FAMILY PROCESS

Parent and Youth Perspectives and Retention in Functional Family Therapy

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This qualitative study aimed to understand factors relating to dropout in Functional Family Therapy (FFT) through exploring the experience of families who have completed FFT and those who have dropped out from therapy. Individual interviews were undertaken with parents and adolescents from 12 families who had completed FFT therapy in England and eight families who had dropped out from therapy. Using thematic analysis, six themes were established, clustered within three domains. The patterns of responses across the accounts of families who did and did not complete FFT suggest processes that may facilitate retention in FFT. These include relational processes specific to family therapy including having a shared problem definition and a balanced therapeutic alliance. In addition, processes commonly observed across both individual- and family-based interventions were found. These include the credibility and relevance of the therapeutic work, openness in therapy, and practical barriers. Findings also suggest that establishing motivation to participate in therapy may be more important for retention in therapy than overcoming practical barriers. Barriers to retention in therapy also differ for parents and young people. These differences highlight the importance of the therapist maintaining credibility and support for parents while concurrently reducing blame toward the young person to encourage youth openness. Findings have implications for therapist actions to retain families when using the FFT model.

Keywords: Dropout; Engagement in treatment; Experience of treatment; Functional family therapy; Qualitative research

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Functional Family Therapy (FFT) is a systemic, manualized family intervention. The model aims to improve adolescent externalizing behavior through changing and strengthening family interactional patterns. Therapeutic activities tailored to the family's individual needs and guided by the FFT model are delivered across three structured

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phases. These are Engagement and Motivation, Behavior Change, and Generalization. FFT is usually delivered over a three-to-six-month period (Sexton & Alexander, 2004). FFT has been associated with improved behavioral and family outcomes across US and European settings. However, relative efficacy varies according to study characteristics, particularly the comparison group used (Hartnett, Carr, Hamilton, & O'Reilly, 2017).

Around 30-40% of youth with conduct disorder drop out from therapy (National Institute for Health & Care Excellence, 2013). Early dropout may lead to poorer outcomes relative to those remaining in therapy (Kazdin & Wassell, 1998). Completion rates in FFT have been higher than comparison interventions, for example, Baglivio, Jackowski, Greenwald, and Wolff (2014). However, retention in FFT varies. For example, completion rates of 77–89% are reported across studies of FFT in the United States where the intervention was first developed (Baglivio et al., 2014; Sexton & Alexander, 2004; White et al., 2013). However, completion rates in a UK RCT were much lower at 60% (Humayun et al., 2017). This suggests that, even with strong engagement in FFT, there is a substantial proportion of families who drop out. Dropping out from FFT has been linked to poorer outcomes (Graham et al., 2014). Therefore, understanding retention in FFT, and reasons why certain families drop out, may be important for improving therapeutic outcomes.

Extensive research has considered characteristics of the client, family, and therapist associated with dropout in child and adolescent psychotherapy, as well as processes that occur in therapy. These include child and family characteristics, therapist characteristics, the therapeutic relationship, practical barriers, and psychological barriers. Some commonalities are identified across intervention types. However, there are also differences seen between individual and family interventions, and between individual interventions.

Studies of individual child and parenting interventions for antisocial behavior found that child and family characteristics linked to dropout include problem severity and socioeconomic disadvantage (Kazdin et al., 1997; Kazdin & Mazurick, 1994). Research of individual, group, and family intervention for adolescents with substance misuse suggests that the match of gender and ethnicity between therapists and client may also relate to dropout in therapy (Mensinger & Diamond, 2005). Consistent with these findings in wider interventions for children and adolescents, dropout in FFT has also been linked with family characteristics such as income and family chaos (Slesnick & Prestopnik, 2004). Dropout in FFT has also been linked to therapist case mix (Turner et al., 2018). However, Hartnett, Carr and Sexton (2016) did not find any demographic or clinical characteristics to be associated with dropout in FFT when delivered in the UK.

