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Taking Brief Strategic Family Therapy from bench to trench: evidence generation across translational phases

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Abstract

In this article we review the research evidence generated over forty years on Brief Strategic Family Therapy illustrating the NIH stages of intervention development and highlighting the translational process. Basic research (Stage 0) led to the discovery of the characteristics of the population and the nature of the problems that needed to be addressed. This step informed the selection of an intervention model that addressed the problems presented by the population, but in a fashion that was congruent with the population's culture, defined in terms of its value orientations. From this basic research an intervention that integrated structural and strategic elements was selected and refined through testing (Stage I). The second stage of translation (Stage II) included efficacy trials of a specialized engagement module that responded to challenges to the provision of services. It also included several other efficacy trials that documented the effects of the intervention, mostly in research settings or with research therapists. Stages III/IV in the translational process led to the testing of the effectiveness of the intervention in real world settings with community therapists and some oversight from the developer. This work revealed that an implementation/organizational intervention was required to achieve fidelity and sustainability of the intervention in real world settings. The work is currently in Stage V in which new model development led to an implementation intervention that can ensure fidelity and sustainability. Future research will evaluate the effectiveness of the current implementation model in increasing adoption, fidelity, and long-term sustainability in real world settings.

Keywords

Brief Strategic Family Therapy; Adolescent substance use; Translational research

Translational research focuses on understanding the scientific and operational principles underlying the process involved in turning observations in the laboratory, clinic, and community into interventions that improve the health of individuals and the public. However, translational research has taken different meanings for different researchers (Woolf, 2008; Rubio et al., 2010). In behavioral intervention research, several

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conceptualizations share the notions of steps, stages, or phases for intervention development and testing, but models differ in what stages they include and in the way they number and name their stages. While models typically agree that efficacy and effectiveness research vary along a continuum from maximizing internal validity to maximizing generalizability, they differ in the importance and the role of theory and basic research in intervention development and in the point at which they emphasize a focus on implementation. The NIH stage model was created to define and refine the activities involved in behavioral intervention development and it stresses that “intervention development is not complete until an intervention reaches its maximum level of potency and is implementable with a maximum number of individuals in the population for which it was developed” (Onken, Carroll, Shoham, Cuthbert, & Riddle, p. 26). In particular, this model heightens the significance of testing interventions in the community prior to the full effectiveness testing, emphasizes the importance of considering the intervention’s ease of implementation as early as possible in the intervention development process, and underscores the value of examining mechanisms of behavior change in every stage of intervention development. Under this model development of a behavioral intervention is composed of six stages: basic science (Stage 0), intervention generation, refinement, modification, and adaptation and pilot testing (Stage I); traditional efficacy testing (Stage II); efficacy testing with real-world providers (Stage III); effectiveness research (Stage IV) and; dissemination and implementation research (Stage V). Some important considerations with respect to this model is that it is iterative, non-recursive, multidirectional and is not prescriptive, that is, it does not require that research is done in a pre-specified order, rather, what is required is that researchers adequately justify the logic of their proposed sequence.

Several family-based treatments for adolescent substance use and behavioral problems have proven to be effective (Tanner- Smith, Wilson, & Lipsey, 2013; Hogue, Henderson, Ozechowski, & Robbins, 2014), are far along the NIH stages of intervention development, and are being implemented broadly (Horigian, Anderson & Szapocznik, in press). Brief Strategic Family Therapy (Szapocznik, Hervis & Schwartz, 2003) is a family treatment model developed and tested for nearly 40 years at the University of Miami’s Center for Family Studies for youth with behavior problems such as drug and alcohol use, delinquency, association with antisocial peers and unsafe sexual behaviors. BSFT is an *integrative* model that combines structural and strategic family therapy techniques to address systemic/relational (primarily family) interactions that are associated with adolescent problem behaviors. The structural components of the BSFT treatment draw on the work of Salvador Minuchin (1974; Minuchin & Fishman, 1981), and the strategic aspects are based on work by Jay Haley (1976) and Chloe Madanes (1981). With the use of structural and strategic techniques, the goal of the BSFT model is to change the patterns of family interactions (structural) that allow or encourage problematic adolescent behavior (strategic/problem focused). By working with families, BSFT not only decreases youth problems, but also creates better functioning families (Santisteban et al., 2003). Because changes are brought about in family patterns of interactions, these changes in family functioning are more likely to endure after treatment completion because multiple family members have changed the way they behave with each other. In keeping with the integration of structural and strategic principles, BSFT is a present problem-focused, directive, and practical approach (i.e.,

strategic) – focusing on identifying and enacting the changes in patterns of interactions (i.e., structural) necessary to ameliorate the adolescent's presenting problems. Other family issues, such as problems between the parent figures, are addressed only if they are directly related to the adolescent's drug abuse, problem behavior, or risky sexual symptoms.

