.7	.000	-22.5 -15.9
Functioning (N = 68)	15.6	1.7	.000	12.2 19.1	0.2	1.2	.163	-2.1 2.5	15.8	2.0	.000	11.9 19.7
FACEII												
Family cohesion (N = 60)	3.4	1.6	.039	0.2 6.7	0.1	1.0	.956	-2.0 2.1	3.5	1.8	.057	-0.1 7.1
Family adaptability (N = 54)	3.2	1.3	.016	0.6 5.8	-0.9	0.8	.264	-2.6 0.7	2.3	1.3	.075	-.02 4.8
Parental competence with children (N = 64)	2.0	0.8	.015	0.4 3.5	0.2	0.7	.805	-1.3 1.6	2.2	0.8	.006	0.6 3.7
Family participation (N = 70)	-0.6	0.5	.280	-1.6 0.5	1.0	0.4	.018	0.2 1.8	0.9	0.5	.073	1.8 -.08

Note. Data were imputed for missing assessments, see note in Table 1.
 Family Cohesion: 43 completed all three assessments, 5 missing in posttreatment only, and 12 missing in 6-month follow-up only.
 Family Adaptability: 37 completed all three assessments, 7 missing in posttreatment only, and 10 missing in 6-month follow-up only.

hibited each of the listed problem behaviors in the past 30 days (Table 1). The mean score of the Functioning Scale was 35.0 ($SD = 17.3$) at pretreatment indicating a relatively low level of functioning in the children. Based on findings from paired-sample t tests of the parents' evaluations, there was a significant decrease in the severity of problem behaviors in the child ($t = 8.557, df = 75, p < .001$), significant improvement in child's level of functioning ($t = -6.839, df = 72, p < .001$) from pre- to posttreatment (Table 1).

The youth in the program reported a different pattern in evaluating their problem severity and level of functioning at pretreatment. On average the youth assessed themselves at a lower level of problem severity (30.7 vs. 40.4) and a higher level of functioning (47.6 vs. 35.0) as compared with their parents. The differences between the youth and their parents on evaluating problem severity and level of functioning, however, were reduced at posttreatment. The mean scores for differences in problem severity as rated by youth and parents were 12.9 and 18.1, respectively. Youth, however, still rated themselves at a higher level of functioning at posttreatment than their parents (57.6 vs. 48.5). Paired-sample t tests found that there was a significant decrease in the severity of problem behaviors in the youth ($t = 4.178, df = 38, p < .001$), significant improvement in their level of functioning ($t = -3.275, df = 37, p < .01$) from pretreatment to posttreatment based on the youths' evaluations (Table 1).

The case managers' rating of The Ohio Scale indicated a significant improvement in the areas of assessment of Problem severity and Functioning from pretreatment to posttreatment. Based on findings from paired-sample t tests on the case managers' evaluations, there was a significant decrease in the severity of problem behaviors in the child ($t = 12.409, df = 71, p < .001$) and significant improvement in child's level of functioning ($t = -9.056, df = 67, p < .001$) from pre- to posttreatment (Table 1).

Figure 2 shows the mean scores of problem severity and level of functioning at pretreatment, posttreatment, and 6-month follow-up based on parents', youths', and

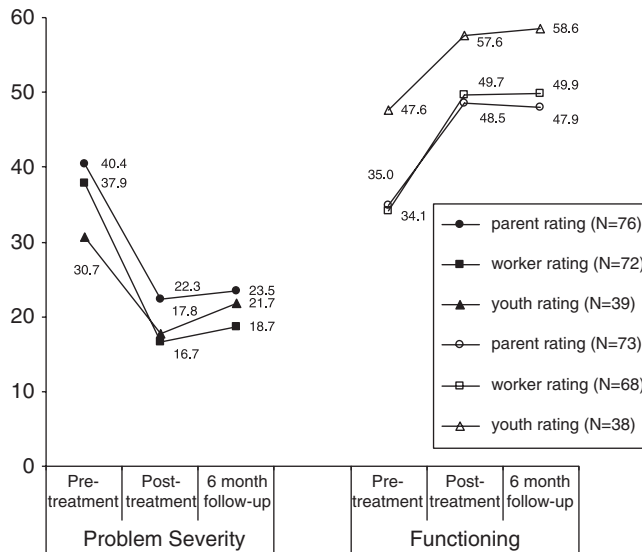


FIGURE 2. The Ohio Scales: Pretreatment, Posttreatment, and 6-Month Follow-Up. Note. Data were imputed for missing assessments, see note in Table 1.

