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Brief Strategic Family Therapy: Engaging Drug Using/Problem Behavior Adolescents and their Families into Treatment

José Szapocznik, Ph.D.,

Brief Strategic Family Therapy Institute, Center for Family Studies, University of Miami Miller School of Medicine

Monica Zarate, M.S.Ed.,

Brief Strategic Family Therapy Institute, Center for Family Studies, University of Miami Miller School of Medicine

Johnathan Duff, M.A., and

Brief Strategic Family Therapy Institute, Center for Family Studies, University of Miami Miller School of Medicine

Joan Muir, Ph.D.

Brief Strategic Family Therapy Institute, Center for Family Studies, University of Miami Miller School of Medicine

Abstract

Despite the efficacy of family-based interventions for improving outcomes for adolescent behavior problems such as substance use, engaging and retaining whole families in treatment is one of the greatest challenges therapists confront. This article illustrates how the Brief Strategic Family Therapy® (BSFT®) model, a family-based, empirically validated intervention designed to treat children and adolescents' problem behaviors, can be used to increase engagement, improve retention, and bring about positive outcomes for families. Research evidence for efficacy and effectiveness is also presented.

INTRODUCTION

The Johnson family includes 15 year-old Andrew, his mother Mrs. Johnson, stepfather Mr. Johnson, and 13 year old son Jordan, and mother and step-father's 5 year old son, Malik. Andrew was referred for treatment by the Probation Officer assigned to his case after his recent release from an inpatient locked treatment facility for sexual offenders where he was receiving treatment following a sexual incident involving two neighborhood boys three and four years younger than him. Andrew had been using alcohol and drugs at the time of the incident. Mr. and Mrs.

Address correspondence to: Jose Szapocznik, University of Miami, 1425 N.W. 10th Ave., Suite 207, Miami, FL 33136. jszapocz@med.miami.edu.

Conflict of Interest: The University of Miami holds the copyright and trademark for the Brief Strategic Family Therapy. Dr. Szapocznik is the developer of this method. The University and Dr. Szapocznik have the potential for financial benefit from the future commercialization of the method.

Johnson struggled with their son's incarceration and consequently only visited him twice during his 16 month stay. Mrs. Johnson reported that upon returning home, Andrew has been increasingly distant from his family; he now consistently isolates himself from others. Andrew is also increasingly in conflict with his parents, is performing poorly in school, and has been using marijuana. Mrs. Johnson worries that Andrew will fall-in with the wrong crowd of peers, and continue a dangerous path toward drug use and delinquency. Mr. and Mrs. Johnson both would like to help Andrew but often appear at odds with each other on how to accomplish this goal.

The example of the Johnson family illustrates that Brief Strategic Family Therapy® (BSFT®) is designed to treat a range of adolescent behavioral problems that often accompany adolescent drug use (Jessor & Jessor, 1977; McGee & Newcomb, 1992), such as school underachievement, oppositional defiance, delinquency, and disengagement from pro-social activities. Although the focus of the BSFT model is to address drug use and related behavior problems of the adolescent, therapists accomplish this by working relationally with the entire family. Family relations therefore, represent the targets for change in concert with the individual problems associated with these maladaptive family relations. Specifically, the BSFT model aims to strengthen adaptive family interactions, such as the concerns of Mr. and Mrs. Johnson for Andrew; and correct maladaptive patterns of family interactions, such as Mr. and Mrs. Johnson being at odds with how to approach Andrew's problems that could be unwittingly supporting Andrew's isolation, alienation from the family, and drug use.

As discussed below, the role of social systems is a central tenet of both the BSFT approach and social work. Clinical social workers will find the BSFT approach to be consistent with their systems training and clinical practice. The BSFT model offers concepts that can be useful to the social worker in practice such as the emphasis on repetitive patterns of family interactions. When multiproblem families present for services, the therapist can become overwhelmed by the many urgent issues confronting (and overwhelming) these families. Attention to repetitive patterns of interactions among family members allows the therapist to attend to family systemic processes common across the many problems confronting a family, without getting lost in the multiplicity of urgent contents. The BSFT model also provides social workers with a set of intervention tools to engage families in treatment, become an accepted member of the family system so that interventions are more easily accepted by the family, tools to create a motivational context for change, and finally tools to change the maladaptive patterns of interactions that do not allow families to achieve their own goals.

BRIEF STRATEGIC FAMILY THERAPY

Over the past thirty years, research investigating the effects of psychotherapeutic interventions for adolescent substance users has demonstrated that involvement of family members in treatment consistently produces more positive outcomes (Cannon & Levy, 2008; O'Farell & Fals-Stewart, 2003; Williams & Chang, 2000). While social workers and other human service professionals as well as public health institutions targeting adolescent drug use such as healthcare and juvenile justice systems have acknowledged the necessity of

involving families in treatment, engaging family members remains a serious challenge (Armbruster & Kazdin, 1994; Hornberger & Smith, 2011; Kazdin & Mazurick, 1994; Kazdin, Mazurick, & Bass, 1993; Stanton & Todd, 1981; Szapocznik et al., 1988). Often families do not show up to the first intake or therapy session, for instance, or drop before treatment goals are achieved (Flicker et al., 2008; Szapocznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1986). In one study with adolescent substance users referred to treatment, it was reported that in usual adolescent services only 22% of the families received any substance abuse or mental health services (Henggeler, Pickrel, Brondino, & Crouch, 1996). Research has demonstrated potential, however, for certain family therapy modalities that emphasize family engagement to enhance retention rates and subsequently improve treatment outcomes (Stanton & Shadish, 1997).

Brief Strategic Family Therapy (BSFT) is a family-based, empirically validated intervention designed to treat children's and adolescents' problem behaviors such as those presented by Andrew in our case example. Based on the structural theory of Minuchin (e.g., Minuchin & Fishman, 1981), and the strategic thinking of Haley (1976) and Madanes (1981), the BSFT model targets for change family patterns of interactions (i.e., repetitive behaviors of family members with each other, such as mother tells Andrew that he cannot use drugs and father undermines mother by saying, "boys will be boys") that may be associated with the adolescent's drug use and related problem behaviors. To produce behavior change, BSFT therapists work to increase motivation for behavior change, reduce concerns about change, identify adaptive interactions and strengthen them, and identify troubled family interactions and modify them. BSFT therapists employ four sets of techniques including *joining*, *tracking and eliciting*, *reframing/creating a motivational context for change*, and *restructuring* throughout the treatment process to elicit change.