Three conceptual principles guide BSFT. The first principle is that the family is a system, where family members are interdependent and interrelated - what one family member says or does affects everyone else in the family. The second BSFT principle is that repetitive family patterns of interaction affect individual family member's development and behavior. Patterns of interaction are defined as the sequential behaviors among family members that become habitual, repeat over time, and are idiosyncratic to a family system. A maladaptive family structure is characterized by repetitive family interactions that persist even when these interactions fail to meet the goals of the family or its individual members. As part of this principle, the BSFT model holds that improvements in family members' experience and behavior require strengthening adaptive family interactions and transforming/restructuring maladaptive family interactions. The third principle reflects BSFT's strategic nature in that therapy is planned, problem focused, and practical (i.e., intended to achieve certain goals).

BSFT is a short-term program usually implemented in 12–16 (range 8– 24) sessions typically delivered once a week for 1 to 1 ½ hours over a 4 month period. The actual number of sessions and length of service are determined by the therapist's ability to achieve the necessary improvements in specific behavioral criteria and severity of family problems. BSFT employs four specific theoretically and empirically supported techniques delivered in phases to achieve specific goals at different times during treatment. Early sessions are characterized by joining interventions that aim to establish a therapeutic alliance with each family member as well as with the family as a whole. The therapist here demonstrates acceptance of and respect toward each individual family member as well as the way in which the family operates as a whole. Early sessions within treatment also include tracking and diagnostic enactment interventions designed to systematically identify family strengths and weaknesses and develop an overall treatment plan. A core feature of tracking and diagnostic enactment interventions includes strategies that encourage the family to behave as they would usually behave if the therapist were not present. Rather than directing comments to the therapist, family members are encouraged to speak with each other about the concerns that bring them to therapy. From these observations, the therapist is able to diagnose both family strengths and problematic relations. Reframing techniques are then used to reduce family conflict and create a motivational context (i.e., hope) for change. Throughout the entirety of treatment, therapists are expected to maintain an effective working relationship with family members (joining), facilitate within-family interactions (tracking and diagnostic enactment), and directly address negative affect/beliefs and family interactions. As treatment progresses, the focus of treatment, shifts to implementing restructuring strategies to transform family relations from problematic to mutually supportive and effective. Restructuring interventions include (i) directing, redirecting, or blocking communication; (ii) shifting family alliances; (iii) helping families develop conflict resolution skills; (iv) developing effective behavior management skills; and (v) fostering parenting and parental leadership skills.

In this special report we present the stages of intervention development for BSFT and the evidence developed at each state of the translational process. The NIH stage model as applied to BSFT is summarized in Table 1.

The Basic Research That Led to BSFT Development- Stage 0

Several studies led to characterizing the population and the nature of the problem which informed the conceptualization of the model and the intervention techniques. Clinical observations of Cuban adolescent behavioral problems and family intergenerational/intercultural conflict in early 1970's made evident the need to better understand the cultural factors contributing to severe intergenerational conflict and drug and behavioral problems of adolescents. The nature of the conflict between parents and their children had a distinct cultural flavor with youth advocating for independence and parents demanding obedience to the old ways. Early formative research conducted at the Center for Family Studies (Szapocznik, Scopetta, Kurtines, & Aranalde, 1978; Szapocznik, Scopetta, & King, 1978; Szapocznik, Scopetta, Arnalde, & Kurtines, 1978) indicated that Cuban families in Miami, tended to value family connectedness over individual autonomy, and that they tended to focus on the present rather than on the past. These findings provided the challenge of developing a treatment model that would align with these values. Additionally this research led to understand intergenerational differences in acculturation as a process that exacerbates family conflict. Studies have documented the value of the family as a central system in adolescent's healthy development (Szapocznik & Coatsworth, 1999).

