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Office versus Home-Based Family Therapy for Runaway, Alcohol Abusing Adolescents: Examination of Factors Associated with Treatment Attendance

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Abstract

There is a dearth of research examining treatment engagement and attendance among runaway youth and their families. Such research is needed in order to inform treatment providers on factors associated with engagement and maintenance of these difficult to engage families into counseling. This study examined differential treatment attendance for alcohol abusing runaway youth residing at a local shelter. A traditional office-based family systems approach, Functional Family Therapy (FFT), was compared to a non-traditional, home-based, multi-systemic family therapy approach, Ecologically Based Family Therapy (EBFT). As expected, treatment engagement and attendance was significantly higher for those assigned to EBFT (N = 37) compared to FFT (N = 40). Predictors of treatment attendance (income, family chaos, externalization problems and level of youth substance use) were examined within each treatment modality. Findings suggest that home-based (compared to office-based) treatment modalities may significantly increase treatment attendance and engagement of runaway youth and their families. Non-traditional forms of treatment may need to be considered in order to best meet the needs of highly chaotic and disorganized family systems.

Keywords

Runaway and homeless youth; family therapy; engagement; treatment attendance; substance use

Even when substance abusing individuals contact a treatment system, early drop-out is a significant problem. Lawendowski (1998) suggested that adolescents tend to be more ambivalent and resistant to change. Indeed, Szapocznik, Perez-Vidal, Brickman, Foote, Santisteban, Hervis, & Kurtines (1988), in a study of treatment engagement, found that 62% of youth between the ages of 12 and 21 years refused to attend treatment sessions. Several studies have examined the relationship between age and dropout rates directly and some found evidence that, along the age continuum of substance abusers, youth is linked to higher treatment dropout rates (Ball, Lange, Meyers, & Friedman, 1988; Feigelman, 1987).

The general consensus is that runaway youth are difficult to engage and maintain in therapy (Morrissette, 1992; Smart & Ogborne, 1994) and are “difficult to work with” (Kufeldt & Nimmo, 1987). Given that treatment attendance is often a complicating factor for successful treatment outcome (Institute of Medicine, 1990), and that few studies have examined predictors of treatment attendance among runaway youth and their families, further research in this area is needed to help guide treatment providers. This paper examines factors associated with

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treatment attendance among alcohol-abusing runaway youth and their families utilizing a home-based versus office-based family therapy intervention.

Runaway youth are beset with many problems including physical and sexual abuse, high levels of alcohol and drug use, depression, teen pregnancy, and frequent prostitution (Johnson, Aschkenasy, Herbers, & Gillenwater, 1996; Zimet, Sobo, Zimmerman, Jackson, Mortimer, Yanda, & Lazebnik, 1995). The alcohol abuse rate of runaway and homeless youths is estimated to range from 70% to 85% (Rotheram-Borus, Selfridge, Koopman, Haignere, Meyer-Bahlburg, & Ehrhardt, 1989; Shaffer & Caton, 1984; Yates, MacKenzie, Pennbridge, & Cohen, 1988), and the level of alcohol involvement in runaways is at least double that of school youths (Forst & Crim, 1994). Limited evidence suggests that rates of alcohol abuse are similar to rates reported among homeless adults (Robertson, 1989). Runaway and homeless youth use alcohol at a younger age and experience greater impaired social functioning owing to alcohol use compared to non-homeless adolescents (Kipke, Montgomery, & MacKenzie, 1993). Even given their severe alcohol abuse and related problem behaviors, one study determined that only 15% of this population of youth had ever received treatment for alcohol problems (Robertson, 1989).

Research suggests that family disturbance is highly correlated to the act of running away, hence family therapy is identified as an important treatment to evaluate with this population. Engaging parents in counseling is almost always advisable given their involvement in precipitating the running away behavior (Rohr & James, 1994) and obvious role in reunification with their child. In fact, Teare, Furst, Peterson, & Authier (1992) found that in their sample of shelter youths, those not reunified with their family had higher levels of hopelessness, suicide ideation and reported more family problems than those reunified. Youths' perceptions of family dysfunction were significantly associated with reunification and those not reunified were at greater risk of suicide, had more overall dissatisfaction with life, and more generalized negative expectations about the future.