case managers' report. Across multiple reporting sources, findings based on pairwise comparisons indicated there were significant changes from pretreatment to posttreatment, significant changes from pretreatment to 6-month follow-up, and nonsignificant changes from posttreatment to 6-month follow-up for problem severity and level of functioning in children (Table 2). In other words, significant positive changes in the children's behavioral outcomes from pretreatment to posttreatment were maintained 6 months after the families terminated from the program.

Placement Status

Data were obtained on the placement status of 75 children before their receiving treatment and at posttreatment. Among the 75 children, 41.3% (31) had been in out-of-home placement before receiving home-based services in such settings as: psychiatric hospitals (40%), juvenile detention centers (32%), foster care (16%), other youth facilities (8%), and residential treatment facilities (4%). At posttreatment, only 5.3% (4) of child participants were in out-of-home placement. Three of them were placed in psychiatric hospitals and 1 was in a residential treatment facility. Findings based on Wilcoxon's signed-rank tests indicated significant differences in the pattern of distribution of placement status of children from pre- to posttreatment with a significantly higher percentage of children in out-of-home placement pretreatment than at posttreatment ($p < .001$).

Of these 75 children, complete data were obtained on 59 of them regarding their placement status at pretreatment, posttreatment, and 6-month follow-up. Among these 59 children, 40.7% were placed at out-of-home placement before treatment. Only 5.1% (3) and 15.3% (9) were in out-of-home placement at posttreatment and 6-month follow-up, respectively (Figure 3). Specifically, 3 children were placed in psychiatric hospitals at posttreatment. At 6-month follow-up, 5 children were placed in psychiatric hospitals, 1 in a residential treatment facility, and 3 in juvenile detention centers. Findings based on using the Wilcoxon signed-rank tests indicated significant

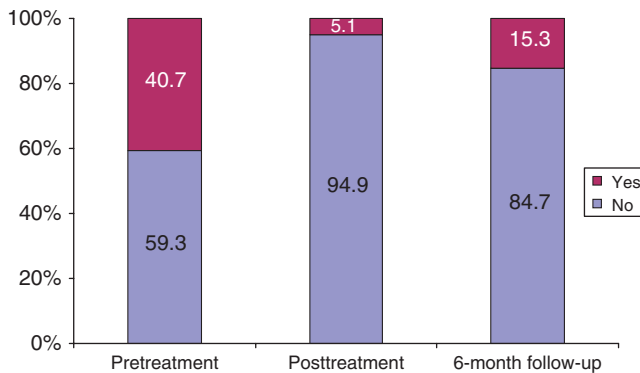


FIGURE 3. Placement Status of Children: Pretreatment, Posttreatment, and 6-Month Follow-Up ($n = 59$).

Note. Pretreatment and Posttreatment: Aysmp. Sig. (two-tailed) from Wilcoxon's signed-rank test = .000. Posttreatment and 6-month follow-up: Aysmp. Sig. (two-tailed) from Wilcoxon's signed-rank test = .026. Pretreatment and 6-Month Follow-up: Aysmp. Sig. (two-tailed) from Wilcoxon's signed-rank test = .224.

differences in the pattern of distribution of placement status of children from pre- to posttreatment, posttreatment to 6-month follow-up, and pretreatment to 6-month follow-up. A significantly higher proportion of the children were in out-of-home placement at pretreatment than at posttreatment. In addition, there were also a higher percentage of children in placement at 6-month follow-up than at posttreatment. There was a still significantly lower percentage of children in placement at 6-month follow-up than at pretreatment (Figure 3).