Development of the BSFT Intervention, Adaptations and Refinement- Stage

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Consistent with the value placed on the family and the intergenerational/intercultural conflicts evidenced by these families, a structural (Minuchin, 1974; Minuchin & Fishman, 1981) approach was selected that addressed the family as a whole, transformed negative affect into bonding, and opened lines of communication and negotiation between the generations. Because the families presented to treatment with a sense of urgency, including a sense that existing problems needed quick resolution and because they tended to have a present orientation, a strategic (Hayley, 1976; Madanes, 1981) application to structural family therapy was selected which was problem focused, practical, and planned. A planned focus on patterns of interactions, permitted therapists not to get lost in the many contents concerning the family, but rather to focus on interactions that were maladaptive - that is, that were preventing the family from achieving their goals (Szapocznik, Scopetta, Kurtines, & Aranalde, 1978).

BSFT Adaptations

As BSFT has been modified and improved across the phases of translation, variations of the treatment model were created in an effort to meet clinical gaps that the earlier model failed to meet. Two of these adaptations are helpful to review for the role that they played in the further development of BSFT and in the field as a whole.

One-person Family Therapy (OPFT)

Prior to developing the specialized BSFT Engagement interventions, other approaches were tested. These aimed at achieving whole family changes in repetitive patterns of interactions while working with less than the whole family unit. One of these approaches was One Person Family Therapy (Szapocznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1983; 1986; Foote, Szapocznik, Kurtines, Perez-Vidal, & Hervis, 1985). This intervention aimed to explore whether improvements in maladaptive repetitive patterns of family interactions could occur while working primarily with one powerful member of the family. Family systems approaches to therapy traditionally assumed that the identified patient's psychopathology is a symptom of underlying maladaptive interactions in the family that acted to sustain the identified patient's symptoms; and that to change these maladaptive patterns of interactions, work with the whole family was required. The goal of one person family therapy was to determine if families indeed needed to be present for maladaptive patterns of interactions to change. In developing one person family therapy, researchers capitalized on the systemic principle of complementarity, which suggests that if one member of a system alters her/his behavior, it will have effects on the other members of the system.

OPFT was delivered by family therapists who were familiar with BSFT. OPFT had the same goals as BSFT, but the intention was to bring about the same changes as conjoint BSFT without having the whole family present for all sessions. Like conjoint BSFT, OPFT was delivered about once a week, for a total of 12 sessions. At most, two of the sessions were allowed to include multiple members of the family. The other sessions included one member of the family with whom the therapist would work who was either a powerful member of the family or a member of the family that was central to family interactions. In contrast to the conjoint BSFT approach, OPFT did not assume that joining needed to occur with each family member. Through role-playing and sketching out family relationships, the therapist was able to observe enactments of family patterns of interactions, discern the role the individual played in these interactions, and to plan how the one person would change her/his behavior to interfere with the family's repetitive patterns of interactions. Through various cognitive exercises such as role reversal and Gestalt guided imagery techniques, the client's internalized representations of their family relationships were altered. The therapist helped the client then identify modifications that they could make to their own behavior within the family. In response to the new behaviors, the family system typically reacted by attempting to keep the client from disrupting the family homeostasis, which often created a systemic crisis. At this time, the whole family was brought in for one of two conjoint sessions. In these conjoint sessions, with a family in crisis, the therapist had the opportunity to apply conjoint BSFT techniques to facilitate changes in the family's repetitive patterns of interactions that were preventing the family from achieving their own goals. Theoretically, family interactional patterns could be changed by working primarily with one client; and motivation was elicited through crises in the whole family to come into a treatment session.

A randomized clinical trial compared OPFT with conjoint BSFT (Szapocznik et al., 1983; 1986; Foot et al., 1985). At four and six month follow-ups both treatments were associated with reduced externalizing, internalizing, and drug use behaviors. There were also improvements in family functioning, measured by blind, independent raters, over time for

both treatments. OPFT performed as well on adolescent and family outcomes compared to conjoint BSFT. This work demonstrated that it was possible to change family interactional patterns and achieved desired adolescent outcomes while working mostly with a key family member. This work, however, was discontinued because teaching OPFT was far more challenging than teaching conjoint BSFT. However, what was learned in working with one person was used to build the Engagement module of BSFT, which requires working with less than the whole family to bring the whole family into treatment.