A commonly identified therapeutic process associated with dropout across intervention types is the client–therapist relationship (therapeutic alliance; Robbins et al., 2008; Sharf et al., 2010). In family therapy, parent and adolescent alliance may both play a role in dropout. However, the way in which these aspects of the therapeutic alliance relate to dropout appears to vary between different family therapy models. In Multidimensional Family Therapy (MDFT), the individual alliances between family members and therapists are seen to be associated with dropout (Robbins et al., 2006). In Brief Strategic Family Therapy (BSFT) as well as the individual alliances, the balance of therapeutic alliances between family members was also important (Robbins et al., 2008). An unbalanced therapeutic alliance, where one or more family members have a stronger bond with the therapist than others, was seen to be associated with dropout. Unbalanced therapeutic alliance has also been linked to dropout in FFT (Robbins et al., 2003). However, inconsistencies are seen in the available research. For example, Flicker et al. (2008) found that whether there was a relationship between therapeutic alliance and dropout in FFT varied according to family characteristics such as ethnic background.

Other barriers to retention in child and adolescent psychotherapy include situational or practical barriers such as competing demands, the relevance and demands of therapy, as

well as psychological barriers such as worries, stigma, or distrust (Kazdin et al., 1997; Koerting et al., 2013). Many of these barriers are not specific to one intervention approach but found across a range of intervention types (Sprenkle & Blow, 2004). Intervention setting, that is, home or clinic, is a situational factor that has been considered as a barrier to retention in FFT. However, so far this factor has only been considered as part of a comparison between different interventions rather than within the same intervention (Slesnick & Prestopnik, 2004). This makes it difficult to draw strong conclusions from the finding.

These findings suggest that some of the barriers to retention identified across therapeutic interventions are seen in FFT. However, differences between the findings in FFT and other interventions are also seen. This suggests that factors associated with dropout in some other therapeutic approaches may operate differently in FFT. There is also inconsistency across studies of FFT, suggesting for example that the factors associated with dropout in FFT in the United States may differ when it is delivered in other countries. More research is needed to understand the processes and mechanisms involved in dropout in FFT in more depth, and in a UK setting.

Previous research considering the experience of therapy in FFT from the perspective of families who have completed therapy provides further insight into processes relating to retention in FFT. Findings from qualitative research with therapy completers reveal barriers to satisfaction including location of sessions and difficulties with openness in a family setting (Celinska et al., 2015). In addition, therapy completers highlight important characteristics in implementation of FFT including trust and honesty (i.e., feeling of respect for individual needs and being able to speak openly), motivation for change, support networks, and psychosocial influences (McPherson et al., 2017). Parent- and therapist-reported characteristics of success in the engagement phase of FFT include reducing negativity and blame, being a sensitive and credible helper, a balanced alliance, and a family focus (Hartnett et al., 2016). While these recent studies have considered process in FFT in relation to satisfaction and success of therapy, they include only families who completed FFT. Further research is needed to explore the experience of FFT from the perspective of families who have dropped out from services. This may help with understanding inconsistencies in previous research and provide insight into the way in which therapeutic practice can overcome barriers to retention.

The present study aims to understand experience of therapy and processes relating to dropout from FFT in the UK. This will be achieved through considering the perspectives of those who discontinued therapy early in addition to those who completed therapy. This study also aims to consider the experience of adolescents, whose voices have often been missing in research of this type. These questions were considered through in-depth interviews with adolescents and parents from families who have either completed or discontinued FFT early. A qualitative approach makes it possible to consider in-depth the experience of family members, how this experience changes over the course of therapy, and the patterns of experience among those who completed or discontinued FFT early as well as among parents and adolescents. Investigating the processes relating to retention in FFT that are still not well understood will have important clinical implications for improving retention in FFT.

METHODS

Research Design

This study adopted a qualitative approach. This aims to explore the experience of young people and parents from families who have completed FFT and those who have dropped out from therapy. Qualitative enquiry allows an in-depth and open-ended exploration of

participant perspective. Thematic analysis was used to draw out the patterns of experience across parents and youth from families who completed or dropped out of FFT in order to understand characteristics related to dropout from therapy. The interviews were undertaken with families from two community-based FFT services in England.

Participant Selection

The sample of families was purposively recruited and stratified into two groups based on the following criteria:

(1). Families who had completed all three phases of FFT and terminated on mutual agreement or therapist recommendation (completer families).
(2). Families who did not complete all three phases of FFT (noncompleter families).

The two groups were defined in this way because in FFT there is no required number of sessions. Families are expected to complete three distinct phases (Engagement and Motivation, Behavior Change, and Generalization), but there is no specified number of sessions in each phase. Completion of each phase is determined by the therapist based on the progress the family has made. Families who have not completed all three phases are considered not to have completed the FFT intervention.