Post and McCoard (1994) found that during a crisis, runaway youths and families may be more amenable than usual to counseling, and the need for intervention is intense, with the timing (when they have sought help at a shelter) critical. These researchers also noted that runaways who go to shelters, unlike many, are asking for help. Their reported greatest needs concerned living arrangements, family relationships, and communication with their parents.

Reviews of formal clinical trials of family-based treatments consistently found that more drug-abusing adolescents enter, engage in, and remain in family therapy longer than in other modalities (Liddle & Dakof; 1995; Waldron, 1997). However, few studies have directly compared family therapy models, making conclusions about the superiority of one approach over another difficult. Moreover, researchers have noted limited variation in theoretical orientation across models (Stanton & Shadish, 1997). For example, the vast majority of family-based interventions (i.e., traditional approaches) for substance abuse problems focus on family interaction patterns and parenting behaviors as major targets of change. The two approaches examined in this paper include the office-based Functional Family Therapy (FFT) and Ecologically Based Family Therapy (EBFT) which is conducted in the home.

Functional Family Therapy (FFT; Barton & Alexander, 1981; Alexander & Parsons, 1982), has a family systems conceptual base. Similar to other systems models, problems with alcohol and drugs are viewed as behaviors which occur in the context of and have meaning for family relationships. FFT has received considerable research attention during the past 30 years. It was initially developed and empirically supported for crisis intervention with juvenile offenders, including runaway adolescents and their families (Alexander, 1971). Alexander and his colleagues conducted several treatment outcome studies examining the effectiveness of FFT

with runaway and status delinquents in reducing out of home placement, improving parent-child process and reducing negativity using a 12-week format (Alexander, 1971; Alexander & Parsons, 1973; Barton, Alexander, Waldron, Turner, & Warburton, 1985). In these studies, FFT made significantly more improvements in adolescent and family functioning compared to individual therapy, a client-centered family therapy approach and a control group with minimal attention from probation officers.

EBFT is a multisystemic, home-based treatment based on the recognition that substance use and other related problem behaviors derive commonly from many sources of influence and occur in the context of multiple systems. It is based largely on family systems (Haley, 1976; Minuchin, 1974) conceptualizations of behavior and behavior change. EBFT posits that behavior problems can be maintained by problematic transactions within any given system or between some combination of pertinent systems, including the intrapersonal system of the individual adolescent, the interpersonal systems of the family and peers, and the extra-personal systems of the shelter, juvenile justice system, school, and the community.

In-home therapy has been successful with families assessed as disorganized, chaotic, and with few resources (Henggeler, Borduin, Melton, Mann, Smith, Hall, Cone, & Fucci, 1991). Henggeler et al. (1991) noted that home-based interventions are particularly successful in facilitating treatment engagement of multi-problem youth. That is, working with the family in their home, and in their neighborhood, allows the assessment of multiple ecological influences impacting the adolescent and family. In-home sessions also allow the intervention to be perceived as a natural process and enhances treatment engagement and acceptability (Henggeler et al., 1991; Joanning, Thomas, Quinn, & Millen, 1992; Kazdin, Stolar, & Marciano, 1995). A high percentage of missed or canceled office-based appointments occur because a family does not have reliable transportation or because the meeting time conflicts with a parent's work schedule (Henggeler & Borduin, 1995). These authors note that a therapist's time is often used most efficiently when sessions are conducted in the family's home as it is much easier for unmotivated families to ignore an appointment at a clinic than to ignore the therapist who knocks at their door at the scheduled time.

It is expected that treatment engagement and overall attendance will be significantly higher for families assigned to the home-based intervention as it removes many barriers for chaotic and disadvantaged families that otherwise would preclude their attendance in the session, as noted by Henggeler et al. (1991). Thus, based upon the theoretical model of home-based therapy, we expected that lower income, more family chaos, and more adolescent problem behaviors (externalizing behaviors and substance use) would predict higher treatment attendance for the home-based compared to the office-based intervention.