Family Effectiveness Training (FET)

FET was developed from research on family-based risk factors that are shown to be predictive of adolescent substance use (Szapocznik, Santisteban et al., 1989). The risk factors were specifically identified for Hispanic immigrant families in which intergenerational conflict combined with generational differences in acculturation to undermine parental leadership, which in turn made possible the emergence and maintenance of adolescent problem behaviors. Younger persons, in this case adolescents, tended to acculturate more quickly than older persons, in this case their parents, which led to differences/conflicts across generations in values, attitudes and behaviors that had a clear cultural flavor (Szapocznik, Scopetta, Kurtines, & Aranalde, 1978).

According to family systems theory, a healthy family is flexible enough to accommodate to developmental and cultural challenges, while supporting the growth of each individual member. With this goal, the FET intervention attempted to achieve two general outcomes: the first was to provide the family with the knowledge and skills needed to manage potential developmental conflicts in the future through negotiation skills and by having family members better understand each other's' cultural perspective. Moreover, as families' discussed cultural and intergenerational differences, maladaptive patterns of family interactions that emerged were treated with the BSFT intervention. Through 13 weekly sessions a facilitator created a participatory process in which cultural and intergenerational areas of potential conflict were introduced and discussed by the family. The first component of treatment assisted the family in adapting to their child becoming an adolescent. The second component, engaged the family in discussions and interactions around cultural content, while treating maladaptive patterns of family interaction using the BSFT interventions. These two components were aimed to prevent further intergenerational conflict as the child developed into adolescence.

A randomized trial of the efficacy of FET compared to a minimal contact wait-list control revealed significant relative gains in relevant outcomes. Seventy nine Hispanic families with youth (aged 6–12) were recruited in the Miami area. The youth in the FET group were rated as significantly improved on behavioral problems and the families in the FET group exhibited improved functioning and family environment. Thus, there is evidence that psychoeducation integrated with BSFT interventions are efficacious for the prevention of conflict around developmental and cultural challenges for Hispanic families, can help reduce behavioral problems in children aged 6–12.

Efficacy Testing: Determining the Value of BSFT the Intervention – Stage II

The 1960's and 1970's saw an explosion of adolescent drug use. Nationally, in the late 1970s and early 1980s, there was widespread believe among counselors that families needed to be involved in the treatment of adolescent problem behaviors, but repeatedly counselors complained about their inability to bring families into treatment. In the early model development work, engaging and retaining families of problem adolescents in BSFT treatment was also a challenge. In response, BSFT theory and practice was extended to incorporate the “presenting problem” of the family's lack of engagement in treatment. Clinically, as family members were given the task of bringing whole families into BSFT treatment, this provided an opportunity for examining family structure. Interactional patterns that emerged were viewed as a challenge for the therapist to strategically overcome in order to bring whole families into treatment. The BSFT Engagement module was thus developed with the aim of engaging whole families into treatment. Once the approach was developed, it was tested in three separate studies that used BSFT specialized engagement techniques. In the first study (Szapocznik et al., 1988), Hispanic (mostly Cuban) families with drug abusing adolescents were randomly assigned to BSFT with Engagement as Usual (the control condition) or to BSFT + BSFT Engagement (the experimental condition). The Engagement as Usual condition was modeled after community-based adolescent outpatient programs' approaches to engagement in the Miami area. 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 (defined as attending an admission session). Furthermore, 75% of families in the BSFT Engagement condition completed treatment (defined as the family and the therapist reaching a mutual decision that treatment could be terminated), compared with only 25% of families in the Treatment as Usual condition.

In a second study testing BSFT engagement (Santisteban et al., 1996), families were randomly assigned to a BSFT Engagement or Engagement Control (no specialized engagement) condition. In the BSFT Engagement condition, 81% of families were successfully engaged, compared to 60% of the families in the Engagement Control condition (defined as attending the admission session plus one family therapy session). A key finding of this study was that the effectiveness of BSFT Engagement procedures was moderated by Hispanic nationality. Among the non-Cuban Hispanics (composed primarily of Nicaraguan, Colombian, and Puerto Rican families) assigned to the BSFT Engagement condition, the rate of engagement was high (93%) compared to in to the much lower rate (64%) found in Cubans assigned to this same BSFT Engagement condition. All of these differences were significant. Most of the Cuban families had U.S.-born adolescents, whereas the majority of adolescents from other national backgrounds were foreign-born. Evidence suggests that U.S.-born Hispanic adolescents tend to be more Americanized compared to adolescents born outside the United States (Schwartz, Pantin, Sullivan, Prado, & Szapocznik, 2006). There is also evidence that, in Hispanic families, acculturation to American values and behaviors is associated with decreased orientation toward family (Sabogal, Marin, Otero-Sabogal, Marin, & Perez-Stable, 1987). As a result, it is possible that the lower engagement rate found for Cubans was due to higher rates of Americanization in the Cuban families. It is possible that

