



Effectiveness of Functional Family Therapy for Mandated Versus Non-Mandated Youth

By Katarzyna Celinska, Ph.D.

ABSTRACT

This study compares the outcomes for youth mandated to participate in Functional Family Therapy (FFT) to those whose participation was referred but voluntary. FFT is a short-term intervention for delinquents and status offenders, along with their parents. The study sample consists of 120 cases: 70 youth and parents who were mandated by the Family Court to participate in FFT and 50 youth and their parents who were referred to FFT by other agencies. The sample is diverse in terms of gender, race and ethnicity. The outcome variables consist of a set of scales obtained from the Strengths and Needs Assessment (SNA). Changes in life domain functioning, child strengths, acculturation, caregivers' strengths, caregivers' needs, child behavioral emotional needs, and child risk behaviors are assessed. The analysis indicates that both groups improved across all domains. Overall, being mandated to participate in FFT does not predict greater improvements in outcomes. The findings suggest that status offenders and minor delinquents who participated in FFT could be processed less formally without foregoing the therapy outcomes.

Keywords: Functional Family Therapy, family therapy, Family Court, mandated youth, non-mandated youth, delinquency, delinquents, status offenders

INTRODUCTION

Functional Family Therapy (FFT) is a short-term intervention for delinquents, status offenders as well as youth at-risk for delinquency along with their parents or guardians. Research presented in this article is a part of a larger quasi-experimental study conducted by this author between 2005 and 2013 with youth and their parents residing

Katarzyna Celinska, Ph.D., is an Assistant Professor in the Department of Law, Police Science, and Criminal Justice Administration at John Jay College of Criminal Justice, New York City, New York. Her research interests include evaluation of violence prevention programs and women's incarceration. Her research was published in the *Prison Journal*, *Journal of Juvenile Justice* and *Journal of Family Therapy*. She is currently writing a book on criminological theory, criminal justice policies and practice in corrections. She teaches various courses including *Women and Crime*, *Major Works in Criminal Justice* and *Policy Analysis*. Correspondence: kcelinska@jjay.cuny.edu

in the Middlesex County, New Jersey. The families participated in FFT as implemented by the Children at Risk Resources and Interventions—Youth Intensive Intervention Program (CARRI-YIIP) at the University of Medicine and Dentistry in New Jersey (UMDNJ), which has since merged with Rutgers University.

Research suggests that the most effective delinquency prevention interventions address skill building, counseling and/or provide multiple coordinated services. Many scholars indicate that family therapy and family counseling are among the most effective and successful interventions with FFT as one of the leading examples (Lipsey, Howell, Kelley, Chapman, & Carver, 2010; Lipsey, 2009).

This study compares the therapeutic outcomes of youth and their parents who were mandated versus those who were not mandated to participate in FFT. The sample is diverse in terms of gender, race and ethnicity. The outcome variables are scales obtained from the Strengths and Needs Assessment (SNA), a clinical and research tool completed by the therapists before (SNA initial) and after (SNA discharge) intervention.

The results of this study will contribute to our knowledge on FFT and to the literature on interventions designed to reduce delinquency and other risk behaviors. The findings will shed light on how mandating services impacts the outcomes while controlling for observable differences between mandated and non-mandated youth. No other study on FFT has addressed the effects of voluntary versus non-voluntary participation. In fact, no published studies compare outcomes for mandated versus non-mandated youth in any other family therapy or intervention either. The findings of this research will suggest policy implications for the Family Court and the juvenile justice practice.

A THEORY OF COGNITIVE DISSONANCE

Although this study is not a test of cognitive dissonance theory, its concepts can assist in explaining some of the dilemmas that are faced by families and youth mandated to participate in FFT. According to the theory of cognitive dissonance and the concept of effort justification people tend to value the outcome more if they put extra effort in obtaining it ([Festinger, 1957](#); [Festinger, 1962](#); [Zentall, 2012](#)). Based on this theory, families that are mandated might be more resistant to participate in FFT, especially given the program's requirement that both youth and a parent participate in weekly therapeutic sessions. This requirement may lead some parents to resist the program, and to experience less motivation and engagement in therapy. [Brehm and Cohen \(1962\)](#) indicated that degree of perceived choice is critical in arousing, or even provoking, dissonance. Less choice may lead to more dissatisfaction. In addition, some parents might view the requirement to participate in FFT as an attack on their parental competency, behavior in general and/or morality. As a result, the families may experience dissonance (as a mechanism of ego-defense and to maintain a positive image), and the intervention's outcomes might be negatively affected ([Kenworthy, Miller, Collins, Read, & Earleywine, 2011](#); [Gawronski, 2012](#)).