Recruitment Process

Ethical approval was granted by the NRES Committee London—Bromley. Two UK-based clinics agreed to participate in the research. Families from these clinics had been asked by their therapist whether they agreed to be contacted about research. Those who agreed were consecutively contacted by phone by a researcher and invited to participate following their use of FFT services. Parents and youth gave informed consent before participating. The study aimed to recruit between 6 and 12 families in each of the two groups (completer and noncompleter families) in line with guidance on theoretical saturation in thematic analysis (Guest et al., 2006).

Participant Characteristics

Twelve completer families (12 parents, seven youth) and eight noncompleter families (seven parents, three youth) participated in the study. Participant characteristics are presented in Table 1. Youth were mostly male (70%) and White or White British (80%), and mean age was 13.75 (SD = 1.92). Parent reported youth problem behavior on the Strengths and Difficulties Questionnaire (SDQ) Total Difficulties scale at entry to therapy was within the very high clinical range (mean = 21.53, SD = 5.45). Statistical tests indicate that completer and noncompleter families did not differ significantly on any of these characteristics at baseline.

Therapy Characteristics

Therapy characteristics are presented in Table 1. The average number of therapy sessions for completer families (i.e., those who completed all three phases of treatment) was 10 (SD = 3.36, range = 7–19 sessions) and for noncompleter families was four (SD = 2.88, range = 2–11 sessions). FFT comprises three clearly distinct phases. In this study, the noncompleter families were defined as those who had not completed all three phases of therapy. It is a consequence of this definition that there is a difference observed in the number of sessions between completers and noncompleters, but also an overlap between the minimum number of sessions of completer families and the maximum number of

TABLE 1
Participant and Therapy Characteristics

	All families (*N* = 20)	Completer families (*N* = 12)	Noncompleter families (*N* = 8)
Youth gender			
Male	14 (70%)	8 (66.7%)	6 (75%)
Female	6 (30%)	4 (33.3%)	2 (25%)
Youth ethnicity			
White/White British	16 (80%)	10 (83.3%)	6 (75%)
Black/Black British	4 (20%)	2 (16.7%)	2 (25%)
Youth age			
Mean (*SD*)	13.75 (1.92)	14.17 (1.69)	13.13 (2.17)
Range (years)	10–16	12–16	10–16
Parent SDQ total score[a]			
Mean (*SD*)	21.53 (5.45)	22.25 (6.05)	20.29 (4.39)
Sessions attended			
Mean (*SD*)	7.75 (4.19)	10 (3.36)	4.38 (2.88)
Range	2–19	7–19	2–11
Therapist adherence[b]			
Mean (*SD*)	3.18 (0.91)	3.21 (1.00)	3.13 (0.83)
Range	2–5	2–5	2–4.5

Note. [a]Parent ratings of child functioning was measured using the Strengths and Difficulties Questionnaire (SDQ) at entry to therapy.
[b]Therapist Adherence to FFT was measured using the Therapist Adherence Measure (TAM) based on an average of supervisor ratings of therapist adherence to the FFT model over the course of therapy.

sessions of noncompleter families. Six noncompleter families discontinued during Engagement and Motivation (phase one) and two during Behavior Change (phase two). FFT was delivered by eight therapists across two clinics (one to four cases per therapist). Most therapists delivered therapy to both completer and noncompleter families. One clinic was situated in a metropolitan district in the North of England, and the other in an Inner London borough. Therapy was delivered in either the home or clinic setting depending on which of the two clinics the family attended. The average therapist adherence to the FFT model for each family, based on supervisor rating, was within the acceptable range (3.18, *SD* = 0.91). Therapist adherence did not differ significantly between completer and noncompleter families.

Data Collection

Individual interviews were carried out following participation in FFT, either in person or over the phone. Interviews followed a semi-structured discussion guide. Interviews were audio recorded, transcribed verbatim, and anonymized before analysis.

Study Materials

The same discussion guide structure was followed for all participants. Minor adaptations tailored the discussion for adolescents or parents from completer or noncompleter families. The discussion guide was developed based on existing theory. It included directive and nondirective questions. Nondirective questions allowed open discussion about

experiences with the services. For example, asking about reasons families agreed to try FFT or reasons they decided to stop FFT. More directed questions explored topics which literature reviewed earlier in this paper have highlighted to be of importance for retention, alliance, and the FFT model. For example, asking whether families had any fears or worries about taking part in FFT or asked families to describe the relationship with the therapist. The discussion guide is available in Appendix S1.