more Americanized families perceive less need for family involvement in adolescent drug abuse treatment. This finding resulted in the incorporation of, specific family reconnection strategies, focusing on reorientation toward the importance of family, into the current version of BSFT Engagement.

A third study (Coatsworth et al., 2001) tested the ability of BSFT + BSFT Engagement to engage and retain adolescents and their families in comparison to a *community* control condition. An important aspect of this study was that the control condition was implemented by a community treatment agency and, as such, was less subject to the influence of the investigators. The Hispanic adolescents and families in this study were primarily Cuban or Nicaraguan. Findings in this study indicated that BSFT Engagement successfully engaged 81% of families into treatment – significantly higher than the 61% rate in the community control condition. Likewise, among families who were successfully engaged, 71% of BSFT cases, compared to 42% in the community control condition, were retained to treatment completion.

The efficacy of the BSFT model in reducing behavior problems and drug abuse has been tested in several randomized, controlled clinical trials. In the first trial, Szapocznik and colleagues (Szapocznik, Rio, et al., 1989) randomized 6–11 year old Cuban boys with behavior and emotional problems to one of three conditions: BSFT model, individual psychodynamic child therapy, or a recreational placebo control condition. The two treatment conditions, implemented by highly experienced therapists, were found to be equally efficacious, and more efficacious than the recreational control, in reducing children's behavioral and emotional problems and in maintaining these reductions at 1-year follow up. However, at 1-year follow-up, the BSFT condition was associated with a significant improvement in blind, independently rated family functioning, whereas individual psychodynamic child therapy was associated with a significant deterioration in family functioning.

In a second study, Santisteban and colleagues (Santisteban et al., 2003) randomly assigned Hispanic (half Cuban and half from other Hispanic countries) behavior-problem and drug abusing adolescents to receive either the BSFT model or adolescent group counseling. The BSFT condition was significantly more efficacious than group counseling in reducing conduct problems, associations with antisocial peers, marijuana use, and in improving observer ratings of family functioning. In this study, baseline family functioning was found to be a moderator of treatment effects. For families entering the study with comparatively good family functioning, family functioning remained high in the BSFT condition, whereas it deteriorated in the families of adolescents in group therapy. For families entering the study with comparatively poor family functioning, the BSFT condition significantly improved family functioning, whereas family functioning did not improve in families assigned to adolescent group therapy. Additionally, adolescent group counseling was associated with clinically significant increases in marijuana use.

The efficacy of BSFT was further tested by Nickel and colleagues (2006) in two separate studies on bullying behavior with boys and girls. The study on bullying behavior in boys, found that when compared with supportive listening, BSFT was more efficacious than the

control group in reducing bullying behavior, cortisol levels, state/trait anger and in increasing mental health and social functioning. Likewise a trial involving girls who were bullying others demonstrated that BSFT was more efficacious than supportive listening in reducing bullying, substance use, risky sexual behaviors, anger, interpersonal problems and in increasing mental health and social functioning.

Effectiveness Testing: Examining BSFT Under “Real World” Conditions- Stage III/IV

