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## Brief Strategic Family Therapy: Twenty-Five Years of Interplay Among Theory, Research and Practice in Adolescent Behavior Problems and Drug Abuse

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### Abstract

This article describes a systematic program of research that focuses on Brief Strategic Family Therapy (BSFT) and the adaptations that were developed based on BSFT principles. The culture-specific origins of BSFT are reviewed, as well as its broader applications to the field of family therapy. Research is reviewed demonstrating that BSFT is a promising family-based approach to treating Hispanic youth behavior problems and drug abuse. Treatment innovations are described that address the combination of intergenerational and cultural differences that occur among youths and their Hispanic parents. Programmatic work is described that challenges basic principles of family therapy by expanding BSFT to a One Person modality and a strategic engagement procedure. Both of these novel approaches are intended to add tools to therapists' repertoire in working with difficult-to-engage families. A preview discussion of results is presented from a randomized clinical trial that is an application of an ecosystemic prevention version of BSFT. The implications of the work of the Center for Family Studies are discussed in the context of the broader service system. Ultimately, this article articulates a way of thinking about adolescent problem behavior, its social interactional determinants, and a range of theoretically consistent family-centered strategies that attempt to change social ecological processes that impact adolescent developmental trajectories.

### Keywords

brief; family-based; research; social interaction; systemic research; Hispanic

## INTRODUCTION

The purpose of this article is to describe a 25-year systematic program of research, conducted at the Center for Family Studies, designed to expand our knowledge about family-based interventions in treatment of youth behavior problems and drug abuse. This program is developed through a strategy of integrating theory, research, and practice. Although we are testing other theoretical paradigms at the Center for Family Studies, the focus of this article is on Brief Strategic Family Therapy (BSFT) and the interventions that emerged from this model. The BSFT framework is the result of a continuous interplay among theory, research, application at several levels (Coatsworth, Szapocznik, Kurtines, & Santisteban, 1997; Szapocznik, Kurtines, & Santisteban, 1994; Szapocznik *et al.*, 1997; Szapocznik, Kurtines, Santisteban, & Rio, 1990).

With respect to theory, our approach draws on both the structural (Minuchin, 1974; Minuchin & Fishman, 1981; Minuchin, Rosman, & Baker, 1978) and strategic (Haley, 1976; Madanes, 1981) traditions in family systems theory. Regarding application, our work has largely focused

on developing family-based interventions for the remarkably persistent problem of conduct problems and drug abuse among Hispanic and African American youths. This emphasis on the family is consistent with most minority culturally defined values that give family a pivotal role in human development (Szapocznik, 1994). With respect to research, we have (a) investigated various aspects of structural family systems theory and expanded its boundaries, (b) developed and validated a measure of structural family functioning, (c) conducted efficacy trials based on structural family systems theory, and (d) explored the role that cultural factors may play in intervention development and treatment outcomes. The BSFT approach to working with families described in this article is a direct outgrowth of our efforts to develop and investigate theoretically based and culturally appropriate interventions for youths with both behavior problems and drug abuse.

## A BRIEF HISTORICAL OVERVIEW

The Center for Family Studies was established in 1972 as the Spanish Family Guidance Center to develop an understanding of the drug abuse problem among Cuban youth in Miami (Szapocznik, Scopetta, & King, 1978). These youths and their families seemed to have become adversaries around a struggle that was culturally flavored: Americanism vs. Hispanicism (Szapocznik & Kurtines, 1979; Szapocznik, Kurtines, & Fernandez, 1980). From the onset of our work, we perceived the problem behaviors as occurring in the context of immigrant Hispanic families that had been immersed in mainstream culture (Szapocznik, Scopetta, Kurtines, & Aranalde, 1978). Our approach to this early challenge was consistent with a movement within psychology that suggests that behavior is best understood in the social context in which it occurs (Szapocznik & Kurtines, 1993). This contextualist view is concerned with the interaction between the organism and its environment.

We adopted a structural family systems framework as an intervention model that matched our target population's characteristics (Szapocznik, Scopetta, Aranalde, & Kurtines, 1978) and addressed the psychosocial challenges they were experiencing (Szapocznik, Scopetta, & King, 1978). With a structural family systems framework we also adopted its emphasis on behavior, interactions, and the interplay of behaviors that came to define all of our subsequent work. More recently, we widened our contextual focus beyond the family and became more directly concerned with the impact of other systems (e.g., school, peers, community) on the developing child (Perrino, Gonzalez-Soldevilla, Pantin, & Szapocznik, 2000; Szapocznik & Coatsworth, 1999). Faithful to our interactional perspective, we approached the study of social ecosystems in terms of the interactions within and between these systems. Responsive to our social context, as Miami's immigrant Hispanic community changed from Cuban to broadly Hispanic, so did our work. In a community like Miami, it was also impossible to be concerned with context and fail to see the enormous needs of our African American families (Szapocznik, Blaney, Foote, & Rodriguez, in press). Thus, our work in the last decade has encompassed African American as well as Hispanic families in their social contexts.

For our first 15 years we worked in an emic world. That is, we were immersed inside Hispanic culture and worked in a way that was inherently consistent with our Hispanic culture. In those early years, the primary researchers were Hispanics who worked from a Hispanic world-view, and who worked with Hispanic families that lived in Hispanic neighborhoods. From this vantage point, we focused on the clinical aspects of structural family theory and its applications (Szapocznik & Kurtines, 1989), that permitted us to identify the boundaries of the theory, while expanding the boundaries through new applications (Szapocznik *et al.*, 1990). This clinical, theoretical, and research work conducted with Hispanics clearly has had implications for the broader field of family therapy. In part, this article describes a research program on innovations in theory and practice that were developed with mostly Hispanic populations, but are applicable to the broader field of family therapy. Hispanics through their participation in these cutting-

edge studies made a substantial contribution to mainstream theories and practices of family therapy, contributing to the general view in the nation about efficacious family-based treatments for adolescent drug abuse (Liddle & Dakof, 1995a, 1995b; Robbins, Szapocznik, Alexander, & Miller, 1998; Szapocznik & Kurtines, 1989; Szapocznik *et al.*, 1990). Indeed, structural family therapy had been developed a decade earlier by a team of primarily Hispanic therapists led by Salvador Minuchin (Minuchin, 1974; Minuchin & Fishman, 1981; Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967; Minuchin *et al.*, 1978) who worked with African American and Hispanic families in Philadelphia.

## INITIAL TREATMENT DEVELOPMENT EFFORTS

Our work began with the study of cultural differences between Cuban adolescents and their families, on the one hand, and mainstream White American families, on the other (Szapocznik, Scopetta, Aranalde *et al.*, 1978). We studied the differences in basic value orientations or world-views of these two populations in the Miami area using methodology developed by Kluckhohn and Strodtbeck (1961). The results revealed that Cuban families, compared to mainstream White American families, valued leaders who were active, directive, and present-oriented. Subsequently, we conducted a search of family intervention models and concluded that a combined structural and systemic approach to family therapy was particularly well suited for Cuban families (Szapocznik, Scopetta, & King, 1978).

Next, we conducted a series of pilot research studies that compared individual, conjoint structural family, and family–ecological interventions to determine which of these was most useful with Hispanic clinic families (Scopetta *et al.*, 1977). The results of these pilot studies suggested that conjoint structural family therapy achieved therapeutic goals better than an individual approach, and just as well as a family–ecological approach. These treatment development efforts further determined that the suitability of the structural interventions was enhanced by including strategic techniques (e.g., Haley, 1976) and by keeping the interventions time-limited. Hence, we developed an intervention that we called Brief Strategic Family Therapy.