Data Analysis

Using NVivo software, a Thematic Analysis (Braun & Clarke, 2006) aimed to describe and understand the similarities and differences in patterns of meaning across participants. Codes were developed inductively based on the content of the text. This involved a process of systematically labeling each phrase or sentence with one or more codes reflecting the content of that data item. The codes were then studied to identify patterns linking similar codes in a meaningful way. Themes were reviewed to ensure they were internally cohesive and sufficiently distinct, and overarching domains were developed based on relationships between the themes.

Each theme was linked to the research question "to understand experience of therapy and processes relating to dropout from FFT" by considering the patterns in the narratives presented by completer and noncompleter parents and youth. This included consideration of the ways in which respondents reported changes in the themes over the course of therapy. In the findings presented, the value or salience of a theme is not based on the frequency of its use. Rather, interpretations are drawn based on the context within which themes are discussed.

Measures to Ensure Rigor of Findings

The study was conducted and reported in line with established criteria for rigor in qualitative research (Tong et al., 2007). Credibility of interpretation is demonstrated through use of verbatim quotes from a range of participant sources, as well as consideration of discrepant data. A well-established methodology (Braun & Clarke, 2006) is used and procedures clearly documented to ensure the study is repeatable. The extent to which findings are transferrable is considered in relation to their consistency with wider research findings and through presenting the characteristics of the included sample. To minimize effects of the researcher on participant responses, interviews were carried out by a researcher who was independent from the clinical service they received. Participants were also assured their responses would remain anonymous. To minimize effects of the researcher on interpretation of findings, an inductive approach to analysis was used. This approach involved coding across the entire dataset to establish themes.

RESULTS

The patterns of codes across all interviews were organized into six central themes, clustered within three overarching domains. These are presented in Figure 1. The following section presents the themes that were identified, and the findings for each theme. For each theme, we first consider the pattern of observations of parents and adolescents from completer families and then consider the observations of parents and adolescents from noncompleter families.

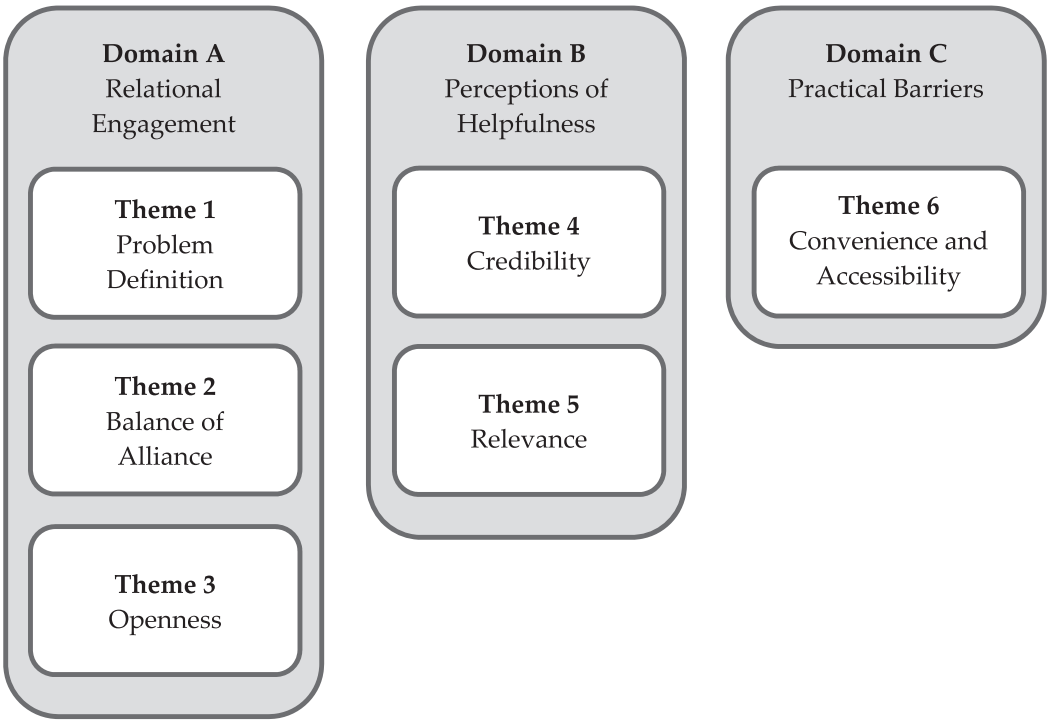

FIGURE 1. Domains and themes.