While BSFT was tested in community settings in a few of the efficacy trials, these trials occurred with research therapists and with complete oversight of the researchers, in line with the intent to maximize internal validity of the intervention. With the intention of maximizing external validity and generalizability, an effectiveness trial (Robbins, Feaster, Horigian, Rohrbaugh et al., 2011) of BSFT was conducted within the National Institute on Drug Abuse’s National Drug Abuse Treatment Clinical Trials Network (CTN). The study compared BSFT and Treatment as Usual (whatever treatment the agency typically provided for drug using adolescents) by randomizing 480 families of adolescents (213 Hispanics, 148 White and 110 Black; 377 male, 103 female) referred to drug abuse treatment at 8 community treatment agencies located around the United States. Seventy two percent of these adolescents were referred for treatment by the juvenile justice system and most of the remaining cases were referred from residential treatment. Sixty nine percent had diagnoses of drug abuse or dependence. Services in both conditions were delivered by therapists in community agencies, but under supervision of the master trainer and researchers. These therapists were randomized within agency to deliver either the BSFT or treatment as usual (TAU). In this intent to treat study design, and consistent with research in BSFT efficacy, BSFT was significantly more effective than TAU in engaging and retaining families in treatment. 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 significant, and were consistent across ethnic groups. It is important to note that therapy took much longer to administer than expected. The usual expectation is that BSFT therapy should last approximately four months, which is consistent with how BSFT is implemented in practice. However, the median length of treatment for those participants who were retained in treatment across both conditions was approximately 8 months. With respect to adolescent drug use outcomes, the effectiveness study showed no significant differences between conditions on the number of drug using days per 28-day periods across the one year post-randomization. However, nonparametric analyses showed that the median number of self-reported drug use days per month at the 12-month follow-up was significantly higher in the treatment as usual condition (3.5 days) than in the BSFT condition (2 days). It is important to note that the median number of drug use days was low and restricted, with an interquartile range between 1 and 3 days of self-reported use per month. Such a restricted range made it difficult to detect statistically significant or clinically meaningful effects. As detailed above, an overwhelming majority of adolescents in the study were referred from juvenile justice or from residential treatment, both of which involved

surveillance and limited opportunities to engage in drug use. These referral sources may have been responsible for the relatively low baseline rates of drug use, and in the case of the juvenile justice referrals, continued surveillance may have been responsible for the low levels of drug use over time.

Patterns of findings for family functioning differed between adolescent and parent reports. The BSFT condition produced significantly greater improvements in parent-reported family functioning (defined as positive parenting, parental monitoring, effectiveness of parental discipline, parental willingness to discipline adolescents when necessary, family cohesion, and absence of family conflict) compared to the treatment as usual (TAU) condition. Adolescents in both conditions reported significant improvements in family functioning, with no statistically significant differences by treatment condition.

Post hoc analyses of the BSFT effectiveness study evidenced that BSFT was more effective than TAU in reducing alcohol use in parents, and that this effect was mediated by parental reports of family functioning. In addition, BSFT as compared to TAU, had its strongest effect in reducing adolescent drug use among youth whose parents used drugs at baseline (Horigian, Feaster, Brincks et al., 2015). A long term follow up of the BSFT effectiveness study found that at a mean of 4.7 years (range 3–7) post-randomization, individuals who were received BSFT reported fewer lifetime arrests ($IRR = .68$) and incarcerations ($IRR = .63$) as well as fewer last-year arrests ($IRR = .54$) and incarcerations ($IRR = .70$) (Horigian, Feaster, Robbins, et al., 2015). They also self-reported lower externalizing behaviors while there were no statistically significant differences in drug use at the follow-up. Despite a lack of differences in substance use, there is evidence for the long-term effects of BSFT on important treatment outcomes.

Therapist Behaviors, Therapy Process, and Outcomes

Process research has demonstrated that negativity in family interactions in the first session leads to failure to retain families in treatment past the first session (Fernandez & Eyberg, 2009); that families are more likely to engage into treatment if negativity is reduced (Robbins, Alexander, & Turner, 2000); and that reframing is the technique that is least likely to damage therapists' rapport (alliance, bond) with family members (Robbins et al., 2006). Process research has also evidenced that that early engagement requires therapists to maintain a balanced bond with the parent (often the father figure) and the problem youth. If, in the first session, the strength of the bond the therapist develops with the parent and the youth is not balanced, this unbalance leads to early dropout from treatment (Robbins et al., 2000). These findings have been incorporated into BSFT treatment as conducted today.

Effects of Therapist Adherence and Behaviors on Treatment Outcomes.

Using data from the BSFT effectiveness trial, Robbins and colleagues (Robbins, Feaster, Horigian, Puccinelli et al., 2011) examined the extent to which BSFT therapists adhered to the BSFT model. To do this, adherence items were assessed along four theoretically and clinically relevant prescribed therapist behaviors: joining, tracking and eliciting enactments, reframing, and restructuring. The scales for the four domains of adherence used in the study

were confirmed through factorial analyses. These items were assessed by trained independent raters who watched randomly selected videos of therapy sessions.