## BRIEF STRATEGIC FAMILY THERAPY

Brief Strategic Family Therapy is best articulated around three central constructs: system, structure/patterns of interactions, and strategy (Szapocznik & Kurtines, 1989). A system is an organized whole that is comprised of parts that are interdependent or interrelated. A family is a system that is comprised of individuals whose behaviors necessarily affect other family members. In addition, family members become accustomed to the behavior of other family members, because such behaviors have occurred thousands of times over the many years. These behaviors synergistically work together to organize a family's system.

A central characteristic of a system, *per se*, is that it is comprised of parts that interact with each other. The set of repetitive patterns of interactions that are idiosyncratic to a family is called the family's structure, which is the second central construct. A maladaptive family structure is characterized by repetitive family interactions such that family members repeatedly elicit the same unsatisfactory responses from other family members. From a contextual family systems perspective, a maladaptive family structure is viewed as an important contributor to the occurrence and maintenance of behavior problems, drug abuse, and other antisocial behavior. Research demonstrates that family relations are predictors of drug abuse and related antisocial behaviors (cf. Szapocznik & Coatsworth, 1999). Fortunately, research also suggests that adolescent drug abuse and behavior problems can change as a result of changes in the family relations (Liddle & Dakof, 1995b; Santisteban *et al.*, 2000). Equally important, interventions aimed at changing family patterns of interaction represent a strategic point of entry. The goal of BSFT is to target repetitive interactions within or between systems in the

family social ecology that are unsuccessful at achieving the goals of the family or its individual members. This emphasis on the nature of social interactions among family members is sometimes referred to as family process (Robbins *et al.*, 1998). Process also refers to the message that is communicated by the nature of interactions or by the style of communication, including all that is communicated nonverbally such as feelings, tone, and power relationship.

The third fundamental concept of BSFT is strategy, which is defined by interventions that are practical, problem-focused, and deliberate. Practical interventions are selected for their likelihood to move the family toward desired objectives. One important aspect of practical interventions is choosing to emphasize one aspect of a family's reality (e.g., "that a drug abusing youth is in pain") as a way to foster a parent-child connection, or another aspect (e.g., "this youth can get killed or overdose anytime") as a way to heighten the sense of urgency. This positive or negative reframing is done in lieu of portraying the entire reality of a situation. Such a practical selective focus is done, in part, in an effort to create movement outside or beyond the family's maladaptive patterns of interaction.

The problem-focused aspect of our treatment strategy refers to targeting family interaction patterns that are the most directly relevant to the symptomatic behavior targeted for change. Although the families that we treat usually have multiple problems, targeting only those patterns of interactions linked to the symptomatic behavior contributes to the brevity of the intervention. For example, a couple's ability to parent is likely to be targeted because of its direct link to problem behaviors. However, the couple's sexual problems in their marital relationship might not be targeted in this brief therapy model.

Our intervention strategies are very deliberate, meaning that the therapist determines the maladaptive interactions that, if changed, are most likely to lead to our desired outcomes (i.e., adaptive, prosocial behavior). The treatment intervention is designed to help the family shift from one set of interactions that maintain drug use (e.g., disengaged parent-child relationship) to another set of interactions that will reduce drug use (e.g., higher quality of parent-child interactions resulting in more effective monitoring of a youth's behavior).

Thus, BSFT is based on developing a clear understanding of the nature of maladaptive family interactions and their relationship to the target symptom, which permits designing deliberate, problem-focused interventions. In sum, system, structure/interactions, and strategy are three basic constructs of family systems theory that serve as the foundation for BSFT. With this strong clinical and theoretical foundation, we pursued the systematic development of a measure that assesses family functioning according to underlying structural family theory, and can be used to evaluate structural family system changes targeted by BSFT.

### **Measure to Assess Structural Family Functioning**

One important step to measuring family functioning was the development of the Structural Family Systems Ratings measure. This theoretically and clinically meaningful measure of structural family functioning represents one of the most important advances of our program of research (cf. Kazdin, 1993; 1994). To launch our development of this observational measure, we borrowed from the work of Minuchin and his colleagues (Minuchin *et al.*, 1978) with the Wiltwyck Family Tasks as standard stimuli. Moreover, we standardized and manualized the administration procedure to enhance the reliability and replicability of the scoring procedure (Hervis, Szapocznik, Mitrani, Rios, & Kurtines, 1991).

We operationalized the three core family systems concepts into the following five interrelated theoretically and clinically important dimensions (Robbins, Hervis, Mitrani, & Szapocznik, 2000; Szapocznik & Kurtines, 1989): (a) "Structure" measures leadership, subsystem organization, and communication flow; (b) "Resonance" measures the sensitivity of family

members toward one another (focusing on boundaries and emotional distance between family members); (c) “Developmental Stage” measures the extent to which each family member’s roles and tasks are consistent with what would be expected given their age and family role; (d) “Identified Patienthood” measures the extent to which family members view the symptom bearer (e.g., adolescent drug abuser) as the cause of all of the family’s problems; and (e) “Conflict Resolution” identifies the family’s style in addressing disagreements through denial, avoidance, diffusion or expression and negotiation of differences of opinion. In a recent study (Robbins, Feaster, & Szapocznik, 2000), we found that these five theoretically derived factors achieved a better fit than empirically derived latent constructs.

The psychometric properties of the instrument were examined in a series of construct validity studies conducted with 500 Hispanic clinic families (Szapocznik, Rio, Hervis *et al.*, 1991; NIDA Grants DA 2059, DA 5334, & NIMH Grant MH 34821). We found that the Structural Family Systems Ratings measure (a) is sensitive to improvements produced by BSFT (Santisteban *et al.*, 1996; Szapocznik, Santisteban *et al.*, 1989), (b) distinguishes interventions that bring about structural family change from those that have non-family foci (Santisteban *et al.*, 2000; Szapocznik, Rio *et al.*, 1989), and (c) is unobtrusive as evidenced by the nil effect of repeated administrations of the Wiltwyck task on family interactions (Szapocznik, Santisteban *et al.*, 1989).

The Structural Family Systems Ratings measure has become an essential tool for answering some of the critical questions posed by subsequent steps in our program of research. We have continued to refine the measure by attempting to apply its use to nonresearch, clinical settings (Szapocznik & Kurtines, 1989). Currently, we are striving to adapt the measure to the range of family constellations that occur in contemporary society (e.g., single parent and extended kinships) with a variety of other target problems (e.g., families with a diabetic child, HIV + adults, caregivers of Alzheimer’s patients) and ethnic populations (e.g., African American and Hispanic). Developing a theoretically valid and psychometrically sound measure of structural concepts in family functioning permitted us to engage in research to evaluate the impact of BSFT on structural family functioning.

### Empirical Testing of the Treatment Model

**BSFT vs. Non-Family Interventions**—Two clinical trials empirically compared BSFT with other modalities. The first compares structural family therapy/BSFT to individual psychodynamic child therapy for emotionally and behaviorally troubled children. The second compares BSFT and group counseling for adolescents with behavior problems.