METHOD

Participants

Youth were recruited from two runaway shelters in a large southwestern city. Seventy-six adolescents are included, which constituted 31 males (15 EBFT, 16 FFT) and 46 females (22 EBFT, 24 FFT). The number of male and female adolescents included in each treatment did not differ. The average age of the adolescents was 15.0 (SD = 1.36), which also did not differ between treatment groups ($p > .10$, M (SD) = 15.16 (1.44), 14.85 (1.27) for EBFT, FFT respectively). The reported ethnicities included Native American (N = 10), African American (N = 5), Hispanic (N = 36), Anglo (N = 20) and "Other" (N = 6). Family constitution included 41 single-parent and 36 two-parent families. See Table 1 for additional demographic information. In order to be eligible for participation, youth were required to (1) have at least 10 days of alcohol use in the last 90 days, with the alcohol problem being primary over any other drug problem, (2) live within a 60 mile radius of the research site, (3) have the legal

option of returning to a home situation (including foster care or other family member), and (4) have a primary caretaker who agreed to participate in family therapy.

Procedure

Adolescents at the shelter who were identified as potentially eligible for participation were interviewed in-person by a project research assistant. Those passing quick-screen criteria were engaged into the project. Prior to the youth's pre-treatment assessment his or her parent or legal guardian was contacted to engage into the study. Once parental signed consent was obtained, the youth's consent was obtained and their pre-treatment assessment conducted. If the youth did not use alcohol at least 10 days in the prior 90 days, he or she then continued with treatment as usual through the shelter. Otherwise, youth continued with the assessment battery. They were told that the assessment would take up to 3 hours to complete and that they would receive $25 at the end of their participation. Generally, youth completed their assessment within three days of their arrival to the shelter. Upon completion of the assessment battery, youth were randomly assigned to either EBFT or FFT. Thirty-seven youth were assigned to EBFT, while 40 youth were assigned to FFT.

If reading ability was in doubt, interview forms were read by the examiner to the participant. All other individuals (siblings, other caretakers) who participated in the family therapy condition signed a treatment consent form at the first therapy session.

Family Therapy

Treatment was provided by four therapists trained in the family therapy interventions. Therapists included one male and three females with varied educational backgrounds. Two therapists were master's level counselors, one was a licensed psychologist, and one was a licensed alcohol and drug abuse counselor. The intervention included 16 therapy sessions, to be completed within 3 months, but no longer than 6 months.

Ecologically Based Family Therapy—With EBFT, treatment is not limited to the family but is directed toward assessing these multiple influences and intervening so that change is supported throughout all the systems affecting the problem behavior. EBFT includes sessions or parts of sessions held conjointly with all family members living in the home, but also includes individual sessions with the youth targeted on decision-making, emotion-regulation, or other intrapersonal factors which may be influencing substance use and other problem behaviors. An EBFT manual (Slesnick, 2003) was developed to guide therapists' intervention with the families.

Functional Family Therapy—In FFT, treatment is conducted in the office setting, with all family members present. The focus of sessions is on family interaction. The therapy process is best understood in terms of the two major phases in which the basic elements of the model are implemented. The first phase focuses on readiness to change and involves creating the context in which behavior change can occur. The therapist's aims in this phase are to: (1) engage the family in therapy, (2) enhance the family's motivation for change, and (3) assess the relevant aspects of family functioning to be addressed in treatment. The second phase focuses on establishing and maintaining behavior change. In this behavior change phase, the motivational framework created and the assessment data obtained in the first phase are used to guide the selection and implementation of specific behavioral change techniques. Treatment procedure was guided by the FFT manual developed by Alexander and Parsons (1982).

Materials

The assessment included interviews and self-report questionnaires. Assistance in completing forms was provided to youth as needed. Only those assessment instruments utilized in the current study are described.