Results of these analyses revealed that higher levels of restructuring and reframing (reducing negativity and creating a motivational context for change) significantly increased the likelihood of families being engaged into treatment. Furthermore, higher levels of each of the four BSFT technique domains, therapist joining, tracking and enactment, reframing, and restructuring predicted significantly higher rates of retention, defined as a family attending at least 8 sessions. As would be expected, joining decreased across time while restructuring increased. Findings revealed that smaller declines in joining and larger increases in restructuring predicted significantly less adolescent drug use at the 12-month follow-up. That is, therapists who were high in joining in early sessions and remained so throughout treatment were associated with “better” adolescent drug use outcomes. Therapists whose attempts to restructure maladaptive family interactions increased most during the course of treatment were also associated with “better” adolescent drug use outcomes. Thus, therapists who failed to maintain high levels of joining and/or implement sufficient numbers of restructuring interventions were less able to affect the youths’ drug use.

These results demonstrated that the specific therapist behaviors prescribed by the BSFT approach are needed to engage families into treatment, retain them, improve family functioning, and reduce adolescent drug use. When therapists did not engage sufficiently in these behaviors, adolescent outcomes tended to suffer. The authors experience during the trial led them to conclude that adherence levels were affected by a number of within-agency systemic factors, including over-burdened therapists and therapists’ lack of embeddedness within dedicated BSFT units. These conclusions have been confirmed in subsequent experience in implementation of BSFT in real-world settings.

Implementation in Widespread Practice- Stage V

The lessons learned from the BSFT effectiveness multi-site trial led to the recognition that providing training to therapists was insufficient to achieve fidelity and sustainability. It was essential to obtain the support of all levels the organization. Therefore, BSFT theory and practice was extended to the agency as a system in which the presenting problem was to obtain organizational support for BSFT adoption, fidelity and sustainability. BSFT, as currently implemented, intentionally executes strategic interventions at the organizational level to ensure successful implementation of BSFT which translates to increased therapist fidelity, improved adolescent outcomes, and long term sustainability. In the current BSFT Implementation model, the agency is viewed as a system, of which the therapist is one member. Because the vast majority of agencies implementing the BSFT program are adopting an evidence-based program for the first time, changes in their standard practices are required to successfully implement the BSFT model. Strategic interventions at the level of the organization can engage the leadership in ways that will overcome barriers to adoption (funding by case rather than by hour), fidelity (allowing adequate time for therapist supervision and training and placing leadership in charge of ensuring fidelity), and sustainability (basing funding on outcomes rather than client hours; Szapocznik, Muir, Duff, Schwartz, & Brown, 2015). Once the leadership accepts their crucial role in implementation,

the BSFT model managers and the agency collaborate on therapist selection and the agency establishes a dedicated BSFT unit. Agency leaders regularly receive information on fidelity and it is their responsibility to ensure that therapists achieve and maintain fidelity. The BSFT Institute team supports the agency leadership with extensive training, supervision of therapists and fidelity feedback to therapists, middle management and upper management. To support sustainability, one of the BSFT therapists in training is identified conjointly by the agency and the BSFT Institute to become the BSFT on site supervisor. The role of this person is to advocate for BSFT within the agency as well as to ensure long term fidelity among the other BSFT therapists. Critical to the sustainability of the model is licensing the agency's BSFT unit. A decade earlier, the model called for certifying therapists. However, this led to therapists shopping around for other jobs using their new credentials, and they often quickly left the agency for better paying positions, thereby threatening the sustainability of the model at the target agency. Agencies, rather than therapists, are now granted a license to practice the BSFT model once staff have been trained to a pre-designated level of competency and once the agency possesses the necessary resources to implement the model. Part of the work of sustainability is ensuring that therapists trained in the BSFT model receive adequate compensation, commensurate with their new competencies. Current implementation of BSFT has achieved sustainability in a number of sites for over six years. In addition, agency data suggests improved engagement and retention of families, and improved outcomes in a range of populations, including delinquent adolescents and families in the welfare system in which the outcome is retention of the youth within the home without additional incidents.