One of the most important innovations of the BSFT approach has been the belief that challenges in engaging families into treatment are derived from the same interactional problems maintaining the adolescent's problem behaviors. In the Johnson case for example, Mr. and Mrs. Johnson were often incongruent in their parenting beliefs, preventing them from taking a unified, collaborative stance in supporting Andrew. Their discrepant parenting opinions similarly represented an obstacle to entering treatment. The same intervention techniques, namely joining, tracking and diagnostic enactment, and reframing therefore, were utilized to engage the family into therapy. In this paper we describe how the principles and techniques used in the BSFT approach can be applied by social workers to engaging family members for treatment and provide a detailed case example of how this approach looks in practice. We also provide evidence for the efficacy and effectiveness of BSFT engagement strategies and briefly discuss potential policy implications.

BSFT THEORETICAL UNDERPINNINGS: SYSTEM, STRUCTURE, AND STRATEGY

The BSFT approach is based on the fundamental assumption that the family is the most proximal and influential context for child development (Szapocznik & Coatsworth, 1999). As suggested by Bronfenbrenner (1986), we perceive the family as the principal force shaping the way a child thinks, feels and behaves. Research demonstrates that adjusting

family interactional patterns can significantly improve adolescent behavior problems (Liddle & Dakof, 1995; Robbins, Alexander, & Turner, 2000). The BSFT approach asserts, therefore, that family relations - as the child's most proximal social-ecological context - play a central role in the development and maintenance of behavior problems including drug abuse, and consequently represent a primary target for intervention.

Fundamental to social work practice is the concept of systems and the impact of the social ecology on human development and behavior (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2010). The BSFT approach recognizes that although the family is the primary context of human development, the family itself is also part of a larger social system and, like an adolescent is influenced by his or her family, the family is influenced by the larger social system in which it exists (Bronfenbrenner, 1979). For instance, the Johnson family resided in a relatively close, tight-knit community in which many community members knew about their son Andrew's recent difficulties. Their shame, combined with their desire to not draw attention to his incarceration, influenced Andrew's presenting symptom of isolation. The BSFT therapist in this case, recognized this sensitivity to contextual factors that created on the one hand risk through peers of substance abuse, and on the other the family's shame toward its community that was manifested in Andrew's isolation.

Theoretical Underpinnings

The BSFT approach is best articulated around three central constructs: system, structure/patterns of interactions, and strategy (Szapocznik & Kurtines, 1989).

System—The first construct central to the BSFT approach is a systems approach. Systems are a basic element of modern family systems theory (Bavelas & Segal, 1982). Systems and eco-systemic perspectives have long been central to social work theory and practice (Wakefield, 1996). It is not surprising then, that in the authors' experience, social workers readily learn BSFT.

A system is an organized whole comprised of separate interrelated and interdependent parts. A family, for example, is a system comprised of individuals whose behaviors and interactional patterns inherently affect each other. The BSFT model is based on the principle that family members are interdependent: The experiences and behavior of each individual family member affect the experiences and behavior of all other family members. According to family systems theory for example, the troubled adolescent is a family member who displays risk taking behaviors such as drug use that reflect, at least in part, what else is going on in the interactions among family members (Szapocznik & Kurtines, 1989). The adolescent's behavior therefore, is believed to reflect larger maladaptive family interactions. The case of the Johnson family, as we will explain, represents an example of how the son Andrew's problem behaviors, particularly his isolation and involvement in drugs, co-occurred with maladaptive interactional patterns that prevented the family from adequately achieving their goal of changing Andrew's conduct.

Structure—The second construct fundamental to the BSFT approach is structure. The set of repetitive patterns of interactions within the family system is called the family's structure.

A maladaptive family structure is characterized by repetitive family interactions in which family members repeatedly elicit the same unsatisfactory and potentially harmful responses from other family members. In our case example, Mr. and Mrs. Johnson's inability to effectively collaborate on parenting functions interfered with their goals of changing Andrew's behaviors. In particular, when the conflict between the parents was around Andrew's behavior, often the parent in frustration with each other lashed out at Andrew, causing him to withdraw and pull away from the family.

Strategy—The third essential concept of the BSFT approach is strategy, characterized by using interventions that are practical, problem-focused, and deliberate. Practical interventions are selected for their likelihood to move the family toward desired objectives. The overarching goal of BSFT strategy is to target the repetitive maladaptive patterns of family interactions while strengthening adaptive patterns of interaction that will achieve the caregivers' goal of reducing the adolescent's problematic and risky behavior.

As a problem-focused approach, the BSFT model targets family interaction patterns that are directly relevant to the youth's symptoms. As we will see in the Johnson family, addressing the conflict between the two parents was essential to avoid their taking their frustration out on Andrew. Interventions simultaneously attempted to reduce the attacking and blaming among the parents, allow for more positive communication that led to collaborative parenting behaviors that could effectively improve the issues that so much concerned them in Andrew's behaviors, isolation, poor school functioning and drug use. Also, of course, confronting the shame that prevented them from talking with Andrew about the sexual incident that sent him to jail, was essential to avoid a similar incident re-occurring.

BSFT intervention strategies are very deliberate, meaning that the therapist identifies the maladaptive interactions that if changed are most likely to lead to the desired outcomes (i.e., adolescent prosocial behavior). For instance, before working on Andrew's behavior management, the BSFT therapist has to focus on reestablishing the positive emotional connection between Andrew and his parents so that their attempt to address his behavior can be viewed as an expression of concern and love for him and will be less likely to be rejected.

BSFT: THE INTERVENTION

To produce behavior change, BSFT therapists employ four sets of techniques, *joining*, *tracking and eliciting*, *reframing/creating a motivational context for change*, and *restructuring*. As Figure 1 indicates, though there is a general sequence to their use, the sequence is used continuously during the intervention, and early interventions such as joining are often used frequently throughout the treatment process.

Joining is the process by which the therapist moves from being an outsider to becoming a member of the therapeutic team that includes the therapist and the family. The fundamental principle underlying joining is that the therapist must empathize with each family member's wants and needs and must offer a tangible way to help each family member to reach her or his stated goals. Joining includes not only accepting, respecting and following initially the family's unwritten rules and established power structure, but behaving in ways that blend

with the family. If family members use specific slang words, for example, the therapist may use these same words when interacting with the family. Social-psychological research has demonstrated that family members are most likely to trust the therapist when she or he behaves in ways that are familiar to the family.