Family Functioning

Family cohesion

Data were obtained from 60 families regarding family cohesion at pretreatment, posttreatment, and 6-month follow-up. Figure 4 shows the distribution of families for each family type at pretreatment, posttreatment, and 6-month follow-up. At pretreatment as well as at posttreatment approximately one-third of these families were found to be “disengaged” (35.0% and 33.3%, respectively). At posttreatment fewer families were found to be “separated” (23.3%) than at pretreatment (31.7%), and more families (31.7%) were found to be “connected separated” at posttreatment than at pretreatment (26.7%). In addition, the percentage of families considered to be “very connected” nearly doubled from pretreatment to posttreatment (6.7% vs. 11.7%). Regarding changes between posttreatment and 6-month follow-up, there were more families in the categories of “connected separated” and “separated” and fewer families in the categories of “very connected” and “disengaged” at 6-month follow-up than at posttreatment. Pattern of distribution also showed the families in the category of “very connected” stayed the same (6.7% vs. 6.7%) but more were classified as “connected separated” (26.7% vs. 36.7%) from pretreatment to 6-month. There were also slightly fewer families in the categories of “separated” and “disengaged” at 6-month follow-up than at pretreatment (Figure 4).

Findings based on pair-wise comparisons indicated there were significant changes from pretreatment to 6-month follow-up, nonsignificant changes from pre- to posttreatment, and non-significant changes from posttreatment to 6-month follow-up in terms of family cohesion (Table 2). Overall, families tended to become connected and less separated and/or disengaged from pre- to posttreatment and to 6-month follow-up.

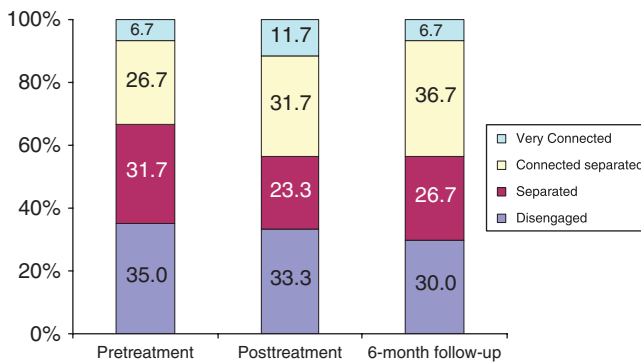


FIGURE 4. FACEII: Family Cohesion at Pretreatment, Posttreatment, and 6-Month Follow-Up (N = 60).

Note. Data were imputed for missing assessments, see note on Table 2.

Family adaptability

Data were obtained from 54 families at pretreatment, posttreatment, and 6-month follow-up. Figure 5 shows the distribution of families for each family type at pretreatment, posttreatment, and 6-month follow-up. At pretreatment and at posttreatment slightly more than a quarter of these families were found to be the “structure” type (27.8% and 29.6%). There were fewer families in the categories of “rigid” at posttreatment than at pretreatment (16.7% vs. 29.6%) and more families in the categories of “very flexible” at posttreatment than at pretreatment (16.7% vs. 3.7%). Regarding changes between posttreatment and 6-month follow-up, while the percentage of families in the category of “flexible” remained unchanged, there was a slight decrease for families in the categories of “very flexible” at 6-month follow-up than at posttreatment. In addition, there were slightly more families in the category of “structure” (31.5% vs. 29.6%) and “rigid” (18.5% vs. 16.7%) at 6-month follow-up than at posttreatment.

Findings based on pair-wise comparisons indicated there were significant changes from pre- to posttreatment in family adaptability and nonsignificant changes from posttreatment to 6-month follow-up in terms of family adaptability (Table 2). Overall, families showed a trend of becoming more flexible and less rigid with treatment with these changes being maintained at 6-month follow-up.