The theory of cognitive dissonance is utilized in evaluation and satisfaction studies. For example, many scholars from the field of mental health indicate that the theory of

cognitive dissonance links satisfaction levels with the intervention's outcomes and the intervention itself with the clients' perceived role in seeking services (Garland, Aarons, Saltzman, & Kruse 2000; Garland, Saltzman, & Aarons, 2000). In short, clients, including adolescents, who believe that participating in an intervention was voluntary and who felt free to leave at any time, are more likely to be satisfied.

There are no published studies on voluntary versus non-voluntary participation in FFT. However, few published studies showed no significant differences in outcomes between those who were mandated and those who were non-mandated to participate in an intervention. Examples include studies on women-batterers (Tutty, Babins-Wagner, & Rothery, 2009), drinking among college students (Merrill, Carey, Lust, & Kalichman, 2014), detainees with alcohol, drug and mental problems (Broner, Mayrl, & Landsberg, 2005) and substance-abuse treatment clients (Marshall & Hser, 2002).

FUNCTIONAL FAMILY THERAPY

Created in the early 1970s by the psychologist James Alexander, FFT is a model intervention designed to reduce and prevent delinquent behavior (Sexton & Alexander, 2004). FFT is currently provided in 45 states and in Europe, New Zealand, Canada and Singapore. FFT has been endorsed by various governmental and non-governmental institutions including the Office of Juvenile Justice and Delinquency Prevention, the Center for Disease Control and Prevention, the U.S. Department of Justice and the Center for the Study and Prevention of Violence. FFT is one of only a handful of interventions to be recognized as the Blueprint for Healthy Youth Development Model Program (www.fftllc.com; Alexander, Pugh, Parsons, & Sexton, 2000). However, FFT and other model programs require continued evaluation, because their effectiveness varies based on fidelity to model design, program setting, amount and quality of intervention, risk level of juveniles, characteristics of the served juveniles and the quality of the therapists (Lipse, Howell, Kelly, Chapman, & Carver, 2010).

FFT is a short-term intervention, usually completed within 3 months. The goal of the intervention is to prevent further delinquency or aggressive behavior by improving communication skills and strengthening relations among all family members. Youth and at least one parent are required to participate in weekly therapy sessions.

FFT differs from the traditional family therapy approach in a number of ways. First, FFT is a highly structured and standardized intervention. It includes three discrete phases: the engagement and motivation phase in which the therapist works on establishing a close relationship with each family member and on reducing blame; the behavioral change phase in which every family works on improving communication, on anger management and on parenting skills; and the generalization phase in which the family learns how to sustain what they have learned and how to utilize available community resources (Alexander & Sexton, 2002).

Another important and unique aspect of FFT is the role of therapists in the intervention. In order for FFT to be effective the therapists go through specialized, rigorous and frequent training. They are monitored both on- and off-site for their

adherence to the model. The FFT therapists are trained to treat each family on an individual basis and to be culturally sensitive. They are focused on influencing changes in three major areas: cognition, emotions and relationships (Sexton & Alexander, 2004).

The first experimental research on FFT showed a significantly lower rate of recidivism among FFT participants versus control groups (e.g., [Alexander & Parsons, 1973](#); [Klein, Alexander, & Parsons, 1977](#); [Barton, Alexander, Waldron, Turner, & Warburton, 1985](#)). In one of two more recent published evaluations of FFT, [Celinska, Furrer and Cheng \(2013\)](#) found that youth in both the experimental and the comparison group significantly improved on several domains of the SNA. However, only FFT participants improved significantly on life domain functioning, behavioral and emotional needs, and risk behavior. In another recent study, [Sexton \(2010\)](#) found that FFT was effective in significantly reducing the recidivism rate among young parolees but only when the therapists adhered to the FFT model. The effectiveness of FFT depended on the quality of FFT therapists and on the fidelity to the model.

DATA AND METHODS

The current study has been approved by the appropriate Internal Review Boards. Youth came from a single county in NJ and participated in FFT as implemented by the CARRI-YIIP program at the UMDNJ (now, Rutgers University).

The Strengths and Needs Assessment (SNA)

The outcome variables for this project come from the Strengths and Needs Assessment (SNA) and the Services Tracking Form (STF). The SNA is a comprehensive clinical tool and a communimetric research measure. It is used for both, clinical assessment and program evaluation ([Lyons, 2009](#); [Celinska, et al., 2013](#)).