A second technique used in the BSFT approach is *tracking* in which diagnostic enactment interventions are utilized to systematically identify family interactional strengths and weaknesses that can be used to formulate a treatment plan. A core tactic of tracking and diagnostic enactment is encouraging the family to behave as they do when the counselor is not present. For instance encouraging family members to speak directly with one another about the concerns that bring them to therapy, rather than directing comments to the therapist. One of the primary goals of the Johnson family for example, was to reduce Andrew's isolation and distance from other family members. When Mrs. Johnson revealed this in a session, the therapist encouraged her to state this to Andrew directly. As family members interact with one another more naturally within session, the therapist tracks or follows the interactional process and then identifies/diagnoses family strengths as well as problematic patterns of interactions.

Diagnosis is the process by which the therapist identifies the interactional patterns within the family that are most closely related to the adolescent's symptoms. Developing a diagnosis involves asking the family to interact and observing the specific interactions that involve the adolescent (either directly or indirectly) and that are most problematic. Families may interact spontaneously, or the BSFT therapist may need to ask them to interact. One of the most straightforward ways to prompt an interaction is to redirect to the family communications that were initially directed toward the therapist. Once the therapist did this with the Johnson family for instance, the therapist observed how when Mrs. Johnson spoke to Andrew, Mr. Johnson quickly revealed his disagreement with his wife—thus the family behaved as if the therapist was not present, allowing the therapist to observe these interactions.

Another set of techniques involves *reframing* and *creating a motivational context for change*. Robbins and colleagues (2006) showed that families are more likely to remain in treatment if their interactions are positive and constructive, particularly during the initial therapy session. Negativity is one of the strongest predictors of early dropout from family therapy, though it also represents one of the primary reasons why families seek help. One of the most effective ways to reduce is to reframe (change) the perspective through which an interaction is viewed, thereby creating a motivational context for change. For example, when Mr. Johnson disagreed with his wife, the therapist reframed the behavior as "I can see how committed both of you (the parents) are to doing the right thing for Andrew," thereby creating a potential motivational context within which to address the parent's disagreement with each other. That is, changing the meaning of the interaction from negative to positive to allow the individuals involved in the interaction to move to a different level of discussion about their behavior.

Finally, once the therapist has been accepted as a temporary member of the family, maladaptive family patterns of interactions associated with the adolescent's problem behaviors have been identified, a treatment plan can be formulated (i.e., which patterns of

interactions need changing). Once this plan is in place, the therapist is ready to restructure or change the targeted maladaptive family interactional patterns. Like all BSFT interventions, restructuring interventions work in the present and can involve a variety of strategies. BSFT therapists may use, for example, reframing, assigning tasks, or shifting boundaries and alliances within the family to change the maladaptive interactional patterns most influencing the identified problem, as we will see in the case of the Johnson family.

BSFT Engagement

Family therapists face the daunting challenge of engaging multiple family members into treatment. Our research demonstrates that, if a family is characterized by maladaptive interactional patterns that prevent it from achieving its goals of eliminating a youth's drug use and related problem behaviors, typically those same maladaptive interactional patterns serve as an obstacle to bringing the whole family into treatment. BSFT specialized engagement strategies capitalize on the same basic diagnostic principles to identify patterns of interaction that may interfere with the family coming into treatment, and intervention techniques used in the therapy model itself.

BSFT Engagement begins with the first phone call. During this first contact, therapists often only have access to one person, typically a parent and usually the adolescent's mother who calls for help. Effectively navigating this first contact sets the tone for the entire process of treatment. During the initial contact, the therapist begins to join with the caller, and to gather information about (a) who needs to be included in the family sessions, and (b) what barriers may keep key family members from participating in treatment. In joining with the caller during this first call, the therapist must remain cautious to avoid forming any alliance against other family members. For instance, in our clinical case, the BSFT therapist recognized during the first phone call with Mrs. Johnson that she had reservations about her husband's willingness to participate in therapy. To address this without creating alliances against other family members, the therapist validated and reframed Mrs. Johnson's concerns about getting the entire family to attend while not allying with the mother against others who were reluctant to attend therapy.

Often one essential family member, such as the drug abusing youth or an alienated father figure, may not want to come to treatment. The BSFT therapist will frequently offer to contact this family member directly and join with him in an effort to convey that he has something to gain from coming into treatment. Essentially, the therapist tries to get "around" the problematic interactional patterns of behavior by inserting herself into the engagement process. When a family member, usually a mother, calls and asks for help, the therapist uses this first call as an opportunity to begin to explore the family interactions. Specifically, the therapist will give the caller a task – "bring all the members of the family into the first session." The organizational structure of the family will become apparent when the caller either responds that "my son won't come to treatment," or "my husband won't come to treatment," or "it is best if just my son and I come – it is not necessary to bring my husband." In the first and second cases, the caller may lack the influence needed to bring that family member into treatment. In the third case, the caller either prefers not to bring her spouse, or is at best ambivalent about bringing him. In each case, and with the caller's

approval, the therapist will reach directly to the family member (a) who does not want to come to treatment or (b) whom the caller is not eager to bring to treatment.

By listening for and tracking the caller's comments about family interactions, the therapist gains valuable information about potential interactional patterns that may interfere with engagement. Since it is not possible to observe any enactments when calling, we can nevertheless infer some interactional patterns by asking relationally-oriented questions. In the case of the Johnsons, the therapist noticed Mrs. Johnson had some ambivalence about asking her husband to join in therapy. The therapist reframed Mrs. Johnson's concern, stating "I also sense that you want to protect your husband from worry and you very often keep things to yourself...I can tell you care for him very much," and then offering to contact him herself to reduce the burden on the mother. Though Mrs. Johnson eventually agreed to ask him, the therapist recognized immediately that Mr. and Mrs. Johnson's communication patterns represented a possible area for change. While the therapist makes some assumptions about the general direction in which a family should move from maladaptive behaviors to those that are more effective in achieving the family's own goals, what is critically important is that the therapist does not challenge the system initially. As we take each step, we ask the relevant family members permission to take that step.