Parental Competence with Children

Data were obtained from 64 families on the Parental Competence with Children measure. The mean score of 36.2 ($SD = 5.3$) at posttreatment compared favorably with the mean score of 34.2 ($SD = 6.4$) at pretreatment. Based on findings from the paired-sample t test of the parents’ evaluations, parents increasingly perceived themselves as being competent in parenting their children from pre- to posttreatment and these improvements were statistically significant ($t = -2.509$, $df = 63$, $p < .01$) (Table 1).

Figure 6 shows the mean scores of Parental Competence with Children at pretreatment, posttreatment, and 6-month follow-up. There was a continuous increase in the mean scores from pretreatment to posttreatment to 6-month follow-up (34.2 vs. 36.2 vs. 36.4). Findings based on pair-wise comparisons indicated there were significant changes from pre- to posttreatment, as well as from pretreatment to 6-month

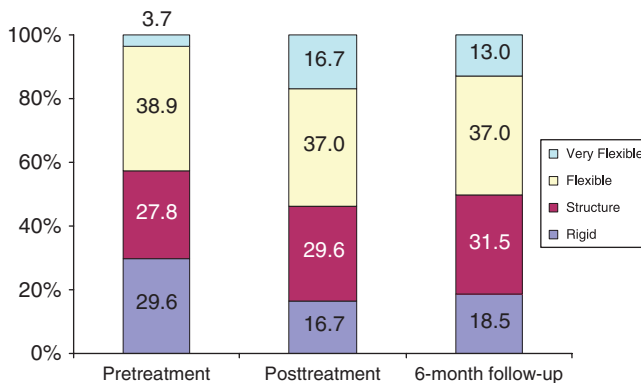


FIGURE 5. FACEII: Family Adaptability at Pretreatment, Posttreatment, and 6-Month Follow-Up ($N = 54$).

Note. Data were imputed for missing assessments, see note on Table 2.

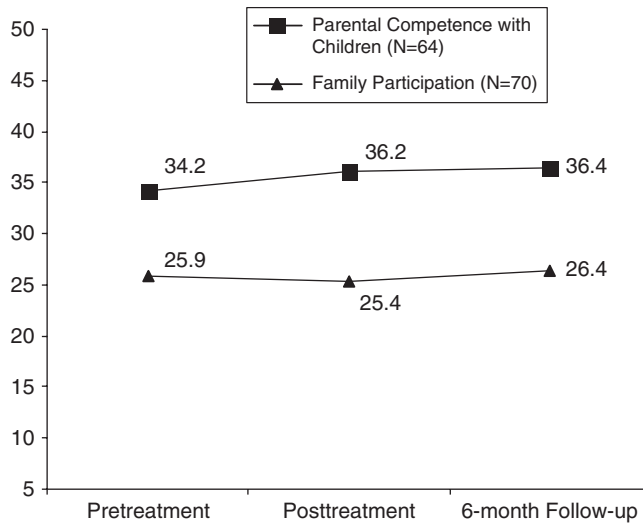


FIGURE 6. Parents' Evaluation of Parental Competence and Family Participation: Pretreatment, Posttreatment, and 6-Month Follow-Up.

Note. Data were imputed for missing assessments, see note in Table 1.

follow-up, with nonsignificant changes from posttreatment to 6-month follow-up on the Parental Competence with Children measure (Table 2). In sum, parents perceived themselves as becoming significantly more competent in addressing problems with their children with treatment and they were able to maintain these positive changes at 6-month follow-up.

Family Participation

Seventy families provided data on the Family Participation measure at pretreatment and posttreatment as reported by the parents. At the pretreatment, these families already reported a very high level of participation in the treatment process (25.9, $SD = 3.0$). At posttreatment these parents continued to report a high level of family participation (25.4, $SD = 3.7$) despite a slight but nonsignificant decrease in the mean scores from pre- to posttreatment (25.9 vs. 25.4). Findings from the paired-sample t test did not indicate significant differences in parental competence with service providers from pre- to posttreatment based on the evaluation of parents ($t = 1.089$, $df = 69$, $p = .280$) (Table 1).