Domain A: Relational Engagement

The first domain, relational engagement, addresses the ways in which families discussed their own role in the therapy and their relationship with the therapist. The three themes within this domain relate to views of the problem and their own role in therapy, feeling supported by the therapist, and feeling open and comfortable to engage in therapy.

Theme 1: Problem definition

The first theme, problem definition, centers on family members' perspective of who is responsible for the presenting problem or how it might be solved.

Many completer parents reported a reduction in blame over the course of therapy. This included acknowledging their own role in family problems, "[I] was blinkered into thinking the problem was his... But I realised after many sessions that I was creating a lot of the problems as well, without even knowing" (Completer-Parent) and identifying that problems did not sit with an individual within the family, "I'm still not perfect by any means. But then neither's he. Life's not perfect" (Completer-Parent). A similar pattern was seen for young people from completer families, who also acknowledged or learnt to acknowledge their own role in therapy, "If we're learning to communicate and that, we both thought we should be in the same room rather than one to one separately" (Completer-Youth).

On the other hand, noncompleter parents often continued to describe their problems within the context of the young person's behaviour, "The problem obviously lay more from [my son]'s behaviour" (Noncompleter Parent). This was reflected in their preferred focus for the therapy, "We'd gone through the things for me, and I think with him especially it could have gone on a bit longer, him having some [one to one] sessions" (Noncompleter

Parent). In addition, some noncompleter parents also reported that their adolescent did not accept their own role in the problem that therapy was looking to address, "[My son] does not want someone to tell him the truth" (Noncompleter Parent).

Theme 2: Balance of alliance

The second theme, balance of alliance, addresses the relationship with the therapist, and the extent to which family members felt equally supported by the therapist.

Both adolescents and parents in completer families often reported feeling supported, "She was on both of our sides at times… it was helpful to know that I've got someone backing me" (Completer-Youth). This included therapists giving each family member the chance to give their own side of the story, "[FFT Therapist] give us equal time and we were able to say what we wanted to say and things" (Completer-Parent), or helping each to see from the others point of view, "he put [my son]'s point across to me, you know, and my point across to [my son]" (Completer-Parent).

Conversely, both parents and adolescents within noncompleter families often reported that the therapist took sides with the young person, directing blame toward the parent, "She did blame my mum a lot more than she blamed me" (Noncompleter Youth). This at times alienated parents, affecting their view of the credibility of the therapeutic work, "She annoyed me a couple of times… he's the one that's causing the trouble… why are you on his side?" (Noncompleter Parent).

Theme 3: Openness

The third theme, openness, relates to families engaging openly in therapy. This was particularly discussed in relation to youth experience.

Completer parents often reported overcoming early barriers to openness once a relationship was developed with the therapist, "After the first couple of sessions, you're put at ease… you feel more comfortable doing it" (Completer-Parent). This was facilitated where the therapist was perceived as nonjudgemental or trustworthy, "I didn't feel judged or anything like that, so therefore it was that safe bubble where you could say how you really felt" (Completer-Parent). Adolescents in completer families were also reported to overcome barriers such as shyness, "..even because [my son's] a bit of a shy person, but he seemed to open up and tell people how he felt" (Completer-Parent). In some cases, the therapist also facilitated better communication as a family, "We were able to say a lot of things that we would not ever have said to each other without having had somebody facilitating it" (Completer-Parent).

In contrast, some noncompleter parents reported worry about being judged or blamed for what they said, "I think you get frightened you're gonna be told you're a bad mum or you've done something wrong" (Noncompleter Parent). A common experience among noncompleter families also related to communication for young people. Some adolescents in noncompleter families reported ongoing difficulties with openness generally, that the therapy had not overcome, "I ain't a strong communicator anyway, that's one of my problems… I have anxiety issues as well and she just made me feel really uncomfortable" (Noncompleter Youth). Parents also reported specific difficulties for adolescents being open with other family members in the therapy session, "I think there's certain things that [my son] probably would have said without me being there…" (Noncompleter Parent).