The very same principles that apply to the understanding of family functioning and treatment also apply to engaging families or a family member who are reluctant to entering or staying in therapy. The term "resistance" typically used to apply to an individual, is used in the BSFT approach to apply to the therapist-family interactions. Resistance to entering treatment is what happens when a family member is reluctant to come into treatment given the behavior of the therapist. We have established in our research (e.g., Szapocznik, et al., 1988) that once the therapist changes her/his behavior, the resistance to entering treatment disappears and the family member comes into treatment. Hence, resistance is the reluctance of a family member to behave as the therapist wishes when the therapist behaves in a way that elicits that reluctance. Resistance to entering treatment disappears when the therapist changes her/his behaviors to be more effective in achieving the therapist's therapeutic goals of bringing the reluctant family member into treatment.

As we will see below in the case of the Johnson family, the same techniques described above to treat the family once all members come to therapy (i.e., joining, tracking, assigning tasks, interactional diagnosis, reframing, guiding and coaching) are also used to engage and retain family members who are reluctant to participate in therapy (c.f., Szapocznik et al., 2003). Consistent with the relational focus of the BSFT model, resistance to treatment is defined in terms of the family's interactional patterns that preclude the family or its individual members from participating in treatment. Therefore, BSFT engagement techniques are applied to overcome these patterns and are not aimed to permanently change the family (which is done once the family enters treatment).

Case Example

BSFT therapists rely on direct observation to understand family functioning and to develop a working diagnostic map of the family's patterns of interactions that will lead to effective treatment. Successfully engaging all family members to participate in sessions is not always

an easy task for BSFT therapists. BSFT therapists, therefore, rely on well developed and empirically supported BSFT engagement strategies to promote participation. These practical strategies may include: a) conveying to family members acknowledgement and understanding of their point of view; b) exploring individual gains from participation in treatment; c) exploring obstacles to regular participation in sessions; and d) offering more positive perspectives of individual family members or the problem situation. BSFT therapists work diligently to persuade family members to participate actively in the process of change and to trust the BSFT therapist in guiding them to create that change.

The case of the Johnson family illustrates the strategies BSFT therapists implement when engaging a family into treatment and illustrate how the very same principles of understanding family functioning also apply to the engagement of family members into treatment. Consistent with the relational focus of the BSFT model, this case demonstrates how the BSFT therapist uses the principles of BSFT engagement to identify the patterns of interaction that are precluding the family from participation in treatment and how therapist behaviors impact entry into treatment.

The Johnson family lives in a small, tight knit community where everyone knows one another and the comings and goings of neighborhood kids rarely go undetected. Their family includes mother, step-father, 15-year old step-son Andrew, 13-year old step-son Jordan, and 5 year old son, Malik. The family has lived in the same neighborhood for most of their lives and the events that led to their son's arrest were not only a tragedy to the family but a shock to the small community. Andrew's arrest and subsequent placement in a locked treatment facility resulted after charges were made against him for his involvement in sexual acts with two young neighborhood boys who lived across the street from his home. He was 13 years old at the time and the other two boys were 9 and 10 years old. Andrew was adjudicated and subsequently sent to an inpatient locked treatment facility for sexual offenders. His family was devastated by the decision of the court and especially upset that he would be sent away for 16 months. The treatment facility where Andrew was sent was a long way from home from his home and because the family had limited resources and was ashamed of what had happened, visitation proved very rare. Andrew's mother, in fact, only visited him twice while he was away, and other family members did not visit him at all. Lack of family contact during his long absence resulted in noticeable symptoms of withdrawal and alienation from his family when he returned to the home. Andrew presented with other problem behaviors including poor school performance, conflict with parents, and using and selling marijuana. The Johnson family was referred for treatment by the Juvenile Justice Probation Officer assigned to the case following Andrew's conditional release from the inpatient facility where he received treatment for his sexual offense. As is often the case because of available funding streams in communities, with youth presenting with a range of problem behaviors, referral was made to an outpatient adolescent drug abuse and delinquency treatment unit.

Once the referral was made, the BSFT therapist contacted the family within 48 hours as expected of BSFT therapists when engaging a family. On this first call, the BSFT therapist reached the mother, the biological guardian, who had some reluctance about speaking with the therapist—said she wasn't feeling well and would prefer to speak at another time. The

BSFT therapist insisted they speak, using a warm tone that expressed her desire to support the family. The mother shared with the therapist her complaints about her son's behavior. The mother explained she wasn't happy that Andrew was keeping to himself and hardly engaging with the rest of the family and that they were at the end of their rope as to what to do. The BSFT therapist listened, validated and reframed mom's complaints as concern and deep caring for her son and expressed to her that it would be very helpful to invite her husband and the rest of the family to explore how to unify the family and heal from the events surrounding her son's arrest. The mother accepted the reframe of care and concern and agreed with the therapist that she did want her family to reconnect and indeed needed more support from her husband, Andrew's stepfather. The BSFT therapist used this window as an opportunity to inquire about how the mother could invite her husband and sons to the sessions. The mother, however, said that "my husband works long hours and I don't want to bother him because he gets upset—he does enough for the family already and I know he won't want to come and the boys are in school and I know they won't want to participate."

BSFT therapists work with limited information during the process of joining and tracking an initial call, thus the BSFT therapist needs to ask appropriate questions that will elicit the essential data needed to assess the family's pattern of interaction, particularly those patterns of interaction central to reluctance to treatment. The mother's comments are important information for the BSFT therapist because, though it is not possible at this point to observe how the mother interacts with family members, the therapist can infer some interactional patterns that might contribute to a family's reluctance to participating in sessions. In this case, either the mother felt that she would be unable to bring the stepfather to therapy or more likely she was a bit ambivalent about bringing him to therapy. The therapist determined, therefore, that she must reach out to other family members directly to secure full family participation in treatment. BSFT therapists are aware that there are two important systemic concepts in engagement of families, namely that 1) the same family dynamics that are associated with the symptom (e.g. acting out behaviors), also cause "resistance" to engagement; and 2) clinicians behaviors affect engagement and retention. To engage families into treatment, BSFT therapists therefore diagnose the failure to engage, use practical strategies to get around resistant patterns and change those patterns later during treatment.