Conclusions and Future Directions

Brief Strategic Family Therapy as implemented today is the result of forty years of the interplay between theory, clinical practice and research. This special article describes how clinical observation informed subsequent steps of research and how research has shed light on how to design effective translation. Originally developed to address conflicted parent and adolescent relationships in Hispanic immigrant families, the model has evolved and been tested in response to specific clinical needs: specialized engagement techniques were added to bring reluctant families into treatment, reframing became increasingly prominent as a way to reduce negativity, increase motivational context for change, and increase engagement and retention; and an implementation program, supported by the creation of the BSFT Institute was established. The model has now been tested with a broad range of racial/ethnic populations and target problems. The experience of BSFT implementation with the insights provided by the effectiveness trial made clear that an organizational-level systemic approach is critical in ensuring successful adoption, fidelity, and sustainability of BSFT. This approach is used in BSFT implementation today. Future research in BSFT will assess the full model as implemented today, including specialized engagement folded within BSFT, and an organizational implementation intervention that views the agency as a system in which problem focused interventions are conducted to achieve the support of agency leadership in ensuring successful adoption, therapist fidelity, and sustainability of the model over time. Future research can also aid to rigorously document the cost effectiveness of BSFT implementation.

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Table 1:

NIH intervention development stages as applied to BSFT

STAGES OF BSFT DEVELOPMENT		PUBLISHED RESULTS
STAGE 0	Characteristics of Population	<ul style="list-style-type: none"> Cuban immigrants hold cultural values such as family, hierarchy, and present orientation (Szapocznik Scopetta, Kurtines, & Aranalde, 1978).
	Family process	<ul style="list-style-type: none"> Intergenerational acculturation conflict occurs within immigrant families (Szapocznik, Scopetta, & King, 1978).
STAGE I	Intervention Conceptual Model	<ul style="list-style-type: none"> Family problems can be understood from a systems perspective that explores interdependency between members and repetitive patterns of interaction that form the family structure. Therapy would be most effective if it was planned, practical, and problem focused (Szapocznik, Scopetta, Aranalde, & Kurtines, 1978).
	Design of the Intervention	<ul style="list-style-type: none"> Brief Strategic Family Therapy is made up of different components: Joining, tracking and eliciting, diagnosing, reframing, and restructuring (Szapocznik & Kurtines, 1989; Szapocznik, Hervis & Schwartz, 2003).
	Model adaptations and refinement	<ul style="list-style-type: none"> A one-person family therapy adaptation was created to deal with the challenges of bringing whole families into treatment (Szapocznik et al., 1983).
		<ul style="list-style-type: none"> Family Effectiveness Training was developed to confront the challenges of acculturation and intergenerational differences for Hispanic immigrant families (Szapocznik, Santisteban, et al., 1989).
STAGE II	Efficacy	<ul style="list-style-type: none"> Specialized techniques for engagement and retention were developed and tested (Szapocznik et al., 1988; Santisteban et al., 1996; Coatsworth et al., 2001).
		<ul style="list-style-type: none"> BSFT resulted in improved family functioning relative to psychodynamic therapy, thus preventing iatrogenic effects (Szapocznik, Rio, et al. 1989).
		<ul style="list-style-type: none"> BSFT, relative to group therapy, reduced drug use and conduct problems while it improved family functioning – again, preventing iatrogenic effects (Santisteban et al., 2003).
		<ul style="list-style-type: none"> BSFT, relative to supportive listening, reduced bullying and state/trait anger while it improved mental health and social functioning in boys (Nickel, Muehlbacher, et al., 2006).
		<ul style="list-style-type: none"> BSFT, relative to supportive listening, reduced substance use, bullying, and sexually risky behaviors while it improved mental health problems in girls (Nickel, Luley, et al., 2006).
STAGE III/IV	Effectiveness	<ul style="list-style-type: none"> BSFT, relative to treatment as usual, reduced externalizing behaviors, arrests and incarceration while it improved engagement, retention, and family functioning (Robbins, Feaster, Horigian, Rohrbach, et al., 2011; Horigian, Feaster, Robbins et al., 2015).
		<ul style="list-style-type: none"> Adherence to manualized BSFT predicted all outcomes (Robbins, Feaster, Puccinelli et al., 2011).
STAGE V	Implementation in Real world settings	<ul style="list-style-type: none"> The BSFT Organization implementation intervention is necessary to achieve fidelity and sustainability of BSFT (Szapocznik et al. 2015).