Sample Characterization—The examiner administered a demographic questionnaire to characterize the sample. These demographic items included age, gender, homeless experiences, income, self-identified ethnicity, and parent and sibling information.

Based on information gathered from this questionnaire, a variable was calculated to estimate the family's level of chaos and disorganization. Five questions were utilized that addressed this issue. Adolescents were asked if they ever resided in a foster home, group home, were ever a ward of the state, or were physically or sexually abused. Each of these questions were coded as 1 for "yes" and 0 for "no," and were summated to create the "family chaos" variable.

Youth Externalizing Problem Behavior—The Youth Self-Report of the Child Behavior Checklist (YSR; Achenbach & Edelbrock, 1982) provides a standardized format to quickly elicit reports of children's behavior across a wide range of problem areas. The 120-item scale assesses behaviors in children associated with delinquency, aggression, attention problems, somatic complaints, thought problems and social problems. The measure has strong psychometric properties and is highly reliable (Achenbach & Edelbrock, 1982). The Externalizing (hyperactive behavior, sexual problems, delinquency, and aggressiveness) factor score was utilized as a dependent measure in this paper.

Substance Use—The primary measure of quantity-frequency of adolescent substance use was obtained by the Form 90 interview, developed for NIAAA funded Project Match (Miller, 1996). This semi-structured interview combines the timeline follow-back method (Sobell & Sobell, 1992) and grid averaging (Miller & Marlatt, 1984). The Form 90 yields a daily reconstruction of all drug classes, including alcohol, and also shown good reliability and validity with adult substance users (Westerberg, Tonigan, & Miller, 1998) with kappas for different drug classes ranging from .74 to 1.0 (Tonigan, Miller, & Brown, 1997). This interview measure yields the total percent days, in the last 90, of all alcohol and drug use.

The interviewer administered the Computerized Diagnostic Interview Schedule for Children (DISC; Shaffer, 1992) to the adolescent sections on drugs and alcohol. The CDISC is a computerized structured interview containing 263 items pertinent to a comprehensive psychiatric diagnostic interview based upon DSM-IV criteria, and includes modules to diagnose alcohol, tobacco and other substance abuse and dependence. The diagnosis for other substance abuse specifies drug class, including stimulants, sedatives, opiates, hallucinogens, etc.

RESULTS

Descriptive Statistics

The adolescent's reported annual family income did not differ between treatment groups (t (73) = − 0.43, p = .67, M (SD) = $25,630 (26,832), $28,606 (33,348) for EBFT, FFT respectively). The amount of family chaos had a possible range from 0 to 5, with a score of 5 indicating more family chaos. Amount of chaos did not differ between EBFT and FFT groups (t (75) = 1.44, p = .16; M (SD) = 1.7 (1.4), 1.3 (1.2) for EBFT, FFT respectively). Additionally, the percent days of alcohol and/or drug use did not differ between EBFT (M (SD) = 44.70 (33.23)) and FFT ($M(SD)$ = 43.75 (30.64); t (75) = 0.13, p = .90). Twenty-two youth met criteria for alcohol abuse and 43 youth met criteria for dependence, while 12 youth did not meet CDISC

criteria for either abuse or dependence. The percent days of alcohol use in the last 90 days was 28.28 (27.51) for EBFT and 21.77 (21.58) for FFT. Average number of standard drinks during each drinking episode was high with 9.20 (5.66) for EBFT and 9.66 (5.22) for FFT.

Because the authors were concerned that those youth who did not meet CDISC criteria for alcohol abuse or dependence would use less alcohol than those adolescents with abuse criteria, the following analyses are presented. For just those 12 youth that did not meet abuse or dependence, percentage of days of alcohol use was 31.16 (33.54), which not only did not differ from those who did meet CDISC criteria, but, in fact, was higher. Further, the average number of standard drinks consumed during each drinking episode, by youth not meeting CDISC criteria, was 10.07 (4.7). Thus, even though 15.6% of our sample did not meet the CDISC criteria for alcohol abuse or dependence, their alcohol use was not significantly different from those who met diagnostic criteria.