Working from the mother's responses, noting her ambivalence, the BSFT therapist asked for the mother's permission to contact her husband directly, offering to spare her the anxiety of having to invite her husband to the session. The therapist states, "I wonder if you will allow me to speak to your husband directly to invite him to the sessions since I do not want to add more to your very full plate." The mother proceeds to describe how overwhelmed she has been feeling and how she does not get much of an opportunity to vent her worries and concerns to anyone—especially her husband. The therapist follows with, "it sounds like by getting your husband to attend the sessions you will have an opportunity to let him know ways in which he can support you—talking about your worries and concerns might be one way that he can do that. I also sense that you want to protect your husband from worry and you very often keep things to yourself even though you really need him—I can tell you care for him very much." The mother expressed appreciation that the therapist had listened to her patiently and had been so supportive. She was reluctant to have the therapist call the father

directly and said that she would try on her own to convince her husband. Hence, the therapist was able to overcome the mother's ambivalence about asking her husband to come to the session, in large part by being supportive and by reframing the mother's ambivalence as her profound caring for her husband. The therapist then coaches the mother to invite her husband by letting him know how much she cares for him and how much it would mean to her if he could do this for the family. The BSFT therapist highlights once again the importance of his participation in the sessions. Listening without blaming and positive reframing can be powerful in persuading family members to change an initial reluctant stance. The reframe communicated to the mother that the BSFT therapist was working collaboratively with her and wanted to offer her much needed support. An invitation to the home made it evident to the BSFT therapist that she had been successful in overcoming a first hurdle to engagement, the mother blocking access to other family members.

The BSFT model identifies four frequently occurring family patterns found in families with problem adolescents (these may change by cultural group). These include: 1) Powerful Identified Patient; 2) Contact Person Protecting the Structure; 3) Disengaged Parent; and, 4) a family secret that one or more members of the family do not want discussed in the family. The most frequently observed pattern is characterized by an identified adolescent patient who has a powerful position in the family and whose parents are unable to bring into treatment. This is typically the case with drug using and/or delinquent adolescents over whom the parents have lost all ability to influence their behaviors. In this case, the therapist offers to reach out directly to the powerful adolescent to engage her/him in treatment. This pattern is not evident in the case of the Johnson family as Andrew agreed to participate in treatment. The second most common pattern is characterized by a parent (usually the mother) who is ambivalent about bringing other family members into treatment. This mother might give conflicting messages to the therapist, such as, "I want to connect more with my husband to work through the concerns of our family but he works long hours to support us and I don't want to burden him by asking him to come to therapy." The Johnson family represents a good example of this type of engagement challenge. To bring these families into treatment, the BSFT therapist must form an alliance with the mother, as in the Johnson case, acknowledge her concerns, and ask permission to contact other family members directly. This action circumvents the mother's protective behaviors and allows the BSFT therapist to develop her own therapeutic relationship with other family members to bring them into treatment. While in the case of the Johnson family the mother did not allow direct access to her husband, the therapist's strong supportive stance and positive reframes established an alliance that motivated the parent to get past her ambivalence and invite her husband to the sessions.

The third pattern, the disengaged parent, is characterized by little or no cohesiveness in the parental subsystem and one parent, usually the father, refusing to come into therapy. While the mother in the Johnson case was able to persuade her husband to be present for the first visit with the BSFT therapist, the step-father openly expressed a strong hesitation about participating in treatment. The BSFT therapist in this case was able to directly observe the lack of cohesion in the parental subsystem and identify this maladaptive interaction as a contributing factor to the step-father's reluctance to participation. To strengthen her

engagement effort, the therapist in the first session established a strong therapeutic relationship with the stepfather.

In the fourth pattern found in family's who are difficult to engage, family members worry that dangerous or painful secrets will be revealed during the process of therapy. The sensitive nature of the sexual offense perpetrated by Andrew and the events following his arrest, including rejection by the community, has left family members vulnerable. The idea that therapy will unearth deeply painful feelings and the fear of further exposure may contribute to the Johnson family's hesitation about participation in treatment. In this pattern, BSFT therapists offer family members reassurance that they will address only the issues the family wants to address to allay their anxieties about being "exposed" by the therapist.

Consistent with BSFT approach, the BSFT therapist took the opportunity to join with both parents during the first visit to the home. The mother had been successful in having her husband present during an evening home visit. The therapist said to the husband, "seeing your husband here with you tells me that both of you are invested in making things better for the family." The mother stated that she was able to convince her husband to be home for the session by letting him know that she was aware that Andrew's distancing from the family was upsetting him, that she was feeling the same way and that the sessions could help them be there for one another and help Andrew at the same time. The step-father responded: "I have been very upset with Andrew and I don't like what this is doing to the family—I agreed to be here because I don't like to see my wife upset and I don't want any more trouble from Andrew." While the step-father agreed that he did want things to improve in the family, he also stated, "I'm not sure we need outside help, we are managing as best we can on our own." In an effort to further join with the step-father, the BSFT therapist did not challenge his comments but validated him and reframed by saying, "I can certainly respect what you are saying and appreciate your desire to protect the family." The BSFT therapist understands that to establish a therapeutic alliance, she must not challenge family members, particularly initially. This process aspect of joining requires the BSFT therapist to convey to the step-father that she respects him, understands his perspective and accepts his point of view without criticism or blame. The BSFT therapist assessed that her joining with the step-father was successful once he appeared more at ease and began to open up about his concerns with his step-son including his inability to re-engage with his step-son when he returned home. Andrew was raised by his step-father and both felt very close to one another, so feeling disconnected from his son was painful for Mr. Johnson. While the mother agreed that effort had been made by the step-father, she stated that her husband was hardly around due to work demands and that she often found herself taking care of the family and its challenges on her own. During this conversation, her husband interrupted and stated, "Well I'm the one paying the bills around here and since you are not working, how are we supposed to make ends meet?" The mother became upset and attacked her husband stating, "With everything that's been going on you know that we did not have an option and the boys needed more attention—what else did you expect me to do?" The enactment proved useful to the BSFT therapist because she was able to observe the interaction between the parents. The parents had not come to agreement on how best to manage responsibilities in the family. The therapist was also able to observe that the parents often spoke over each other, were vague, and tended to blame and attack one another.