The SNA is a revised version of Lyon's Child and Adolescent Needs and Strengths Assessment (CANS) ([Lyons, Weiner, & Lyons, 2004](#)). The SNA exhibit validity (face, construct, concurrent and predictive), and reliability (inter-rater and auditor) ([Lyons, et al., 2004](#); [Lyons, 2009](#); [Anderson & Estle, 2001](#); [Anderson, Lyons, Giles, Price, & Estle, 2003](#)). The SNA gauges clients' level of functioning across multiple life domains and assesses their strengths and risks. The SNA is completed by the therapists who use the ratings both to make clinical decisions and to evaluate the clients' progress. Aggregated scores provide standardized psychometric measures for outcome evaluation ([Lyons, 2009](#); [Anderson, et al., 2003](#); [Lyons, Griffin, & Fazio, 1999](#)). The therapists received training in using the SNA; either in person or via a secured Internet site. The training aimed to bolster the validity and reliability of the tool in the clinical setting ([Caliwan & Furrer, 2009](#)).

The SNA measures seven dimensions: Life Domain Functioning (contains 13 items related to current living conditions), Child Strengths (contains 9 items related to family life and personal achievements), Acculturation (with 3 items that focus on language and culture), Caregivers Strengths (with 6 items that are based on their involvement with their child and on the level of stability they provide), Caregivers Needs (contains 5 items

that include mental and physical health problems), Child Behavioral and Emotional Needs (with 9 items that address impulsivity, depression, anxiety, anger control, and substance abuse), and Child Risk Behaviors (contains 10 items including suicide risk, danger to others, sexual aggression, running away and delinquency). Youth and their caregivers are scored by the therapists on each sub-scale item from 0 (no evidence of problems and no need for service) to 3 (severe problems and a need for an immediate intervention or action). The rating 1 indicates a history or evidence of mild problems which warrants monitoring or possibly action. The item 2 indicates moderate problems with a need for action or some kind of strategy to address the problems or needs.

The seven dimensions are the basis for the seven scales, computed as the means of the relevant items (recoded from 1 to 4): Life Domain Scale (LDF), Child Strengths Scale (CS), Acculturation Scale (AC), Caregivers Strengths Scale (CAS), Caregivers Needs Scale (CN), Child Behavioral Emotional Needs Scale (CBEN), and Child Risk Behavior Scale (CR).

Treatment data come from the Services Tracking Form (STF), an instrument that tracks the number of sessions, length in FFT and types of referrals.

Sample

The sample consists of 120 cases collected during 2005-2011: 70 youth and their parents who were mandated by the Family Court to participate in FFT and 50 youth and their parents who were referred to FFT by other agencies and organizations: Mobile Response, Family Crisis Intervention Unit and the Youth Case Management. To be eligible for FFT, a youth must be aged 11-17, live with a parent or guardian, and have a history of aggressive and/or violent behavior, property damage, or truancy. Adolescents with serious criminal behavior, drug or alcohol abuse, or serious mental health problems were not eligible for FFT.

The average age of a mandated adolescent was 16.07 years old while the average age of a non-mandated adolescent was 15.18 years old. Males, white and non-Latinos comprised of a majority of both mandated and non-mandated youth. There were more males (70%) and more Blacks (41%) among mandated as compared to non-mandated adolescents (52% and 14% respectively). According to the SNA data, 8% in the mandated and 4% of the youth in the non-mandated sample had some developmental issues. Twenty percent of mandated youth and 28% of non-mandated youth experienced a traumatic event in their lifetime. Nine percent of mandated and 20% of non-mandated adolescents used prescription psychotropic medications. Alcohol and drug use could be a potential contributor to the behavior that led to a referral to the intervention. Based on the SNA data, 63% of mandated youth and 40% of non-mandated youth reported some substance use in the past or present. Seventeen percent of mandated and 14% of non-mandated adolescents were involved with the child welfare system. Altogether, 60% percent of mandated youth and 80% of non-mandated youth attended regular school. Basic demographic characteristics of the samples are presented in Table 1.