Domain B: Perceptions of Helpfulness

The second domain, perceptions of helpfulness, addresses perceptions that the therapy is or will be useful for addressing a family's needs. The two themes within this domain

address perceptions of the therapist as a capable or credible helper able to successfully facilitate change, and whether the therapy addressed relevant goals.

Theme 4: Credibility

The fourth theme, credibility, deals with how confident or hopeful the family are that FFT will be helpful.

Completer parents often began therapy with expectations that the therapist would be able to offer credible help, sometimes resulting from previous positive experiences with services, "I had the trust in CAMHS anyway, so to me it was a follow on from that" (Completer-Parent). Credibility was also established where therapist action led them to be perceived as professional, skilled, or expert, which helped families to buy into the justification for FFT, "He was very professional, he knew what he was doing, and he had a plan, and explained it all very clearly to us... We all had confidence in him" (Completer-Parent). Credibility was also facilitated by signs of early progress, "When you can see that the work does work that they do with you, makes you want to come back and finish it off" (Completer-Parent). Among adolescents in completer families, feeling understood by the therapist established confidence in the therapists' ability to help, "She was very pinpoint as well... I would be scared to say something and she'd be like 'yeah it's that' and I'd be like 'yeah'" (Completer-Youth).

Conversely, some noncompleter families, particularly parents, expressed lack of confidence in the therapy, for example, that elements were not relevant for their specific problems, "You just think well I'm not wasting my time going to these sessions if this is the kind of answers they've got for us because it's not gonna be you know a solution what we want" (Noncompleter Parent). Some parents reported feeling that there were no clear goals or that progress was too slow, "I just feel that it didn't progress maybe as fast as I would have liked... it just seemed a bit stagnant" (Noncompleter Parent). A similar experience was reported by some young people from noncompleter families, who also felt misunderstood by the therapist, "I felt like she did miss our points quite a lot. She was looking at a tiny, tiny bit of it not the overall sort of thing" (Noncompleter Youth).

Theme 5: Relevance

The fifth theme, relevance, dealt with whether families perceived the focus and goals of the therapeutic work to be relevant and useful in relation to the family member's own ideas of individual and family needs and goals.

In completer families, both parents and adolescents felt that their needs were listened to and the service was personalized to cover topics relevant to family needs and goals, "if we wanted to sit down and work on a certain topic she'll work on a certain topic for a period of time" (Completer-Youth) and that all their desired goals had been addressed, "I felt we'd discussed everything that, in my mind I'd set out that we should discuss" (Completer-Parent).

On the other hand, for noncompleter parents and youth the focus of the work was not always in line with family goals or tailored to individual needs, or was not age or problem level appropriate, "It wasn't so much problem-solving tactics... it wasn't practical solutions, it was things that we just thought well it's not really practical... it was more of a perfect family solution, and that's obviously not what we are, which is why we went" (Noncompleter Parent). Adolescents also reported a lack of clear content, structure, or goals, "We didn't actually get much chance to talk about any topics or anything that was happening at home" (Noncompleter Youth), or that other family members should have been present, "I think my dad should have attended, 100%. It would have been good to work with my dad" (Noncompleter Youth).

Domain C: Practical Barriers

The third domain addresses practical barriers encountered during therapy, such as competing demands or barriers which prevented families from attending sessions. This domain comprised only one theme, convenience, and accessibility.

Theme 6: Convenience and accessibility

The sixth theme, convenience and accessibility, addressed whether families perceived that therapy was sufficiently convenient and easily accessible.

Completer parents often reported that therapy was sufficiently flexible or tailored, "He'd always try to fit it in around, you know, us both being available really" (Completer-Parent). Some families also reported that the home setting was particularly convenient, "The main thing I was impressed by was the fact that he came to our house… it was a real, that was a massive thing actually, to actually have him turn up" (Completer-Parent). Parents from completer families reported making efforts to overcome any practical barriers when they were sufficiently motivated to take part in therapy,

> It was going to help us, so we need to make that time… yeah sometimes it was a bit of an inconvenience… But no, ultimately I think what we had in our minds is 'we need to do this because we need to get better' (Completer-Parent).

Parents from completer families however did report that therapy got in the way of other things their adolescent would have preferred to do, "He still was always going out with those friends of his, so he felt like we were keeping him from where he needed to be" (Completer-Parent).