Treatment Engagement and Attendance

Overall, families assigned to EBFT attended more treatment sessions (*M* (*SD*) = 10.03 (7.65)) than did families assigned to FFT (*M* (*SD*) = 6.35(6.68), t (75) = 2.25, p = .03). Additionally, it was expected that a greater number of families would be engaged into the EBFT treatment. Engagement was defined as attending 4 or more treatment sessions. Twenty-eight families out of 37 (76%) were engaged into EBFT, with 4 families (10.8%) not attending a single session. For FFT, only 20 families out of 40 (50%) were engaged, with 11 families (27.5%) not attending a single session. Thus, overall, engagement significantly differed between the groups (χ^2 = 5.40, p = .02), with more families assigned to EBFT engaged compared to those assigned to FFT.

Differences in treatment engagement between key demographic variables were investigated. For EBFT, the average number of treatment sessions was larger for two parent homes (*M* (*SD*) = 10.05 (6.57)) than for one parent homes (*M* (*SD*) = 9.19 (6.45)), but did not differ significantly. Additionally, treatment attendance did not differ between ethnic groups (Native American = 7.33 (7.55), African American = 10.00 (5.29), Hispanic = 9.35 (6.35), Anglo = 12.50 (7.15), Other = 6.00 (8.49)) or between male (9.47 (6.27)) and female (9.81 (6.71)) adolescents.

For FFT, the average number of treatment sessions was larger for two parent homes (*M* (*SD*) = 8.47 (6.62)) than for one parent homes (*M* (*SD*) = 8.47 (6.62)), but did not differ significantly. Additionally, treatment attendance did not differ between ethnic groups (Native American = 2.25 (3.25), African American = 14.00 (2.83), Hispanic = 4.38 (5.54), Anglo = 8.69 (7.28), Other = 8.50 (8.70)), or between male (7.94 (6.68)) and female (5.52 (6.65)) adolescents.

Predicting Treatment Attendance

Regression analyses to predict treatment attendance were conducted separately for FFT and EBFT. Since these treatment approaches are distinct, the analyses were conducted separately. The same regression model was used for each treatment approach. Although the number of treatment sessions was supposed to be 16, due to ethical concerns a few families had more than the standard 16 sessions. Two families that were outliers on treatment sessions were reset to 16 sessions.

Hierarchical regression models, entering annual family income first, family chaos score second, externalization third, and percent days of drug use fourth, were conducted separately for EBFT and FFT. Due to missing data in annual family income, only 37 FFT and 37 EBFT families are included in the following regression analyses.

EBFT—For families who received EBFT, income did not contribute to treatment attendance. Family chaos showed a marginal amount of variance contribution above income ($sr^2 = .10$, $p = .06$), with more chaos predicting more treatment session attendance. Externalization problem behaviors contributed a significant amount of variance to the number of treatment sessions attended above both income and chaos ($sr^2 = .22$, $p < .01$). Higher problem scores were related to greater number of treatment sessions attended. Finally percent days of drug use did not contribute to treatment attendance. See Tables 2 and 3.

FFT—For families who received FFT, annual family income contributed a significant amount of variance to the number of treatment sessions attended ($sr^2 = .12$, $p < .05$). As expected, families with higher income attended more treatment sessions. Additionally, the amount of family chaos contributed a significant amount of variance above annual family income ($sr^2 = .10$, $p < .05$), with more family chaos predicting less treatment session attendance. Neither externalization problems nor percentage days of drug use contributed any variance to the number of treatment sessions. See Tables 4 and 5.

DISCUSSION

This paper examined predictors of treatment attendance for runaway, substance abusing youth and their families. To date, few studies have examined factors associated with treatment attendance for runaway youth and their families. Given the risk for continued family disruption, for example, through crises associated with youth's removal from the home, examination of effective modalities for engaging runaway youth and their families into treatment is identified as the necessary first step toward successfully intervening with a high risk, understudied, and underserved population.