The first study (Szapocznik, Rio *et al.*, 1989; NIMH Grant MH 34821) tested the relative efficacy/effectiveness of structural family therapy/BSFT and investigated the mechanisms of therapeutic change. In this study, structural family therapy/BSFT was compared to individual psychodynamic child-centered psychotherapy and a recreational control condition. Individual psychodynamic child therapy (Adams, 1974; Cooper & Wanerman, 1977) was chosen for comparison because, at the time of the study, a survey of Hispanic practitioners in private practice revealed that it was the treatment of choice for therapists who worked with emotionally and behaviorally troubled Hispanic children in the Miami area. The control condition was comprised of structured recreational activities; and this condition was used to control for attention placebo effects (McCardle & Murray, 1974; Strupp & Hadley, 1979).

Sixty-nine Hispanic moderately emotionally or behaviorally troubled 6 to 11 year old boys were randomly assigned to one of the three intervention conditions. For the two treatment conditions, Hispanic therapists were selected with at least 10 years of experience in their respective modality. Thus, rather than therapists receiving training in a modality as is typical in modern trials, these therapists were selected from the community to reflect best practices

within their respective modalities as judged by their excellent reputation among their peers. Therapists' treatment adherence was measured to evaluate the extent to which individual child psychodynamic and structural family/BSFT conditions were distinct interventions. To reflect clinical practice, a priori, the clinical and research teams had established that patterns of adherence should be 75% child psychodynamic, 25% BSFT for the child psychodynamic team; and 75% BSFT, 25% child psychodynamic for the BSFT team. That is, therapists in each treatment modality claimed interventions as unique to their own modality, that were also used occasionally (up to 25%) in the other modality. In the child psychodynamic condition, 78% of the therapists' interventions were rated as child psychodynamic. In the structural family/BSFT condition, 61% of the interventions were rated as consistent with structural family/BSFT theory. While treatment adherence was found to sufficiently distinguish the two treatment modalities, the family therapists used more psychodynamic interventions than expected. Item analysis revealed that "psychodynamic" techniques used in the family condition were primarily supportive interventions or reflection of feelings, rather than more uniquely psychodynamic interventions.

Attrition data were analyzed using chi squares, and outcome data were analyzed using a mixed design Analysis of Variance. The results of the analyses revealed several important findings, the first three of which involved treatment outcome and the relative effectiveness of the conditions. The fourth conclusion concerned the articulation of mechanisms that may account for the specific effects of differential treatments. The first finding indicates that the control condition (i.e., recreation activities) was significantly less effective at retaining cases than the two treatment conditions,  $\chi^2(2,19) = 13.64, p < .01$ , with over two thirds of all dropouts occurring in the control condition. These findings suggest that the two experimental treatment conditions had equivalent rates of retention, thus differences in treatment outcome between the treatment groups were most likely due to the treatment interventions. The second finding was that the two treatment conditions, structural family/BSFT and child psychodynamic, equivalently reduced emotional and behavior problems (parent and child reports) and child psychodynamic functioning. In addition, the effects of maturation or regression towards the mean (from significant behavior problems to fewer) were ruled out because the control condition did not evidence improvement in emotional, behavior, or psychodynamic functioning.

The third and most significant differential treatment finding was that family therapy was more effective than child therapy in protecting family integrity at the 1-year follow-up. Although individual psychodynamic child therapy was found to be efficacious at reducing behavior and emotional problems as well as improving child psychodynamic functioning, it was also found bring about deterioration of family functioning at the 1-year follow up. In contrast, the family therapy condition brought about significant improvement of family functioning at the one-year follow up. The fourth finding revealed that there is a complex relationship between specific mechanisms (family interaction vs. psychodynamic child functioning) that may mediate outcome. It seems that the mediator of change is a "corrective experience" in both the structural family/BSFT and child psychodynamic conditions. However, in psychodynamic child therapy, the therapist serves as the person who creates the corrective experience through the transference relationship. In contrast, the structural family/BSFT therapist changes family interactions so that the parent becomes the source of the corrective experience. The findings provided support for the structural family theory assumption that treating the whole family is important because it improves the symptoms and protects the family. In contrast, treating only the child appears to sufficiently treat the symptom, but neglects and increases risk for family functioning.

The second study (Santisteban *et al.*, 2000) examined the efficacy of BSFT in reducing behavior problems. In this study, BSFT was compared to a control condition delivered in a group format. The participants were 79 Hispanic client-families with a 12- to 18-year-old

adolescent who was referred by either a school counselor or parent for conduct/anti-social problems or emotional problems, and family conflict. Client-families were randomly assigned to either BSFT ( $n = 52$ ) or group counseling ( $n = 27$ ). Adolescents in the BSFT condition showed significant reductions in Conduct Disorder and Socialized Aggression from pre- to post-treatment; whereas, group therapy participants showed no significant changes in either Conduct Disorder or Socialized Aggression,  $F(2,76) = 4.75, p < .05$ .

An exploratory analysis of clinically significant changes in Conduct Disorder and Socialized Aggression using the twofold criterion recommended by Jacobson and Traux (1991), revealed that a substantially larger proportion of BSFT cases demonstrated clinically significant improvement. At intake, 39 of the 52 BSFT cases had Conduct Disorder scores that were above clinical cut-offs. At the end of treatment, 44% of the 39 made reliable improvement and 5% showed reliable deterioration. In contrast, only two (7%) of the group counseling cases with Conduct disorder showed reliable change; both showed clinically reliable deterioration in Conduct Disorder. With regard to Socialized Aggression, 81% of BSFT cases and 72% of group counseling cases were above clinical cut-offs at intake. Whereas 16 (38%) of BSFT cases showed reliable change, only 2 (11%) in the group counseling condition reliably changed. Seven (17%) BSFT cases recovered to nonclinical levels, while only one case (6%) from the group counseling condition recovered to nonclinical levels.

Together, these two studies provide some empirical support for the efficacy of BSFT with troubled Hispanic children and adolescents. The remainder of this article presents a broad range of BSFT adaptations, expanding its boundaries and applications.

### Bicultural Effectiveness Training

One of the earliest efforts to expand the boundaries and applications of BSFT emerged from our realization that structural interventions could be enhanced by utilizing our specific knowledge about the culture of recent Hispanic immigrants (Szapocznik, Scopetta, & King, 1978). Indeed, for this population, we found that the process of acculturation can profoundly disrupt the family unit as well as its individual members (Szapocznik, Scopetta, & King, 1978; Szapocznik, Scopetta, Kurtines *et al.*, 1978). The usual intergenerational family discrepancies between parents and adolescents were exacerbated when combined with acculturation, creating considerable intercultural/intergenerational conflict processes (Szapocznik, Santisteban, Kurtines, Perez-Vidal, & Hervis, 1984). The adolescent's normal striving for independence combined with the powerful acculturation to the American value of individualism occurs in marked contrast to Hispanic parents' normal tendency to preserve family integrity by tenacious adherence to the Hispanic cultural value of strong family cohesion and parental control. The combination of the intergenerational and cultural differences produce intensified conflict in which parents and adolescents feel alienated from each other.

As a result of our initial application of BSFT to recent immigrant Hispanic families, it became evident that the process of immigration and acculturation needed to be specifically addressed for a subset of families. Consequently, we developed Bicultural Effectiveness Training (Szapocznik *et al.*, 1984), a psychoeducational adaptation of BSFT principles. Bicultural Effectiveness Training aimed to ameliorate adolescent behavior problems and acculturation-related stresses confronted by two-generation Hispanic immigrant families.