Noncompleter families often reported that for parents or young people making time to attend sessions was difficult or not a priority, "Sometimes [my son] wouldn't make the appointments, because he wouldn't be around, so we had to reschedule quite a lot" (Noncompleter Parent). Barriers included complex family circumstances,

> We had a lot of extreme things going on at home that just made it too difficult too stressful… it wasn't a case of that it was a problem with the service, it was just at that time for me (Noncompleter Parent).

However, barriers such as relevance or motivation were reported by both parents and adolescents to be more significant than the convenience and accessibility of the therapy, "It wasn't even that I was giving up my free time. It was that it was literally pointless. Like, nothing got resolved" (Noncompleter Youth).

DISCUSSION

This study aimed to understand patterns in the experience of FFT among families who had completed therapy as well as those who had discontinued before completion. Six themes were established, clustered within three domains. Content within each theme was often framed differently by completer and noncompleter families, which suggests the identified themes may reflect key processes in dropout from therapy. There was also a difference in the experience of parents and young people. This suggests the processes relating to dropout may differ for parents and adolescents.

Findings

The first domain, relational engagement, comprises three themes which highlight the balance the therapist needs to establish when engaging the family in FFT. Findings in this first domain suggest that acknowledging all perspectives and reducing blame can be

important for engaging the young person and encouraging them to communicate openly. However, findings also indicate that the therapist's actions to acknowledge the young person's perspective can risk the parent feeling blamed or unsupported. This suggests that while the process of achieving a shared problem definition is a fundamental part of engaging families in FFT, the therapist should consider carefully how to support and bring the parent along in this process.

The second domain, perceptions of helpfulness, comprises two themes which suggest that the therapist can facilitate retention in FFT through the way in which the family views the therapist or the therapy. Findings suggest that where the therapist establishes themselves as a capable and credible helper, parents may be more likely to expect therapy to be beneficial and therefore more likely to engage. For adolescents, feeling understood by the therapist helps facilitate this sense of credibility. In addition, ensuring the content and goals of therapy are relevant to individual and family needs and wishes can encourage engagement for both parents and adolescents. Therapeutic activities and goals may be particularly likely to be seen as relevant by family members where the family have agreed on a shared and family focussed problem definition through the processes discussed under the first domain.

The third domain suggests that there are practical considerations that may act as barriers in therapy, but that these interact with other relational factors. Findings suggest that both parents and adolescents' motivation to overcome any practical inconveniences varied according to their level of motivation to participate. Previous research suggests that practical barriers can lead to early termination from therapy across intervention types (Kazdin et al., 1997; Koerting et al., 2013; Mensinger et al., 2006). However, the present findings suggest that a convenient and flexible service, such as a home-based intervention, is not necessarily sufficient to retain families in therapy where motivation is low. Rather, those families where sufficient motivation had been developed over the early stages of therapy were happier to overcome practical barriers to remain in therapy. Conversely, families with low motivation may be less likely to make additional effort to overcome practical barriers. This low motivation may result from processes in the first and second domains, for example, feeling blamed or viewing the therapy as lacking credibility.

The findings extend current understanding of barriers to retention in FFT. Across domains, variation across families suggests that there is no single consistent pathway to early termination from therapy before completion. For example, some responses from noncompleter families suggested they did have, or developed, a balanced alliance. This suggests that the barriers to retention that need to be addressed may depend on the individual dynamics of each family. Further, barriers to engagement were at times reported among families who did complete therapy. For example, some families remained in therapy despite a blaming problem definition persisting. This suggests that the identified barriers are not conclusive predictors of termination from therapy. Consistent with this, key themes in this study, including openness, a balanced alliance, and therapist credibility, have previously been identified in qualitative research looking at satisfaction and success in FFT among completers (Celinska et al., 2015; Hartnett, Carr, Hamilton, & Sexton, 2017). This suggests where barriers are present but do not lead to discontinuation of therapy they may have other implications for the success of the therapeutic process.

Implications

Many processes identified in this study relating to dropout in FFT appear to be similar to those identified in previous research across different intervention approaches. For example, credibility (Nock, 2007; Wergeland et al., 2015) and relevance (de Haan et al., 2013) have been found as barriers to engagement across both individual and family

therapy intervention. On the other hand, balance of alliance (Robbins et al., 2008), which is associated with the unique systemic nature of family approaches, is a barrier to engagement that has been identified in other family therapy interventions. Although many of these barriers for FFT are similar to processes seen in individual or family intervention, the reasons these barriers emerge, and how they may be addressed in practice to reduce dropout is likely to vary according to the intervention of interest. This means that to overcome these barriers in FFT it is important to consider what characteristics of the FFT therapeutic model they may relate to.