During this initial visit, while the BSFT therapist made a earnest effort to be joined strongly with the father to engage him into treatment, the BSFT therapist was also cautious to avoid forming too strong an alliance with the parents that might alienate their sons as the boys were not present for that first visit. To achieve this, she limited herself to simple acknowledgement of thoughts and feelings, reframes to create motivation, and identifying common ground so as to establish possible treatment goals. She stated to the parents, “I sense that both of you are in a lot of pain about what has happened and you’ve had to make tough choices. A meeting to include your sons will provide an opportunity to begin to heal, help you to guide your boys, and connect more as a family.” These joining efforts in addition to getting the therapist accepted by the parents, also established the BSFT therapist as the therapeutic leader.

Efforts to engage this family took a process of two and a half weeks. After the initial home visit with the parents, the BSFT therapist made a second meeting with the parents because they were not convinced that they wanted to participate in family sessions. The parents stated at the end of the first visit that they needed to think about it and that were not sure they could convince the boys. The mother also stated, “I feel guilty about not going to visit Andrew while he was away—I’m not sure I’m ready to talk about it with Andrew.” The father stated, “I really don’t know if this is really a good idea to bring all this up again—things have been bad enough. I think we need to let things be.” The BSFT therapist, noting the parents’ hesitation and attempting to preserve the therapeutic relationship, decided not to challenge their position and agreed to give them time to think about it and time to talk to the boys. The BSFT therapist asked the parents if they needed her support in developing a plan to talk to the boys though the parents declined and said that they could handle this on their own.

In addition, the BSFT therapist reassured the parents that although she was aware of the reason for the referral (Andrew’s earlier sexual offense, and current use and selling of marijuana), she was most interested in supporting the parents’ goals to reconnect and heal as a family. The therapist reassured the parents that she would not initiate a discussion of the issues surrounding the sexual offense because it was clear that the parents wanted to put this behind them. Without such reassurance from the therapist, the parents might experience further reluctance to participation in the sessions. By doing this, the therapist was able to secure a second visit with the parents a week later.

During the second visit, the BSFT therapist supported the parent’s desire for Andrew to do well by saying “you have waited 16 long months to get your boy back and you don’t want to lose him again—you have shared with me all the tears you have shed. I want to help you get your son back and get your family back and I need all of you to make that happen.” The parents were visibly moved by the therapist’s words and responded that even though they had spoken to the boys and that Andrew had been difficult to convince, they understood more than ever that this process required their commitment and they were going to make it—they “did not want to lose their boy again.” The BSFT therapist was then, successful in negotiating with the parents to participate in 12 sessions (BSFT treatment typically takes place once a week for approximately 12–16 weeks). She explained to the parents the commitment they would need to make for the treatment to be effective and the importance

of inviting their boys to the sessions for the family to address their concerns directly and work together to reach solutions. In addition to restoring the family, the therapist and the parents agreed that they wanted to reduce the conflict between Andrew and the parents, eliminate Andrew's use and selling of marijuana, and correct Andrew's disinvestment in school.

The family participated in weekly sessions and despite the step-father's initial reluctance, he actively participated in 9 of the 12 sessions. Andrew participated in all 12 sessions. The therapist determined that the most reluctant family members were Andrew and the step-father, and thus the therapist made considerable efforts to continue to join with all family members, and especially with Andrew and his father. Andrew was reluctant to participate, often stating, "I don't know why I have to be here. I don't want to talk about this. This is stupid." The therapist employed the same joining strategies of not challenging and rolling with his resistance. She responded to Andrew, "I realize that as a teenager there are plenty of places you'd rather be but I am glad you are sitting here with your family. It lets me know that despite all that has happened you still care about your family." BSFT therapists employ "*fearless empathy*" to create a motivational context for family members to participate in treatment and to change their behaviors toward each other. When employing "*fearless empathy*" BSFT therapists boldly address the process in the moment that is relevant and meaningful to the family. They do not minimize, ignore, or avoid intense emotions that emerge in the session because emotions-whether positive or negative- reflect the strength of the bond between family members; negative emotions, typically the strongest emotions, reflect the strength of the connection between family members, and can be reframed as such.

No engagement effort is without additional hurdles. After successfully engaging all family members into treatment, and having all the family attend for three weeks, , the step-father began to miss sessions. He avoided the BSFT therapist and was also not responding to his wife's requests to come to the sessions. The Johnson family had signed a release of information form at intake, allowing the BSFT therapist to exchange information pertaining to attendance and case progress with the Juvenile Justice Probation Officer and the Officer's supervisor. As customary in cases referred through the court system and because this was a court mandated case which required that the therapist report attendance, the therapist communicated about attendance with Andrew's Probation Officer who became concerned about the father missing sessions, and encouraged the BSFT therapist to contact the Supervisor of Probation who was well acquainted with the case. The BSFT therapist had an established relationship with the Probation Officer and knew that invoking his help would assist in overcoming this hurdle. Because attendance is often a challenge with court referred cases, the BSFT model has established a typical way of addressing challenges in attendance: the therapist schedules a meeting with the family and the Probation Officer or the Supervisor. The parents were not surprised about the involvement of the Supervisor of Probation since they were aware that Andrew's behavior and attendance to family sessions was closely monitored by the court. They agreed to the meeting and with the support of the BSFT therapist facilitating the exchange, the father reached an agreement to participate in subsequent sessions. Engaging and maintaining families in treatment requires a range of

intervention approaches to overcome a family's concerns or a family member's reluctance to participating in treatment.

Once the BSFT therapist engages a family in treatment, the delivery of the intervention uses the same domains used during engagement (joining, tracking and diagnosing, reframing) plus a fourth domain, called restructuring. Early sessions are characterized by *joining* interventions that are intended to establish a therapeutic alliance with each family member and with the family as a whole. As our research demonstrates, during engagement and joining it is essential for the therapist alliance with the parent (usually father figure) and the identified troubled adolescent be balanced to prevent either one from dropping out of treatment (Robbins et al., 2003). During this joining phase the BSFT therapist creates a therapeutic context where family members interact in their typical style. This gives the therapist an opportunity to observe family member interactions directly to *track and diagnose* family strengths and weaknesses and develop a treatment plan. In the case of the Johnson family, family members frequently directed their comments towards the BSFT therapist. To encourage direct interaction among family members, the BSFT therapist used spring boarding (using the comments of one family member to elicit a response from another) to gently guide family members to address one another directly. For example, when the mother said, "I don't like that Andrew keeps to himself" the therapist asked the mother to tell Andrew directly. As is common the mother would say to the therapist "but I have told him many times" to which the therapist would respond, "I know, and I would like you to do it here within the session." Once mother tells Andrew directly, the therapist can observe how Andrew responds, and as mother and son speak with each other, they eventually behave as if the therapist was not there allowing the therapist to observe communication patterns, thereby diagnosing both family strengths and also maladaptive interactions that might be contributing to the symptoms (undesirable outcomes that the family would like to get rid of but does not know how). For example, in the case of the Johnson family, the BSFT therapist was able to observe that the Johnson parents often blamed one another for the way Andrew behaved. This enactment gave the therapist the opportunity to observe the communication between the parents that prevented them from collaborating in parenting functions effectively, and how Andrew became vulnerable to the fury that parents had for each other as they attacked each other; in frustration, the parents would turn their frustration and anger with each other on Andrew. Andrew's reaction was usually to shut down and become even more distant from his parents, not surprisingly, the behavior about which the mother expressed greatest concern at the onset of therapy.