Bicultural Effectiveness Training uses strategic, deliberate, and problem-focused psychoeducational interventions designed to change family interactions that are delivered to the conjoint family. A pervasive reframe in this intervention is to change the content of parent-adolescent conflict from one that is initially presented as intergenerational (i.e., parents vs. children) to one that is intercultural (i.e., Americanism vs. Hispanicism). Transcultural experiences that are perceived as stressful are reframed as being unique opportunities that can

be potentially enriching for bicultural skills development. The outcome of Bicultural Effectiveness Training is that family members develop skills to more effectively cope with each other's conflicting cultural values and behavioral expectations (Szapocznik & Kurtines, 1993).

A clinical trial was conducted to compare the efficacy of the Bicultural Effectiveness Training and conventional BSFT (Szapocznik, Santisteban, Rio, Perez-Vidal, Kurtines, & Hervis, 1986; NIMH Grant MH31226). Forty-one Cuban American families with a behavior problem adolescent were randomly assigned to either Bicultural Effectiveness Training or BSFT. Treatment integrity analyses revealed that interventions in both conditions adhered to guidelines, and that the two conditions were clearly distinguishable. Results showed that in both conditions there were significant improvement in adolescent problem behaviors and family functioning. These findings suggested that in families confronting acculturation both conditions, Bicultural Effectiveness Training (a culture-specific psychoeducational modality) and conventional BSFT (a process oriented intervention), were effective in achieving improvements in family interactions and adolescent problem behaviors.

In a subsequent study, we fully integrated BSFT with its psychoeducational version, Bicultural Effectiveness Training, into a package we called Family Effectiveness Training (Szapocznik, Santisteban, Rio, Perez-Vidal, & Kurtines, 1986). Typically, sessions began with a didactic presentation followed by exercises to practice the strategies taught in the presentation. These enactments (Haley, 1976; Minuchin, 1974) served to provoke repetitive, maladaptive family interactions, which were subsequently targeted with BSFT interventions. We conducted another randomized clinical trial to test this newly integrated treatment modality by comparing Family Effectiveness Training to a Minimum Contact Control (Szapocznik, Santisteban et al., 1989; NIDA Grant DA2694). This study examined 79 Hispanic families and their 6- to 11-year-old children who presented with emotional and behavior problem pre-adolescents. The results indicated that families in the Family Effectiveness Training condition showed significantly greater improvement than control families on structural family functioning, child behavior problems, and child self-concept. The expansion of BSFT for use alone or in combination with a culture-specific psychoeducational modality demonstrates the versatility of the BSFT approach. To further explore the versatility of BSFT, we challenged some of the underlying principles of family systems theory.

### **One Person Family Therapy**

With the advent of the adolescent drug epidemic of the 1970s, the vast majority of counselors who worked with drug using youths reported that although they preferred to use family therapy, they were not able to bring whole families into treatment (Coleman, 1976). In response, we developed a procedure that would achieve the goals of BSFT (changes in maladaptive family interactions and symptomatic adolescent behavior) without requiring the presence of the whole family in treatment sessions. For this purpose, we developed an adaptation of BSFT called One Person Family Therapy (Szapocznik, Foote, Perez-Vidal, Hervis, & Kurtines, 1985; Szapocznik & Kurtines, 1989; Szapocznik, Kurtines, Perez-Vidal, Hervis, & Foote, 1989). This approach appears to challenge the most basic assumption of family systems theory: that change in family interactions is achieved by working directly with the conjoint family. One Person Family Therapy capitalizes on the systemic concept of complementarity, which suggests that when one family member changes, the rest of the system responds by either restoring the family process to its old ways or adapting to the new changes (Minuchin & Fishman, 1981). The goal of One Person Family Therapy is to change the drug abusing adolescent's participation in maladaptive family interactions that include him/her. Occasionally, these changes create a family crisis as the family attempts to return to its old ways. We use the opportunity created by these crises to engage reluctant family members.



A major clinical trial was conducted to compare the efficacy of One Person Family Therapy to conjoint BSFT (Szapocznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1983, 1986; NIDA Grant DA0322). An experimental design was achieved by randomly assigning 72 Hispanic families with a drug abusing 12- to 17-year-old adolescent to the One Person or Conjoint BSFT modalities. Both conditions were designed to use exactly the same BSFT theory, so that only one variable (one person vs. conjoint meetings) would differ between the conditions. Analyses of treatment integrity revealed that interventions in both conditions adhered to guidelines, and that the two conditions were clearly distinguishable. The results showed that One Person was as efficacious as conjoint BSFT in significantly reducing youth drug use and behavior problems as well as improving family functioning (Szapocznik, Kurtines *et al.*, 1983, 1986). When we juxtaposed these findings with the findings of our research cited earlier (Szapocznik, Rio *et al.*, 1989), we came to the following conclusion: It appears that an individual modality conceptualized in family terms, can bring about improvements in family functioning; whereas an individual modality conceptualized in individual terms can result in deterioration of family functioning.

### Structural Strategic Systems Engagement

Many families that seek treatment for drug abusing adolescents are not engaged in therapy. In response to this problem, we developed a set of procedures based on BSFT principles to more effectively engage behavior problem, drug abusing youths and their families in treatment. This approach, which we called Strategic Structural Systems Engagement (Szapocznik & Kurtines, 1989; Szapocznik, Perez-Vidal, Hervis, Brickman, & Kurtines, 1989), is based on the premise that resistance to enter treatment can be understood in family interactional terms. We have suggested elsewhere (Szapocznik & Kurtines, 1989) that the family interactional patterns linked to symptomatic behavior in the adolescent are essentially the same patterns that prevent the family from entering treatment. Thus, while the presenting symptom may be drug abuse, the initial obstacle to change is “resistance” to attending treatment. If “resistance” to therapy lies within maladaptive family interactions, then the first phase of therapy is engagement intervention targeting these interactions (Szapocznik, Perez-Vidal *et al.*, 1989).

One Person Family Therapy techniques are useful in this initial phase because the person making the contact requesting help becomes the “one person” through whom work is initially done to restructure the maladaptive family interactions that are maintaining the symptom of resistance. Success of the engagement process is measured by the family’s and the symptomatic youth’s attendance to family therapy. In part, success in engagement permits redefining the problem focus as a family problem in which all have something to gain. Once the family is engaged into treatment, the focus of the intervention is shifted from engagement to removal of the adolescent’s presenting symptoms of problem behavior and drug abuse. A significant paradigm shift in this kind of thinking is that family’s resistance to entering treatment is overcome by changing the therapist’s behavior (Santisteban & Szapocznik, 1994). That is, therapists have to begin therapy with the first phone call (Szapocznik, 1993) and therapists must reach out to the family by assisting the family in its natural setting to overcome the maladaptive patterns of interaction that obstruct the family from entering therapy.