The findings therefore suggest important considerations for clinical practice in delivering FFT. The FFT model (Sexton & Alexander, 2004) emphasizes the importance of developing balanced alliances across family members. However, the present findings highlight the risk that in some cases these strategies to engage the adolescent, such as acknowledging their point of view and ensuring they feel understood, may be inconsistent with the parent's expectations and definition of the problem. This may lead the parent to feel blamed and view therapy as less credible as they do not expect it to resolve the problems that are most significant to them. These findings suggest that to sustain parent engagement over time, the FFT therapist should consider strategies to ensure that support provided for the adolescent is not perceived as blame toward the parent, and that therapy remains meaningful and credible for the parent.

The findings also have implications for understanding about the way in which the setting in which FFT is delivered may affect dropout. This study identifies a new perspective on practical barriers as artifacts of motivational barriers. This has not yet been considered in-depth in wider research. This has specific implications for FFT given that many FFT services are delivered in the home. The findings suggest that although flexibility and accessibility of the service may be important to overcome initial practical barriers, retention in therapy may be more likely to be associated with motivational barriers such as the therapeutic alliance or credibility and relevance of therapy. Findings suggest that providing a home-based intervention may overcome initial practical barriers but will not necessarily increase long-term engagement and retention of families in therapy. This has important implications for the commissioning and setup of services, where initial home visits may be useful but may not be a necessary feature of long-term success of the FFT.

Limitations and Future Research

In an exploratory thematic analysis, with a sample of this size, generalization of findings outside of the included sample is limited, and neither prevalence nor causality can be assumed. In addition, because of the small sample of noncompleter families, the findings in this research are not exhaustive of the experiences of families who drop out from FFT. This study has provided a description of the pattern of experiences of a sample of families who have participated in FFT therapy, and consideration of possible mechanisms that relate to retention and dropout in therapy. The true prevalence and mechanisms by which the identified processes relate to dropout, their applicability to a wider population and how often, where present, they lead to discontinuation of therapy, should be established through more extensive and focussed quantitative research.

A key limitation of this study is the small number of adolescents that were able to be recruited within the study period, particularly in the noncompleter group. The engagement of youth in this research was more challenging than engagement of parents. There is a likelihood that youth with the lowest motivation in therapy were the least likely to engage in research. As such views of youth who participated in the research may differ from those who did not. Although parent accounts give some insight into the experience for these nonparticipating youth, capturing youth perspectives through research remains

an important goal in order to understand and subsequently enhance therapeutic success. Future research should aim to prioritise engagement of adolescents to further develop an understanding of their experience in therapy.

It may also be the case that families who were invited to but declined to participate in the research had different experiences to those who participated in the research; however, exploring this difference is out of scope of this study. Future research should consider how these views may be captured to better understand how the hardest to reach groups can be supported through FFT.

The study was also unable to capture the views of families who choose not to engage in therapy at all, as only families attending sessions at the clinic were able to be recruited. Capturing the experience of families who are referred but do not take up therapy would help explore the steps services can take to engage families at this very preliminary stage.

Future research should also explore the implications of completing FFT where barriers such as imbalanced alliance still remain. Where the barriers are present but do not lead to discontinuation from therapy there may be implications for how actively attendees participate in therapy, or for achieving or sustaining therapeutic change (Turner et al., 2018).

CONCLUSIONS

In the context of a rapidly developing evidence base considering the perspectives of families using FFT services, this is the first qualitative study to our knowledge to capture the experiences of families who have dropped out from FFT. Insight into the experience of parents but also youth, who can be particularly challenging to engage in therapy, is an important step toward understanding and addressing the processes through which families can be best retained in FFT and other types of family therapy.

The findings provide new insight into the role of practical barriers as a potential artefact of motivational barriers to retention rather than a unique barrier in themselves. Findings also highlight that therapist efforts to encourage youth openness and engagement in therapy should take care to establish credibility with parents by ensuring that parents also feel supported.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article:

Appendix S1. Discussion guide.