Based on prior research (e.g., Henggeler et al., 1991) we expected that families assigned to home-based treatment would attend more sessions than those assigned to the office-based treatment. Several barriers to treatment attendance including lower income, family chaos, and adolescent problem behaviors (externalizing behaviors and substance use) were expected to predict higher treatment attendance in the home vs. office-based setting.

As predicted, more families assigned to home-based EBFT were *both* engaged and attended more sessions compared to families assigned to the office-based FFT. 76% of the EBFT families participated in four or more sessions, while only 50% of the families assigned to FFT participated in four or more sessions. Overall, families assigned to EBFT attended nearly twice as many sessions as families assigned to FFT. Thus, for this population, home-based therapy appears to significantly increase treatment attendance. To further understand this finding, we examined predictors of treatment attendance.

Income was positively associated with treatment attendance in the office-based FFT. As expected, those with lower income attended fewer sessions. Interestingly, the relationship between income and treatment attendance was in the opposite direction for EBFT, though this relationship was not statistically significant. Thus, this finding was consonant with our prediction that EBFT serves to reduce treatment attendance barriers that may be related to income. Since low income families were not more or less likely to participate in home-based treatment, this finding suggests that low-income families may be motivated to participate in the treatment but income status may interfere with the ease of the treatment participation outside the home (FFT) when transportation or other factors (e.g., child care) are involved.

Although greater family chaos was associated with reduced sessions in both treatment conditions, family chaos contributed more variance to treatment attendance for FFT than for EBFT. In sum, families with a history of child abuse and removal of the child from the home

attended fewer treatment sessions, and this was especially so for the office-based intervention. These parents and children may be wary of mental health service providers given prior contact or prior negative treatment experiences. Many families and youth who have been through the system report having low trust for the treatment provider, and feeling like they were not helped in the past (Athey, 1995). Anecdotally, youth and parents report feeling blamed by past service providers. These families tend to show a reluctance to involve outside systems in their lives again. The findings suggest that they are especially less likely to "go out of their way" to participate in therapy. Some of this barrier is removed by meeting the family in their home, but this was not significantly so.

As predicted, adolescents' externalizing problems was associated with increased treatment attendance in EBFT but not in FFT. Thus, disruptive, acting out behaviors in the adolescent increases the family's treatment attendance in the home but not in the office. Possibly, with treatment provided in the home, teens are less likely to feel "on the spot." Treatment in the home may put both parents and youth at ease as they are in their own environment and are less likely to be defended against participation than if treatment were conducted in the office. Additionally, the therapist was presented to the youth as an ally to negotiate with other systems, such as the juvenile justice or school systems. Thus, youth with acting out problems were engaged by the therapist who then attended court hearings and school meetings to advocate on the youth's behalf.

Severity of the adolescent's alcohol and drug use did not significantly predict treatment attendance in either EBFT or FFT. Thus, level of substance use by the youth did not influence participation in the office or home-based family therapy. This finding, however, may be an artifact of the eligibility requirement for the project. As the goal of this project was to evaluate family treatment with alcohol problem runaway youth, we had no non-using adolescents and so the range of use was more restricted than if the sample of youth included those without alcohol problems or drug problems.

This study is limited in that it focused solely on shelter residing runaway youth with primary alcohol problems. Thus, the findings may not generalize to those runaway youth who do not access community agencies for assistance and who present with a substance use diagnosis other than alcohol. Another limitation is that findings were based upon data collected solely from youths' perspectives. Parent perceptions of the family environment and of the youth's problem behaviors may differ significantly from those of the youth. For example, Slesnick and Prestopnik (2003) found that, in general, primary caretakers of runaway youth perceive their youth's externalization problems to be more severe than the youth perceives, and primary caretakers perceive the family environment as less problematic than do the youth.

However, even given these limitations, there is a paucity of research examining factors associated with treatment engagement and attendance for runaway youth and families. The findings presented here suggest that runaway youth and their families are amenable to treatment efforts, and that treatment attendance may be enhanced through providing intervention to families in their own environment. Simply moving the traditional therapy context from the office setting to the client's home may significantly increase treatment attendance in a population considered difficult to engage and maintain in therapy.