The efficacy of Strategic Structural Systems Engagement has been tested twice with Hispanic youths (Santisteban *et al.*, 1996; Szapocznik *et al.*, 1988). The first study (Szapocznik *et al.*, 1988; NIDA Grant DA2059) included 108 mostly Cuban Hispanic families of behavior problem adolescents who were suspected of, or were observed using drugs by their parents or school counselors. Of those engaged, 93% actually reported drug use. Families were randomly assigned to one of two conditions: Engagement as Usual, the control condition; or Strategic Structural Systems Engagement, the experimental condition. All families successfully engaged received BSFT. A community survey was used to determine the nature of the engagement

strategies typically used in outpatient agencies serving drug abusing adolescents. The Engagement as Usual condition resembled the usual engagement methods identified. In the experimental condition, client-families were engaged using BSFT techniques developed specifically to overcome the family patterns of interactions that interfered with entry into treatment. Successful engagement was defined as the conjoint family (minimally the identified patient and her/his parents and siblings living in the same household) attending the first session, which was usually for the intake assessment. Treatment integrity analyses revealed that interventions in both engagement conditions adhered to prescribed guidelines using six levels of engagement effort that were operationally defined; and that the conditions were clearly distinguishable by level of engagement effort applied.

Efficacy was measured in rates of both, family treatment entry as well as retention to treatment completion. The results revealed that 42% of the families in the Engagement as Usual condition and 93% of the families in the Structural Systems Engagement condition were successfully engaged,  $\chi^2(1,108) = 29.64, p < .0001$ . Of the engaged cases, 25% (of the 52) in the Engagement as Usual condition and 77% (of the 56) in the Structural Systems Engagement condition were successfully terminated,  $\chi^2(1,108) = 26.93, p < .0001$ . In families that engaged, significant improvements occurred in adolescent and family functioning for both conditions, and these improvements were not significantly different across the conditions. Thus, the critical distinction between the conditions was in their differential rates of engagement and retention.

The second study (Santisteban *et al.*, 1996; NIDA Grant DA0 3224), in addition to replicating the previous engagement study, also explored factors that might moderate the efficacy of the engagement interventions. In contrast to the previous engagement study, Santisteban *et al.* 1996 more stringently defined the success of engagement as a minimum of two office visits, intake session *and* first therapy session. One hundred ninety three Hispanic families were randomly assigned to one experimental and two control conditions. The experimental condition was BSFT plus Strategic Structural Systems Engagement. The first control condition was BSFT plus Engagement as Usual; and the second was group counseling plus Engagement as Usual. In both control conditions, Engagement as Usual involved no specialized engagement strategies.

Results showed that 81% of families (42 of 52) were successfully engaged in the BSFT plus Strategic Structural Systems Engagement experimental condition. In contrast, 60% (84 of 141) of the families in the two control conditions were successfully engaged,  $\chi^2(1, N = 193) = 7.5, p < .006$ . However, the efficacy of the experimental condition procedures was moderated by the type of Hispanic cultural/ethnic identity. Among non-Cuban Hispanics (composed primarily of Nicaraguan, Colombian, Puerto Rican, Peruvian, and Mexican families) assigned to the Strategic Structural Systems Engagement condition, the rate of engagement was 93%, in contrast to an engagement rate of 64% for Cuban Hispanics. These findings have led to further study of the mechanism by which culture/ethnicity and other contextual factors may influence clinical processes related to engagement (Santisteban *et al.*, 1996; Santisteban, Muir-Malcolm, Mitrani, & Szapocznik, in press). The result of these studies provide strong support for the efficacy of Structural Systems Engagement. The result of the second study supports the widely held belief that therapeutic interventions must be responsive to the constantly evolving population-contextual conditions (Santisteban *et al.*, in press; Sue, Zane, & Young, 1994; Szapocznik & Kurtines, 1993).

### Summary of Completed Research

We have reviewed seven major completed randomized trials (see Table I) funded either by the NIMH or NIDA. The first two studies reviewed (Santisteban *et al.*, 2000; Szapocznik Rio *et al.*, 1989) found BSFT to be superior to an alternative intervention. In the first case, BSFT was superior in bringing about improved family functioning when compared to child

psychodynamic therapy. In the second case, BSFT was superior in bringing about improved adolescent and family functioning when compared to a group counseling intervention.

We developed Strategic Structural Systems Engagement as an application of BSFT to the problem of engaging drug abusing, behavior problem adolescents and their families into treatment. In two randomized trials (Santisteban *et al.*, 1996; Szapocznik *et al.*, 1988) we demonstrated the superiority of this application of BSFT in engaging drug abusing, behavior problem Hispanic adolescents and their families into BSFT treatment. This work has contributed to a paradigm shift that received considerable support from Henggeler and colleagues (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998), which is that resistance to treatment is reflective of maladaptive family processes, and engagement begins at first contact.

In three additional studies we showed the versatility of BSFT. In one of these (Szapocznik, Santisteban, Rio, Perez-Vidal, Kurtines *et al.*, 1986) we developed a culture specific psychoeducational adaptation, and found it to be as effective as conventional BSFT. In the second (Szapocznik, Santisteban, Rio, Perez-Vidal, Kurtines *et al.*, 1989), we combined the psychoeducational intervention with conventional BSFT and found the combined modality to be superior to a minimum contact control. Finally, in the third study, we developed a One Person version of BSFT that was as efficacious as conjoint BSFT at reducing adolescent problem behaviors and improving family functioning.

Our most recent adaptation of BSFT has been to widen its focus from intrafamilial interactions to the social interactions in the immediate social environment. The next section reviews our current efforts at testing the social–ecological adaptation of BSFT theory and its applications. Four major randomized studies are underway testing these new adaptations, two of which target adolescents and are described below.

## **STRUCTURAL ECOSYSTEMS THEORY: AN ECOSYSTEMIC ADAPTATION OF BSFT**

Our early pilot work in the 1970s revealed that satisfactory outcomes were achieved by working with the conjoint families of our mostly Cuban Hispanic families. A conjoint approach appeared to be effective throughout the 1980s. In the 1990s, however, we observed that adolescents coming to our clinic were increasingly more severely delinquent and drug involved, and deviant peer involvement became more dangerous. The Hispanic community became more complex, with growing numbers of highly acculturated Hispanics, a broader representation of Hispanics from throughout Latin America, and an increasingly tattered social fabric. Schools deteriorated, while classroom sizes increased and the distance between parents and teachers widened. Drug trafficking exploded, reaching youths earlier. Gangs that recruited young children became more pervasive and increasingly criminalized as well as drug involved. As we have shown, when Hispanic children acculturate at a faster rate than their parents, risk arises from intergenerational conflict (Szapocznik & Kurtines, 1993). In contrast, when Hispanic parents acculturate, a different kind of risk arises (Santisteban *et al.*, in press) from acculturated parenting practices characterized by less involvement with the child and reduced monitoring of the child (cf. Dishion, Capaldi, Spracklin, & Li, 1995; Patterson, Reid, & Dishion, 1992; Patterson & Stouthamer-Loeber, 1984).

In response to the increasing severity in presenting problems, declining social conditions, and a deteriorating cultural fabric, we returned to our original family–ecological contextual roots. Our paradigm shift coincided with the growth of knowledge about risk and protective factors, as well as with our understanding that various aspects of a child's social ecology influence antisocial and drug abusing developmental trajectories (Szapocznik & Coatsworth, 1999).