Figure 6 shows the mean scores on the Family Participation measure at pretreatment, posttreatment, and 6-month follow-up. There was a slight decrease in mean scores from pre- to posttreatment and an increase in the mean scores from posttreatment to 6-month follow-up (25.9 vs. 25.4 vs. 26.4). Findings based on pairwise comparisons indicated there were significant changes from pretreatment to 6-month follow-up in family participation while there were nonsignificant changes from pre- to posttreatment and from posttreatment to 6-month follow-up in (Table 2). In sum, families reported a significantly higher level of participation in the treatment process from pretreatment to 6-month follow-up.

DISCUSSION

I-FAST is a home-based model that is developed and implemented from within the community mental health system. Findings of this feasibility trial provided initial empirical evidence that supported the effectiveness of I-FAST for reducing a child's problem, improving a child's functioning, reducing out-of-home placements, improving family functioning, and increasing parental competence with their children. In terms of child's behavioral outcomes, findings indicated that there was a significant decrease in problem severity and a significant increase in the level of functioning in children from pre- to posttreatment as reported by parents, the youth, and I-FAST case managers. Children were able to maintain their positive changes at 6-month follow-up. In addition, there was a significant decrease in the number of children in out-of-home placement at posttreatment than at pretreatment. Despite more children in out-of-home placement at 6-month follow-up than at posttreatment, the number was still significantly less than the number of children in out-of-home placement before they participated in the program.

In terms of family functioning, findings from FACESII showed significant increases in the level of cohesion and adaptability in these families. Specifically, there was a trend of families becoming more connected and less separated and/or disengaged, more flexible and less rigid, more balanced and less extreme with treatment. All observed changes were significant from pre- to posttreatment and/or from pretreatment to 6-month follow-up. In addition, families were able to maintain these positive changes at 6-month follow-up. Regarding parental competence with children, parents became significantly more competent in addressing problems with their children from pre- to posttreatment, and they were able to maintain these positive changes at 6-month follow-up. Findings regarding family participation in the treatment process indicated a high level of participation throughout the evaluation period. In addition, there was significantly greater family participation in treatment from pretreatment to 6-month follow-up.

The study measured fidelity by having two independent raters who used the I-FAST Checklist rate videotaped or audiotaped family sessions and consultation sessions. We used intraclass correlation to assess interrater reliability of I-FAST. The findings of ICC showed a satisfactory level of interrater reliability.

Limitations of this study must be acknowledged. First, this is an intervention development study in which we used a single group design to examine the feasibility of I-FAST for treating families with children at-risk of out-of-home treatment. Because of the limited sample size, a purposive sampling strategy, and a lack of control group with randomized assignment procedures in the research design, findings of the study are subjected to various internal and external validity threats. For instance, treatment effectiveness might be a result of therapists' characteristics and competencies and not the I-FAST model. In addition, study sample included all families receiving I-FAST service regardless of treatment length and child diagnoses. Such broad sampling criteria make it impossible to definitively demonstrate the specific effect of I-FAST model with specific problems. On the other hand, I-FAST is created with the objective of providing a useful and realistic home-based model for community mental health agencies, which are mandated to provide services to families with at-risk children of a wide range of problems. The dilemma between "rigor and relevance" is one to be thoughtfully addressed in the future research design.