The negative affect that emerges from these types of exchanges is addressed through the use of a number of intervention techniques, one of which is *reframing*, the third domain in the change process. Reframing interventions are used to reduce negativity in the family and it is the best known strategy for transforming negative interactions into positive ones without losing rapport (Robbins, Alexander, & Turner, 2000). Transforming negativity in the Johnson family is crucial to create a motivational context for the family to reach desired goals such as improved connection, healing and support; and to re-engage Andrew into the family. Examples of reframes with the Johnson family are: (to the parents) "I can see that this family is in a great deal of pain as you try to figure out how to improve your family's

wellbeing, even though there is so much hurt—I can hear how much you want things to get better.” When Andrew became very quiet and withdrew in the session the BSFT therapist offered this reframe: “I get the feeling that you get very quiet because you want to protect your parents from your pain and you want to spare them from worrying.” Well delivered reframes motivate family members to see one another in a different light that creates a motivational context for change. That is, it opens opportunities for family to see their own behavior and that of others differently, and thus to behave in new ways.

The fourth domain in the change process, *restructuring*, refers to techniques by which the BSFT therapist orchestrates and directs change by helping families move from their maladaptive patterns of interaction to more adaptive ones. The Johnson’s family maladaptive pattern of triangulation became an important target of change. The BSFT therapist used therapeutic tasks to guide the Johnson parents to engage in direct dialogue to address their concerns and reach resolution without involving Andrew in their conflict. The BSFT therapist gave the Johnson parents the following task: “Talk together as to how you can support each other to better guide your boys because you don’t always seem to be on the same page.” The parents started to express discussed their ideas about Andrew, but soon reverted to their old pattern and step-father involved Andrew by saying, “you just need to start going to school regularly and listen more to your mother and I.” The BSFT therapist gently redirected the step-father by stating: “Dad, I know you want Andrew to do the right thing, but first let’s get you and your wife on the same page—she has said on several occasions that she desperately needs your support and this is your opportunity to offer it to her.” BSFT therapists block the “old behaviors” to make way for the new by guiding family members to stay focused and complete the task at hand.

Once the parents were able to complete the task, the BSFT therapist praised their successful completion of the task by highlighting the strengths of the newly observed more supportive interaction. For instance, after the father listened to his wife’s suggestions without criticism and offered some of his own expressing his desire to work better as a team and the mother stretched out her hand to him and responded how much his support meant to her, the BSFT therapist said: “I can see that when the two of you really focus on one another you can come up with great options to support one another—when you collaborate you do a terrific job in coming up with ideas that you can both agree to on how to guide your boys.” The therapist continued to work toward strengthening parental alliance and support while blocking parents from “dragging” Andrew into their discussion, and blocking Andrew from interrupting the parents’ discussion. Once this task is successfully completed, practice is essential. Hence the therapist will ensure that this task- of parents working together without allowing Andrew to get involved, is repeated several times during treatment until the parents have consistently adopted this new patterns of interactions.

The BSFT therapist also addressed the connection between Andrew and his parents through the use of reframes and therapeutic tasks, encouraging them to express their thoughts and feelings directly. The BSFT therapist offered the following reframe: “Ignoring what hurts us doesn’t really make the hurt go away, sometimes it’s best to share it with the people who love us so they can help us get through it—this is what I am asking you to today so that together you can get past this hurt and connect better as a family.” The BSFT therapist asked

Andrew and his parents to share the pain they felt while Andrew was away: “talk together about what life was like when you were separated—thoughts and feelings you experienced—feelings you still have today.” As the Johnsons began to interact without attacking or blaming but sharing feelings openly and directly and expressing words of care, the therapist noticed that Andrew seemed less defensive and more open with his parents. Andrew, for example, later shared with his parents that he had been selling marijuana and using with his friends. Andrew appeared contrite and the BSFT therapist used this disclosure as an opportunity to strengthen the connection between Andrew and his parents since he trusted them enough to open up. The therapist highlighted the importance of what Andrew had done in saying “what you just said, Andrew, tells me that you really want to connect with your parents and that you want their support. You are letting them know that you need them.” To the parents, she stated “your son is reaching out to you and I am sure it was not easy for him to open up this way, but his reaching out to you lets you know that he needs your guidance and support. BSFT therapists seize moments like the one just mentioned to mobilize family members to behave differently and establish new patterns of interaction—the core of restructuring. The therapist wanted to prevent the parents from responding in their habitual way by attacking Andrew for doing something they did not approve of, and instead highlighted through reframes that Andrew’s sharing his use/selling of marijuana within the family was very positive behavior— a move in the right direction. In fact, for Andrew to continue to be open with his parents, the parents have to reward the behaviors they want to encourage (Andrew telling them what he does) even if they don’t like what he actually does. Hence, we are first focusing on building the relational patterns (accepting that Andrew is open), and placing temporarily in a second place the content of the communication (selling/using drugs).

Once the ability for collaborative parenting has been established and the highways of positive communication and caring between parents and Andrew secured, the therapist helped Andrew discuss how he feels about his using/selling and help the parents to express their views and beliefs about Andrew’s using/selling in ways that Andrew receives their message as caring “we don’t want you to use/sell because we want the best for you. We have dreams of your being successful in life. We worry that if you use you will not do well in school and will hang around friends that will take you down the wrong path. And that if you sell or have marijuana in your possession you will get in trouble with the law. We don’t want you to be arrested again. We want you to have every opportunity in the world, and a record of arrests will close many opportunities to you in the future. Andrew we want the best for you. How can we help you?”