To develop an intervention that targeted the youth's social ecologies, we transported the basic features of BSFT into drug abusing youths' social ecologies. Such a social ecological approach to BSFT, which we have termed Structural Ecosystems Theory (Perrino *et al.*, 2000; Szapocznik & Coatsworth, 1999; Szapocznik *et al.*, 1997), capitalizes on concepts such as interdependency, behavioral interplays or transactions within and between systems and subsystems, systemic leadership (structure), interpersonal distance (resonance), developmental appropriateness, and conflict vs. mutuality/support. To organize the social context of the youths, we have borrowed from Bronfenbrenner's social ecological developmental theory (Bronfenbrenner, 1977; 1979; 1986). Also, to develop a fuller understanding of the multiplicity of factors that influence problem behavior, we have built on the work of other contextualist researchers and interventionists (Hawkins & Weis, 1985; Henggeler, Melton, & Smith, 1992; Henggeler *et al.*, 1998; Newcomb & Bentler, 1988; Newcomb & Felix-Ortiz, 1992; Newcomb, Maddahian, & Bentler, 1986; Randall & Henggeler, 1999).

Structural Ecosystems Theory is concerned with the sociocultural context that sustains families and supports their protective functions (cf. Masten & Coatsworth, 1998; Szapocznik & Mancilla, 1995), or creates ecological vulnerability (Perrino *et al.*, 2000; Szapocznik & Coatsworth, 1999). Structural Ecosystems Theory combines the core BSFT principles about systems, structure/interactions, and strategy with the social ecology paradigm, a developmental focus, and an emphasis on broad social interactions.

### The Social-Ecology Paradigm

The primary social contexts for adolescent development (i.e., family, school, peer, and neighborhood) are thought to be nested within each other like a set of Russian dolls (Bronfenbrenner, 1979). Although our own work emphasizes interpersonal social contexts, we recognize the importance of intra-personal characteristics (e.g., genetic, biological, and psychological organization). We view these intra-personal characteristics as nested within the individual, who is nested in the family, peer group, school; and all of these, in turn, might be nested within the neighborhood and larger social processes such as cultures and political processes.

From Bronfenbrenner's work (1977; 1979; 1986), we borrow the concepts of micro-, meso-, exo- and macrosystems. Microsystems are the settings in which a child directly participates. Mesosystems do not contain the child, and refer to the relationship between members of different microsystems of the same child. Exosystems are those extrafamilial support systems, such as parents' close friends and parents' place of work, that affect family members. It is through their impact on family members that exosystemic interactions have an impact on the child. Individual, family, school, peer, and neighborhoods are influenced by society's broad ideological and cultural patterns and "blueprints," which Bronfenbrenner called macrosystems. Exposure to these macro-level social processes shapes individual development by enriching or impoverishing an individual's microsystems, mesosystems, and exosystems. In addition to our enduring interest in cultural patterns and acculturation (Szapocznik & Kurtines, 1993), we are equally interested in the impact of remnants of institutionalized policies that are damaging (discriminatory) to African American and Hispanic families (Szapocznik *et al.*, in press).

We have suggested that the stronger and more complementary the linkages within and between systems, the more powerful their influence on a child's development (Perrino *et al.*, 2000). Hence, we expect prosocial outcomes for children who have supportive and multi-stranded (i.e., many connections that are mutually supportive) prosocial contexts within and across family, school, neighborhood. Whereas, we expect poorer, problematic outcomes for children whose social contexts lack sufficient inter-connections and support to and from prosocial systems (Szapocznik & Coatsworth, 1999).

## An Ecodevelopmental Focus

Our recent development of Structural Ecosystems Theory focuses on the complex interplay between the “child’s life cycle” and the “life cycle of the child’s social context (family, peers, school, neighborhood)” Indeed, the concept of development is too often dichotomized into either child or life-span/adult, whereas our current developmental foci are concerned with children, adults, and the systems in which they are embedded (cf. Cairns, Elder, & Costello, 1996).

Ecodevelopment is an important Structural Ecosystems concept that refers to complex features that emerge over time, within an individual, in the person’s social ecosystems, and the nature of the interactions within and among these systems as they change and influence each other reciprocally over time (Szapocznik & Coatsworth, 1999). Ecodevelopment suggests that individuals, and the social ecosystems that envelope them, evolve over time in such a way that it is not possible to fully separate an individual’s development from the influences of an evolving ecosystem that contains the person. Equally important, we cannot separate the development of any single system, such as the family, from the changing reciprocal interactions in the social ecology of the family (Szapocznik & Coatsworth, 1999). For example, an aggressive 6-year old child might be in a coercive relation with her/his parents, associate with peers who are rejected by pro-social groups, and be experienced as troublesome and abrasive by the teacher who tries to minimize interactions with the child. An individual perspective might suggest that the site of pathology lies within the child (e.g., Kazdin, Stolar, & Marciano, 1995). An ecodevelopmental perspective suggests, however, that the child’s problem behaviors are maintained by the reciprocal interactions among the child and her or his ecosystem (i.e., family, peer and school). Hence, the child’s behavior problems may be difficult to change as long as the ecosystemic processes that maintain child’s behavior remain unchanged. The implications of such a view for intervention are explored below.

## Emphasis on Broad Social Interactions

One of the defining features of BSFT is its emphasis on social interactions. Consistent with BSFT, Structural Ecosystems Theory is concerned with the influence of repetitive patterns of social interactions among members of a particular system (e.g., mother–adolescent, mother–father interactions inside of the family) on social interactions among members across social ecological systems (e.g., parent–school, parent–peer interactions). A central tenet of Structural Ecosystems Theory is that social relationships within one domain have cascading effects to social relationships in other domains (Szapocznik & Coatsworth, 1999; Perrino *et al.*, 2000), for example, describes the cascading effects of mother–daughter discussions about sexual behavior on the girls’ sexual behavior with her peers. Perhaps the most complete program of research documenting cascading effects across domains is found in the work of the Oregon Social Learning Center. Patterson and colleagues have suggested that coercive parent–child interactions practiced at home in the pre-school years have implications for later child–peer and child–school relations, and ultimately for child pro- or anti-social developmental trajectories (Dishion *et al.*, 1995; Dishion, Patterson, Stoolmiller, & Skinner, 1991; Patterson, 1982; Patterson & Dishion, 1985).

Structural Ecosystems Theory, consistent with BSFT, is primarily concerned with the process (how) of social interactions rather than their content (about what). An exception to this rule is when interactions contain content that is culturally (Szapocznik & Kurtines, 1993) or racially relevant (Jackson-Gilfort, Liddle, & Dakof, 2000). Jackson-Gilfort and colleagues found that the racial content expressed by an African American male drug abusing adolescent in therapy predicted the quality of the adolescent–therapist alliance, a relationship/process variable. It appears that macrosystemic processes get reflected as content in more intimate relationships. In the two examples cited, macrosocial processes had cascading effects on social interactions

in more intimate systems. These macrosystemic effects were manifested in more intimate systems as content: cultural differences in Hispanic families (Szapocznik & Kurtines, 1993) or African American cultural content in the therapy relationship (Jackson-Gilfort *et al.*, 2000).

Content is significant when it influences the quality of social interactions. The process, however, which is the focus of our interventions, is to provide the family with more effective strategies for managing intergenerational disagreements; or to provide the therapist with more effective tools for accepting and understanding black rage. Typically, the direction of interventions to change interactional patterns is from disconnection and/or conflict to collaborative, mutually supportive relationships.

At present, we have two major longitudinal randomized studies in the clinical trial tradition testing the application BSFT principles to adolescents social ecologies. These are discussed next.