Another limitation of the present study was the use of self-reports to measure most studied variables. For instance, parental self-reports of competence with children or child's behavioral problems could be affected by the problem of reporting bias. This study used multiple reporting sources for child's outcomes so that findings from diverse reporting sources, including the parents and youth clients, could be cross-validated. However, the use of observation-based rating systems would present a more rigorous method of evaluation (Reid, Patterson, & Snyder, 2002). Third, not all 77 families provided complete data on the three assessment points of pretreatment, posttreatment, and 6-month follow-up (Tables 1 and 2). We conducted analyses to first determine whether there were significant differences between the completers and noncompleters. There were also no significant differences between those two groups on demographic characteristics including age, gender, educational status, and race; level of problem severity and level of functioning of children at pretreatment based on parents' reports. Although there were no significant differences between the two groups, findings could still be influenced by the problem of measurement attrition (Fraser, 2004). This study also used multiple imputation method to simulate value for the missing assessments to reduce the adverse effect of missing observations in the data analyses (Graham et al., 2003; Schafer & Olsen, 1998). Fourth, while the study developed and used I-FAST Checklist for fidelity analyses, we still need to develop a rigorous and specific fidelity measure protocol including a detailed coding manual to ensure consistence across raters (Forgatch, Patterson, & DeGarmo, 2005). Fifth, ethnic groups including African, Asian, and Hispanic American populations were largely underrepresented in the study.

Potential contributions of the study should be understood in the context of advancement and challenges of intervention research (Fraser, 2004). The present study can be considered as an intervention development study in which we conducted an initial feasibility trial of I-FAST as a home-based treatment model. The effectiveness of I-FAST will still need to be tested further in a large-scale study with an experimental design that will provide more conclusive evidence of I-FAST as an alternative, feasible, and effective home-based treatment model. Specific recommendations for the future large-scale effectiveness study include: (1) use a larger sample size; (2) include control or comparison groups using randomized assignment procedures; (3) use observation-based rating systems in data collection when appropriate; (4) further refine and develop the treatment manual for training purposes and fidelity analyses; (5) increase the rigor of the fidelity procedures using observation-based approaches with a refined, specific, and rigorous fidelity measurement protocol of I-FAST; (6) carefully monitor the data collection process to reduce problems in measurement attrition; (7) include research sites that serve urban and more ethnically/racially diverse populations.

CONCLUSION

I-FAST is a home-based model that was developed and implemented from within the community mental health system. I-FAST was developed from evidence-based common factors to intervene with at-risk families and their children and adolescents. Clinically speaking, I-FAST attempts to explore the appropriateness and feasibility of integrating multiple evidence-based interventions conceptually and methodologically in treatment. Findings of I-FAST will have useful implications for the long-time de-

bate regarding the effectiveness of theory-based family treatment approaches vs. integrative or common factors approaches in treating families. Not minimizing the complexity of providing effective home-based treatment to diverse populations and groups, I-FAST, if found to be effective based on evidence-based effective core treatment components, implies that treatment can become more flexible and allows case managers and therapists to utilize their own expertise in the treatment process to bring beneficial changes to families. By selecting second-order change as the principle that guides the focus of intervention, I-FAST opens the door for case managers and therapists to select from a wide range of therapy models and work collaboratively with the family members to change behavioral patterns that will result in solving presenting problems and achieving treatment goals. Such an inclusive approach empowers therapists and case managers to utilize and build upon their existing expertise in the treatment process, but work within a relatively uncomplicated treatment framework, and still be effective in providing treatment for families.

In terms of service provision, this focused, evidence-based, integrative home-based model facilitates the process of training and allows agencies to develop and consolidate their expertise in home-based treatment. The focus on providing ongoing clinical support and consultation to case managers is in line with the spirit of allowing agencies to develop expertise and organizational experts who can pass the treatment culture to other staff, thereby facilitating the continuation of expertise in home-based treatment at the agency level. If I-FAST is found to be effective with this client population, then it can provide an alternative, feasible, and effective home-based treatment model that addresses the challenges of cost containment, facilitates continuity of expertise in home-based treatment at the agency level, and meets realities of practice demands to serve families with children at risk of out-of-home placement. Because of its focus on evidence-based common factors as well as how to mesh with the realities of everyday practice demands on staff, reduce cost of training, increase utilization of case managers and therapists' existing expertise, and empower the development of expertise at the agency level, this integrative treatment model should have useful implications for translational science that addresses issues of uploading evidence-based practices at the agency level (Brekke, Ell, & Palinkas, 2007).

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