Interactions between family members changed dramatically after Andrew opened up and his parents listened with acceptance of Andrew (not necessarily the behavior). This clearly led to a better emotional connection between parents and Andrew. Toward the end of treatment, Andrew was testing negative for drug use, was doing well in school and spending more time with his parents. He went fishing with his step-father, something they always enjoyed and often did before Andrew was sent away. The case was terminated successfully when the presenting symptom of Andrew’s isolation had disappeared, when Andrew was no longer using and selling drugs, and when the family interactions that have been diagnosed as

maladaptively related to Andrew's problems (e.g., parents unable to collaborate on parenting functions), had been corrected.

Termination in the BSFT model occurs when it is clear that family functioning has improved and adolescent problem behaviors have been reduced or eliminated. The Johnson family received a full dosage of treatment (12 sessions). Improvements were made in family functioning such as parental alliance (parents collaborating and supporting one another), guidance and support to the children improved, triangles were eliminated, effective communication was restored, and emotional connection was re-established. Andrew tested negative for drug use and his academic performance also improved (as evidenced by improved grades and teacher progress reports).

BSFT Engagement: Research Results

The efficacy of BSFT Engagement has been tested in several studies with adolescents with behavior problems and their families. In one study (Szapocznik et al, 1988), Hispanic families with drug abusing adolescents were randomly assigned to BSFT + Engagement as Usual (control condition) and BSFT + BSFT Engagement (experimental condition). The Engagement as Usual condition was modeled after a combination of community-based adolescent outpatient programs' approaches to engagement. The efficacy of BSFT Engagement was measured using two criteria, engaging families to attend the intake session and retaining the families to the completion of treatment. Retention in treatment included as a measure as it is the ultimate goal of engagement interventions and reflects whether the family received an adequate dose of therapy. The results of the study revealed that 93% of the families in the BSFT Engagement condition, compared with only 42% of the families in the Engagement as Usual condition, were engaged into treatment. Moreover, 75% of families in the BSFT Engagement condition completed treatment, whereas only 25% of families in the Treatment as Usual condition did the same. These findings were replicated by Coatsworth, Santisteban, McBride, and Szapocznik (2001) and Santisteban et al. (1996) in two different clinical randomized trials testing the power of BSFT specialized engagement in both achieving engagement and retention.

In a real world effectiveness study in which 480 drug using adolescents and their families from Hispanic, African American and White American backgrounds, were randomized to BSFT or Treatment As Usual across eight community based agencies located throughout the U.S. and Puerto Rico, Treatment as Usual was allowed to vary based on whatever treatment the agency typically provided for drug using adolescents. Seventy two percent of these adolescents were referred for treatment by the juvenile justice system. In terms of *engagement and retention*, families in TAU were 2.33 times (11.4% BSFT; 26.8% TAU) more likely to fail to engage (defined as not completing at least 2 sessions) compared to families in the BSFT condition. Families in TAU were 1.41 times (40.0% BSFT; 56.6% TAU) more likely to fail to retain (defined in this study as completing fewer than 8 sessions) compared to families in BSFT. These differences were statistically significant and were consistent across the three major racial/ethnic groups in the study: African Americans, Hispanic Americans, and White Americans.

Policy Implications

BSFT strategies for engaging families into treatment to improve adolescent problem behaviors such as substance use present several implications for public health policy. A considerable amount of research over the past three decades demonstrates that family involvement represents a critical component to improved outcomes for treatments addressing problem behaviors in adolescents (McGillicuddy, Rychtarik, Duquette, & Morsheimer, 2001; O'Farrell & Fals-Stewart, 2003, Szapocznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1983, Waldron et al., 2007). In fact, recent studies have shown that youth and family servicing systems that have demonstrated the most effectiveness in addressing adolescent substance use, for instance, have been those that have recognized the necessity of family involvement in treatment (Hornberger & Smith, 2011). Public health systems and organizations therefore, would be wise to include policies that emphasize the involvement of families in the treatment of adolescents.

The BSFT strategies for engaging families into treatment such as those seen in the Johnson case provide a useful template for a public health approach to adolescent problem behaviors. When a family needs treatment, the BSFT public health model ensures that the family receives that treatment. Rather than rely solely on the family's motivation for improvement, or the family's own abilities to get itself into treatment, the BSFT model encourages therapists to reach out to actively engage families into treatment and to persevere through obstacles to increase the likelihood of participation and thus, better outcomes. Applied widely, this approach that strategically engages families in treatment would likely increase the effectiveness of interventions targeting adolescents. Hence the use of BSFT to engage and retain families in treatment could result in improved outcomes, which should always be the goal of the policies aimed at correcting delinquent and drug using adolescent developmental trajectories.

Another important policy issue is reimbursement by case rather than by session. When therapists or agencies are reimbursed per session, they are required to conduct a certain number of sessions per week to cover expenses. This requires therapists to take anyone who will show up, without the opportunity to bring services to difficult to engage families, often the families in greatest need. Reimbursement by case with an emphasis on the quality of the outcome, allows therapists to provide services that would usually not be reimbursed on a session per session basis (such as phone calls to engage family members, driving to the family's home, persistence in the face of no-shows, etc).

Finally, the flexibility of the BSFT approach, in which therapy is often provided outside the traditional work day hours and at more convenient locations such as within the family's home, ensures a greater likelihood for family involvement and subsequent treatment effectiveness. This requires agencies to provide therapist with flexible work schedules, and in fact hire therapist for work with families who are available to work evenings and on Saturday.

The person-centered and family-centered approach of the BSFT model focuses on outcomes, a focus recommended for policies around prevention and treatment of troubled youth.

CONCLUSION

Brief Strategic Family Therapy presents a systems approach to addressing adolescent problems behaviors by utilizing structural, strategic interventions targeting interactional patterns of the entire family. The systemic approach of the BSFT approach suggests that the family relationship patterns that prevent families from achieving their goal of helping their adolescents also contribute to failure to participating in treatment. As seen in the case of the Johnson family, the same strategies used in the BSFT intervention can also be utilized to engage families into treatment. The BSFT service delivery model described here has important implications for public health as its empirically supported effectiveness demonstrates that employing the specific strategies for engagement can improve the likelihood of family involvement and retention in the treatment of adolescents and consequently, better outcomes.

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Figure 1.
BSFT Circular Theory of Change