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TABLE 1

Sample characteristics for FFT and EBFT treatment families.

	EBFT (*N* = 37)	**FFT (*N* = 40)**	**Total (*N* = 77)**
Gender (*N*, %)			
Female	22, 60%	24, 60%	46, 60%
Male	15, 40%	16, 40%	31, 40%
Age (*M* (*SD*))	15.16 (1.44)	14.85 (1.27)	15.00 (1.36)
Ethnicity (*N*, %)			
Native Am.	6, 16%	4, 10%	10, 13%
African Am.	3, 8%	2, 5%	5, 7%
Hispanic	20, 54%	16, 40%	36, 47%
Anglo	6, 16%	14, 35%	20, 26%
Other	2, 5%	4, 10%	6, 8%
Annual income (*M* (*SD*))	$25,630 (26,832)	$28,606 (33,348)	$27,138 (30,142)
Currently enrolled (*N*, %)	21, 57%	23, 58%	44, 57%
Sexual abuse (*N*, %)	10, 27%	15, 38%	25, 33%
Physical abuse (*N*, %)	21, 56%	15, 38%	36, 47%
Ward of the state (*N*, %)	10, 27%	6, 15%	16, 21%
Foster home (*N*, %)	9, 24%	7, 18%	16, 21%
Group home (*N*, %)	13, 35%	8, 20%	21, 27%

TABLE 2

Hierarchical multiple regression analyses predicting number of treatment sessions attended for EBFT.

Variable	sr^2	*F (sr)*	R^2	*B*	β
Income	.02	0.65	.02	0.00	−.05
Chaos	.10	3.94†	.12	−1.59	−.34
Externalization	.22	10.74**	.34	0.29	.51
% Days Use	.02	1.04	.36	−.03	−.15

Full model: R = .60, adjusted R^2 = .28

Note. sr^2 = squared semipartial correlation coefficient, indicating the unique variance accounted for by the variable at that point in the equation (ΔR^2), *F(sr)* = test for reliable contribution of the variable [F (ΔR^2)]; R^2 = squared multiple regression coefficient, indicating the total variance in the criterion variable accounted for by the predictor variable in the regression equation at that point; B = multiple regression coefficient; β = standardized multiple regression coefficient.

† p = .055,

** p < .001

TABLE 3

Correlation analyses between regression variables for EBFT treatment families.

	Income	Chaos	Externalization	% Days Use
# of tx sessions	−.14	−.30*	.45**	−.14
Income		−.14	−.22	.17
Chaos			.12	.18
Externalization				−.16

* Note. $p < .05$,

** $p < .01$

TABLE 4

Hierarchical multiple regression analyses predicting number of treatment sessions attended for FFT.

Variable	sr^2	*F (sr)*	R^2	*B*	β
Income	.12	4.81*	.12	0.00	.32
Chaos	.10	4.27*	.22	−1.64	−.30
Externalization	.01	0.41	.23	0.04	.06
% Days Use	.01	0.19	.23	−0.02	−.08

Full model: R = .48, adjusted R^2 = .14

Note. sr^2 = squared semipartial correlation coefficient, indicating the unique variance accounted for by the variable at that point in the equation (ΔR^2), *F(sr)* = test for reliable contribution of the variable [F (ΔR^2)]; R^2 = squared multiple regression coefficient, indicating the total variance in the criterion variable accounted for by the predictor variable in the regression equation at that point; B = multiple regression coefficient; β = standardized multiple regression coefficient.

* $p < .05$

TABLE 5

Correlation analyses between regression variables for FFT treatment families.

	Income	Chaos	Externalization	% Days Use
# of tx sessions	.35*	−.35*	.18	−.07
Income		−.11	.13	.16
Chaos			−.15	.04
Externalization				−.44**

*Note. $p < .05$,

**$p < .01$.