### Applications of Structural Ecosystems to Prevention and Treatment

**Structural Ecodevelopmental Preventive Interventions**—After a series of pilot studies in ecosystemic preventive interventions with African American and Hispanic families, we developed the Structural Eco-developmental Preventive Intervention (Pantin & Szapocznik, 1996; Szapocznik & Coatsworth, 1999). The inclusion of African Americans in this work reflected our response to an increased need for services for this under-served population. This prevention intervention represents our first major effort at expanding the applicability of BSFT concepts to prevention beyond an intrafamily focus as well as to a non-Hispanic population. Although we continue to emphasize the family as the bedrock of child development, this preventive intervention targets changes in the family–school and family–peer mesosystems, parenting support exosystems, in addition to the family’s microsystem. Our intervention is organized around the goal of strengthening parenting functions as well as parental relations to the child, school, and peers (Pantin & Szapocznik, 1996). We also place considerable emphasis on mesosystems that include the family, because we have observed that mesosystems are particularly under-developed for some African American and Hispanic immigrant parents that live in high risk neighborhoods (Szapocznik & Coatsworth, 1999). Finally, we emphasize the creation and strengthening of parenting support exosystems, because in our experience many minority families living in poor urban neighborhoods lack adequate parenting support, particularly in relation to the looming risks to their adolescents in poor neighborhoods. We have selected these strategic points of entry with the belief that effects cascade across social ecological domains (Szapocznik & Coatsworth, 1999).

A first step to improve parent–child, parent–school, and parent–peer relations is to enhance parental involvement and investment in these three areas. We are currently analyzing findings from a major randomized study (Center for Substance Abuse Prevention Grant SPO 7961) of 240 families (80 African American and 160 Hispanic immigrant) in poor neighborhoods with 11- to 12-year old adolescents at risk for problem behaviors such as drug abuse. Youths and their families were randomly assigned to either Structural Ecosystems Prevention Intervention or No Intervention Control.

Preliminary analyses for the 160 Hispanic immigrant families in the sample (Pantin, Coatsworth, Feaster, & Szapocznik, 2000) revealed that Hispanic parent reports of parental involvement were at very low levels at baseline. Parents receiving the experimental intervention, compared to controls, demonstrated increased parental involvement, and this increase was sustained after the intervention was completed and the new school year had started,  $F(3,151) = 4.04, p = 0.0085$ . Parent and adolescent report composites of adolescent problem behaviors were created. These reports revealed that significantly fewer adolescent

behavior problems were reported by Hispanic parents and youths in the preventive intervention condition than in the no intervention control,  $F(4,153) = 2.81, p = 0.0275$ . Further analyses revealed that these differences were due to a surge of behavior problems in control youths during the summer months. Hence, parental involvement in Hispanic families was efficacious in preventing behavior problems during the summer season, a period of especially high vulnerability.

Although data are still being analyzed, findings for African American high-risk youths and their families are puzzling. This group began the intervention with very high levels of parental involvement. Surprisingly, parental involvement decreased as a function of the intervention, so that final mean parental involvement for African American and Hispanics who received the intervention were approximately equal. Those final levels, however, represented a significant increase for Hispanics and a significant decrease for African Americans who received the intervention when compared to their respective controls. Thus, for African Americans, parental levels of investment either naturally regressed towards a moderate point, or the intervention created iatrogenic effects for African American parental involvement. These intervention by culture and context interaction effects are extremely important to identify and study. While it is possible that the positive impact of the intervention on African American families will become visible in the long term, it is also possible that the intervention had a deleterious effect on these families. Unfortunately deleterious effects of interventions are not adequately reported in the literature. As we have argued elsewhere (National Institute of Mental Health, 1998; Szapocznik *et al.*, 1990), it is critical to more carefully and systematically investigate both the efficacy and safety of interventions targeting children and adolescents.

**Structural Ecosystems Therapy**—The development of the Structural Ecosystems treatment model began with a demonstration and pilot study (Center for Substance Abuse Treatment Grant TI00417) with African American and Hispanic drug abusing adolescents. We integrated into the treatment model lessons learned in consultations from Scott Henggeler, the primary developer of Multisystemic Treatment (Henggeler, 1989; 1991; Henggeler & Borduin, 1990; Henggeler *et al.*, 1998). Structural Ecosystems Therapy is like Multisystemic Treatment in its focus on multiple systems as well as its home- and community-based service delivery approach.

As a multisystemic therapy, Structural Ecosystems Therapy distinguishes itself in at least two ways. First, as an adaptation of BSFT, clinical work is guided by BSFT principles of joining, diagnosing and restructuring; and the ecological diagnoses are, consistent with BSFT, organized into the five structural dimensions of structure, resonance, identified patienthood, developmental stage and conflict resolution style. Hence, the principles of BSFT developed for intrafamily interventions are applied to social ecological relationships, including the hypothesized relationship between social interactional patterns and adolescent behaviors. Second, consistent with our contextualist tradition, we place considerable emphasis on cultural issues (Santisteban *et al.*, in press).

In the initial demonstration/pilot study referenced above, 90 substance using African American and Hispanic adolescents were randomized to the ecosystemic intervention or to a community referral. Analyses of outcome at 6 months after baseline revealed statistically significant reductions in some delinquency and drug use indicators, but not all. However, significant intervention by time effects always favored the ecosystemic intervention (Santisteban *et al.*, 2000).

A major ongoing randomized clinical trial (NIDA Grant DA 10574) compares the relative efficacy of Structural Ecosystems Therapy, conventional (intra-familial) BSFT and a community referral control for 180 African American and Hispanic adolescents who meet

*Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994) criteria for drug abuse or dependence. This study examines the relative efficacy of the three conditions in reducing adolescent drug abuse, delinquency, and other behavior problems. It also investigates the impact of the interventions on hypothesized mediating mechanisms of structural family functioning and ecosystemic functioning (child-school, child-peer, family-peer, family-school, family support systems).

In this study, BSFT is conducted as described by Szapocznik and Kurtines (1989; see also Hervis & Szapocznik, 1987; Szapocznik & National Coalition of Hispanic Health and Human Services Organizations [COSSMHO], 1993a,b). Structural Ecosystems Therapy (cf. Mitrani, Szapocznik, & Robinson-Batista, 2000) focuses on the interactional patterns that occur at three broad levels; microsystems (i.e., child-school, child-peer, child-juvenile justice), mesosystems (family-school, family-peer, family-juvenile justice), and exosystems (i.e., parental social support). Our child-peer interventions are conducted in the context of family and family-peer interventions attempting to overcome the pitfalls of peer interventions that are ineffective and may have iatrogenic effects (Dishion, McCord, & Poulin, 1999; Henggeler *et al.*, 1998; Tolan & Guerra, 1994).

Recent developments in our theoretical, research and clinical trajectory have seen an expanding focus of intervention. Structural Ecosystems Theory, and its prevention and treatment applications, represent a considerable broadening of our clinical lens.

## CONCLUSIONS

Brief Strategic Family Therapy (BSFT) and its various applications, have shown promise across seven randomized clinical trials (see Table I) funded by the NIMH or NIDA by: (a) engaging families into treatment; (b) reducing drug abuse, behavior problems, emotional distress in children and adolescents; and (c) improving family functioning. In these studies, BSFT has also shown considerable versatility. Our early comparisons of BSFT to One Person Family Therapy (Szapocznik, Kurtines *et al.*, 1983;1986) are considered the first randomized studies of family therapy in drug abuse treatment (Liddle & Dakof, 1995a). Our program of research was the first family-based and the first minority-focused systematic program of psychotherapy research to achieve national recognition (Szapocznik, Rio, & Kurtines, 1991). We published a BSFT manual (Szapocznik & Kurtines, 1989) describing conventional BSFT, One Person Family Therapy and Strategic Structural Systems Engagement. We also published a manual specific to One Person Family Therapy (Szapocznik *et al.*, 1985). Finally, we published a simplified manual for counselors on conjoint/conventional BSFT, in both Spanish and English (Szapocznik & COSS-MHO, 1993a,1993b).