The data from the STF indicate that mandated youth and their parents participated on average in 12 sessions (mean = 12.04, range: 0-31) and had a total of 16 hours of

TABLE 1
Demographic Characteristics of Youth Who Participated in FFT, N = 130

| <i>Variable</i> | <i>Mandated youth</i> (N = 70) | <i>Non-mandated youth</i> (N = 50) |
|-----------------|-----------------------------------|---------------------------------------|
| Age (average) | 16.07 | 15.18 |
| Gender | | |
| Male | 70% | 52% |
| Female | 30% | 48% |
| Race | | |
| White | 44% | 68% |
| Black | 41% | 14% |
| Asian | 1% | 4% |
| Mixed | 6% | 14% |
| Other | 7% | 0% |
| Ethnicity | | |
| Latino | 30% | 24% |
| Non-Latino | 70% | 76% |

family counseling. The non-mandated youth and their parents attended on average 12 sessions (mean = 11.71, range: 2-24) and spent 18 hours in counseling. The attrition rate for both samples was nearly the same: 19% for mandated and 20% for non-mandated families. The youth and their parents in both samples had on average 5 sessions in the first, engagement phase of FFT. Nearly 70% of mandated youth came to the Family Court through probation. Those who were referred to FFT and voluntary participated came from diverse referral sources including Mobile Response (40%), Family Crisis Intervention Unit (18%) and the Youth Case Management (14%).

ANALYSIS AND RESULTS

Comparison between Two Samples

T-tests were performed to compare mandated versus non-mandated youth. The mandated youth scored higher (i.e. exhibited more problems) than non-mandated youth on two SNA scales: CBEN and LDF ($t = -2.344$ at $p < .05$ and $t = -1.477$ at $p < .05$ respectively). In addition, youth who were mandated to participate in FFT were significantly older by one year on average ($t = 2.465$ at $p < .001$). Although mandated families attended more therapy sessions, this difference was not significant.

Next, chi-square tests compared the samples on three categorical variables: gender, race and ethnicity. The results showed that there were significantly more boys and blacks in the group of mandatory participants (chi-square = 4.032 at $p < .05$ and chi-

square = 16.87 at $p < .001$, respectively). The significantly higher scores on LDF scale indicate more economic, educational and social problems.

Analysis of Outcomes in the Mandated and in the Non-Mandated Samples

Next, changes in the outcome variable are compared—separately for the mandated and for the non-mandated youth (see Table 2 for the results).

The results show that youth and their families who were mandated to participate in FFT experienced positive and significant changes in CBEN, CR (at $p < .05$), and LDF (at $p < .001$). Youth and their parents who voluntarily started FFT experienced positive changes in CAS, CBEN, CS (at $p < .05$), and LDF (at $p < .001$). The results suggest that families in both samples improved in several important areas. Specifically, all youth progressed in the Life Domain, Child Risk Behavior and Child Emotional Behavioral Needs domains. Changes in these areas are possibly the most important in preventing at-risk of delinquency behavior (Celinska, et al., 2013). In addition, the non-mandatory sample experienced improvement in caregivers’ strengths.

Next, the outcomes for mandated and non-mandated youth are compared while controlling for variables that differentiated the two samples—age, race and gender. The *total number of sessions* is also included because sub-sample differences on this measure approached statistical significance. Seven regression models were run with the *pre-post FFT changes in the seven scales* as outcome variables (see Table 3 for a summary of significant results). The changes were calculated based on comparing the results between initial and discharge SNAs. Change was calculated by subtracting the post from the pre score so that smaller and/or negative change values indicated improvement in domain scores.

Attending more sessions is associated with significant improvement in four domains: CAS, CBEN, CR, and LDF (at $p < .05$). Several control variables are significant at a low threshold of $p < .1$: *being mandated* and *black* explain negative change in CAS, being *black* explains negative change in CR, and being a *male* negatively affects change in CS.

TABLE 2
Pre- and Post-Comparison for Mandated and Non-Mandated Youth

| Scale | Mandated | | | Non-mandated | | |
|-------|----------|-----|----------------|--------------|----|----------------|
| | T | df | Sig (2-tailed) | t | df | Sig (2-tailed) |
| AC | .529 | 135 | .598 | .438 | 96 | .663 |
| CAS | .826 | 137 | .410 | 2.313 | 97 | .023** |
| CBEN | 2.627 | 137 | .010** | 3.161 | 98 | .002** |
| CN | -.237 | 137 | .813 | .293 | 97 | .770 |
| CR | 3.141 | 137 | .002** | 1.1617 | 98 | .109 |
| CS | 1.365 | 135 | .175 | 2.341 | 96 | .021** |
| LDF | 3.850 | 137 | .000* | 3.707 | 97 | .000* |

Note: *significance at probability .001 level, **significance at probability .05 level.