The clinical and research work reviewed in this article has received recognition in scholarly reviews (e.g., Alexander, Holtzworth-Munroe, & Jameson, 1994; Liddle & Dakof, 1995a, 1995b; Waldron, 1997). This work has been recommended as a model for working with troubled youths by the U.S. Department of Health and Human Services (DHHS), the National Institute on Drug Abuse, the Center for Substance Abuse Prevention, the Office of Juvenile Justice and Delinquency Prevention, and the Surgeon General. For example, the Surgeon General's report on child mental health cited our Structural Strategic Systems Engagement intervention as an approach to reduce likelihood of families and children prematurely terminating therapy (Department of Health and Human Services, 1999). This is especially encouraging because engagement strategies can contribute to improving the very high drop out rate that plagues mental health agencies throughout the nation (Kazdin, Holland, & Crowley, 1997). Furthermore, the adoption of our engagement strategies will contribute to a needed paradigm shift from blaming individual or families for resisting treatment, to a systemic understanding of the barriers to treatment.



Our BSFT paradigm was also discussed in the Surgeon General's mental health report as representative of "culturally appropriate social support services" (DHHS, 1999). Consistent with this report, we have moved beyond blaming the child as identified patient, and we incorporate the consideration of the cultural context of a client as part of all treatment interventions and case conceptualizations. While much has been accomplished, important challenges remain to our program of research and practice.

### Research to Practice

Despite our ability to publish manuals to disseminate BSFT, we recognize the considerable challenges to transporting BSFT beyond Miami. Indeed, psychotherapy researchers fall short in their ability to communicate the findings of their research to stakeholders such as consumers, policymakers, and the society at-large (Newman & Tejada, 1996). To address this challenge, our current line of studies include measures of cost-effectiveness, effort, as well as dosage measures. These data will permit managed care companies and other stakeholders in systems of care to evaluate the utility of BSFT and its various applications. To further bridge the gap between research and practice, we have established a practice clinic, and contracted with a managed care company to provide services in an effort to demonstrate the viability of the approach in today's economic ecology.

Although we have had a program of training for the last 15 years on conjoint BSFT and specialized engagement, this program had lacked continuity. For example, in the past, as part of an Office of Juvenile Justice and Delinquency Prevention grant to the National Coalition of Hispanic Health and Human Services Organization (COSSMHO), we provided intensive training to professionals in nine agencies in heavily Hispanic communities throughout the United States and Puerto Rico. In addition, ad hoc training requests have resulted in over one hundred training workshops. More recently, however, we have developed at the Center for Family Studies a more systematic program to disseminate all the applications of BSFT. The program includes an externship at the Center as well as formalized training packages for dissemination of the approach.

However, research to practice studies demonstrating the effectiveness of the intervention in community based agencies are yet to be conducted. This is our next major challenge, already under planning. It is particularly important to develop strategies for ensuring fidelity to BSFT in practice settings. As Henggeler has demonstrated, fidelity to the intervention model may be critical to achieving expected outcomes in practice settings (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997; Schoenwald, Henggeler, Brondino, & Rowland, 2000).

Additional future research challenges to our program of research include the following: (a) conducting trials comparing BSFT to other empirically validated family-based and non-family based interventions for adolescent drug abusing and/or problem behavior youth; (b) linking specific therapists behaviors to proximal and distal family and individual outcomes (currently underway) to refine and improve the intervention (cf. Alexander *et al.*, 1994; Waldron, 1997); (c) conducting research on applications to non-Hispanic populations and Hispanic populations in different parts of the country; and (d) conducting research on methods for transporting BSFT from efficacy to practice settings. Although transportability to practice settings is challenging, fortunately during the last 15 years, we have been applying BSFT with populations obtained from the usual referral sources to community agencies. Our current studies for example, obtain most of their referrals from the justice system, and therapy is conducted in homes and other settings in the life context of the participating families (e.g., schools, crack houses, and courts). Overall, our research appears to meet guidelines for an adequate program of research that will be informative to consumers, practitioners, policy makers, and the public at-large (Newman & Tejada, 1996).

Over the past 25 years, the main principles underlying BSFT (i.e., system, strategy, structure/interactions) have remained unchanged, but the applications of BSFT has undergone significant expansion. We have progressed from our initial conceptualization of BSFT as a specific treatment intervention, to utilizing its basic underlying principles as a blueprint for clinical goals and strategies that can be mapped on to psychoeducational, one person, engagement, and ecosystemic approaches. We have been able to develop a range of clinical tools to broaden the practitioner's intervention repertoire. In addition, we are encouraged that our program of research fits with the larger trend in mental health toward incorporating family therapy and multisystemic therapy (Henggeler *et al.*, 1998) into child and adolescent substance abuse treatment (American Association of Child and Adolescent Psychiatry, 1997; DHHS, 1999; Liddle & Dakof, 1995b).

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**Table I**

## Comparison of BSFT-based Interventions

Study	Sample	BSFT-based intervention	Comparison condition(s)	Results
Szapocznik, Kurtines <i>et al.</i> 1983, 1986	72 Hispanic boys & girls	BSFT, & OPFT		BSFT & OPFT reduced drug abuse & improved family functioning
Szapocznik <i>et al.</i> 1988	108 Hispanic boys & girls	SSSE	EAU	SSSE more effectively engaged than Engagement As Usual
Szapocznik, Santisteban <i>et al.</i> 1989	41 Cuban-American boys & girls	BSFT, & BET		BSFT & BET equally reduced behavior problems & improved family functioning
Szapocznik, Rio <i>et al.</i> 1989	69 Hispanic boys	BSFT	Psychodynamic Individual Child Therapy	BSFT & Child Therapy equally reduced child emotional, behavior problems & psychodynamic functioning. Family functioning improved for BSFT, but deteriorated for Child Therapy
Szapocznik, Santisteban <i>et al.</i> 1989	79 Hispanic boys & girls	FET	Minimum Contact Control	FET improved emotional & behavior problems & family functioning more than Minimum Contact Control
Santisteban <i>et al.</i> 1996 <sup>a</sup>	79 Hispanic boys & girls	BSFT + SSSE	BSFT + EAU Group Counseling & EAU	SSSE more effectively engaged than Engagement As Usual
Santisteban <i>et al.</i> 2000.	79 Hispanic boys & girls	BSFT	Group Counseling	BSFT reduced Socialized Aggression & Conduct Disorder more than Group Counseling

*Note:* BSFT = Brief Strategic Family Therapy. SSSE = Strategic Structural Systems Engagement. OPFT = One Person Family Therapy. BET = Bicultural Effectiveness Training. FET = Family Effectiveness Training. EAU = Engagement As Usual.

<sup>a</sup>Santisteban *et al.* 1996 report engagement results, and Santisteban *et al.* 2000 report treatment outcomes from the same randomized clinical trial.