TABLE 3
Regression Models with Dependent Variables: The Changes in the SNA Domains.
N = 120

| <i>Dependent v.</i> | <i>Control v.</i> | <i>B</i> | <i>t</i> | <i>Sig</i> |
|---------------------|-------------------|----------|----------|------------|
| CAS | Mand | .131 | 1.713 | .090*** |
| | Black | .142 | 1.754 | .082*** |
| | Male | -.012 | -.167 | .868 |
| | Age | -.001 | -.030 | .976 |
| | Sessions# | -.013 | -2.411 | .018** |
| CBEN | Mand | .050 | .713 | .477 |
| | Black | .012 | .161 | .873 |
| | Male | .075 | 1.103 | .272 |
| | Age | .008 | .453 | .651 |
| | Sessions# | -.016 | -3.177 | .002* |
| CR | Mand | -0.71 | -1.323 | .189 |
| | Black | .111 | 1.962 | .052*** |
| | Male | .044 | .852 | .396 |
| | Age | .003 | .212 | .832 |
| | Sessions# | -.009 | -2.387 | .019** |
| LDF | Mand | -.027 | -.453 | .652 |
| | Black | .060 | .944 | .347 |
| | Male | .086 | 1.475 | .143 |
| | Age | .000 | -.019 | .985 |
| | Sessions# | -.022 | -5.342 | .000* |

Note: *Significance at .001 level, **Significance at .05 level, ***Significance at .1 level.

The next analysis examined whether the sub-sample experienced differential changes in the outcomes. Although both groups showed positive changes across multiple domains, only one relationship (being mandated and CAS) was significant at a low statistical threshold of $p < .1$. These results suggest that regardless of making participation in FFT mandatory for some families, the outcomes for both groups are nearly the same.

CONCLUSIONS

Whether making an intervention mandatory enhances its effectiveness is an important policy question within juvenile justice. According to the effort justification theory, those who voluntarily participate in the intervention may be more interested and inclined to put more effort toward reaching positive outcomes than those who are mandated to participate. They are also more likely to report positive outcomes in order to justify their efforts.

The question about the mandatory participation and its effects becomes even more important when intervention includes not only adolescents but also their parents. This is the case with FFT, as the intervention requires at least one parent to participate. Thus the motivation to participate in the intervention is supposed to come not only from youth but also from their parents.

This study focused on measuring and comparing the outcomes among 120 adolescents—70 mandated to participate in FFT and 50 who were referred to the program, but were not mandated to participate. The two sub-samples were comparable except for a few statistically significant differences. Mandated participants were older (by a year) and more likely to be males and black. They also scored higher than non-mandated youth on two SNA scales: CBEN and LDF, and attended more FFT sessions, although the latter difference was not statistically significant. The significantly higher scores on LDF scale indicate more economic, educational and social problems, suggesting that mandated participants have access to less social capital and economic resources.

Both groups improved across several outcomes, however, contrary to cognitive dissonance and effort justification theory, neither group showed greater improvements. Reflecting favorably upon the effectiveness of FFT, the most consistent predictor of positive changes in the outcome variable was *the number of attended sessions*.

Findings suggest that regardless of any possible resistance that potentially existed among mandated youth and their parents, therapeutic outcomes were not adversely affected. Perhaps families that are mandated to participate in FFT did not experience expected cognitive dissonance. On the other hand, this finding could be attributable to the role of FFT therapists who, during the first phase of the intervention, work on reducing any apprehension to the intervention and negativity among family members. The FFT therapists do not proceed to the next phase of behavioral change until they assess that the family is engaged and motivated.

Second, this finding has an important policy implication. Youth who were not formally required to participate in FFT improved just as well as those who were. In addition, the attrition rate was nearly identical for both samples. This result suggests a similar motivation level of youth and families in FFT, regardless whether they were mandated or not to participate in the therapy. Finally, based on the characteristics of this sample, I suggest that status offenders and minor delinquents can be treated outside of the court system—saving the court's resources while minimizing youth and their parents' stress and lessening the potential stigma of being brought to court.

An alternative interpretation that deserves consideration is differential treatment for those who were processed and mandated through the court system. Although youth who were mandated to participate in FFT did score higher on CBEN scale, they were also more likely to be older, black and male.

Research suggests that FFT successfully prevents further delinquency and aggressive behavior, especially when implemented in accordance with the model. The multi-phase structure of the therapy allows clinicians to first address problems of reluctance, disengagement and negativity. This approach is especially important for families that are mandated to participate in FFT. Yet results from my sample of minor delinquents and status offenders did not show significant differences in the benefits of FFT that favored

mandated over non-mandated youth and families. These results suggest that less formal processing would benefit all involved.

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