Name of Program/Strategy: Brief Strategic Family Therapy

Report Contents

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1. Overview and description

Brief Strategic Family Therapy (BSFT) is designed to (1) prevent, reduce, and/or treat adolescent behavior problems such as drug use, conduct problems, delinquency, sexually risky behavior, aggressive/violent behavior, and association with antisocial peers; (2) improve pro-social behaviors such as school attendance and performance; and (3) improve family functioning, including effective parental leadership and management, positive parenting, and parental involvement with the child and his or her peers and school. BSFT is typically delivered in 12-16 family sessions but may be delivered in as few as 8 or as many as 24 sessions, depending on the severity of the communication and management problems within the family. Sessions are conducted at locations that are convenient to the family, including the family's home in some cases. Hispanic families have been the principal recipients of BSFT, but African American families have also participated in the intervention.

BSFT considers adolescent symptomatology to be rooted in maladaptive family interactions, inappropriate family alliances, overly rigid or permeable family boundaries, and parents' tendency to believe that a single individual (usually the adolescent) is responsible for the family's troubles. BSFT operates according to the assumption that transforming how the family functions will help improve the teen's presenting problem.

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2. Implementation considerations (if available)

BSFT's therapeutic techniques fall into three categories: joining, diagnosing, and restructuring. The therapist initially "joins" the family by encouraging family members to behave in their normal fashion. The therapist then diagnoses repetitive patterns of family interactions. Restructuring refers to the change-producing strategies that the therapist uses to promote new, more adaptive patterns of interaction.

3. Descriptive Information

Areas of Interest	Mental Health Promotion Mental Health Treatment Substance Abuse Prevention Substance Abuse Treatment
Outcomes	1: Engagement in therapy 2: Conduct problems 3: Socialized aggression (delinquency in the company of peers) 4: Substance use 5: Family functioning
Outcome Categories	Drugs Family Relationships Mental Health Social Functioning Treatment/Recovery Violence
Ages	6-12 (Childhood) 13-17 (Adolescent)
Genders	Male Female
Races/Ethnicities	Black or African American Hispanic or Latino
Settings	Outpatient Home
Geographic Locations	Urban

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Implementation History	BSFT has been in use and under continual development for approximately 30 years. It has been implemented at approximately 110 sites in the United States, as well as in Chile, Germany, and Sweden, and has served more than 2,600 families.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
Adaptations	Originally developed for Hispanic families, BSFT has been adapted for use with other ethnic populations, including African American, German, and Swedish families. BSFT also has been widely used with White families; research is currently ongoing with this population.
Adverse Effects	Among 900 individuals, seven adverse events were determined to be related to the delivery of BSFT. Four events were classified as "runaway." These events were determined to be related to the intervention because the adolescent ran away from home during or immediately after a session. For two events classified as "violence (victim/exposure)," a physical altercation between at least two family members occurred during a therapy session when family members became agitated. The single "arrest" event occurred at the conclusion of one of these two events when a family member was arrested and detained by police.
IOM Prevention Categories	Indicated

4. Outcomes

Outcome 1: Engagement in therapy

Description of Measures	Engagement was defined as attendance by the adolescent and at least one adult family member at the intake session and one therapy session within a 4-week period following initial contact.
Key Findings	In one study, families who received BSFT were significantly more engaged in therapy than families in the comparison groups, who received standard family therapy or standard group therapy ($p < .006$). Two other studies resulted in similar findings, with families receiving BSFT being significantly more engaged in therapy than control families receiving individual and family therapy ($p < .05$) and control families receiving standard family therapy ($p < .0001$), respectively.

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Studies Measuring Outcome	Study 1, Study 4, Study 6
Study Designs	Experimental
Quality of Research Rating	3.4 (0.0-4.0 scale)

Outcome 2: Conduct problems

Description of Measures	Conduct problems were measured using the Conduct Disorder subscale of the Revised Behavior Problem Checklist (RBPC). The subscale consists of 22 items that focus on physical aggression, difficulty controlling anger, open disobedience, defiance, and oppositionality. For each adolescent, an informed observer, such as a parent or guardian, rated the severity of each behavior on a 3-point scale (0 = no problem, 1 = mild problem, 2 = severe problem).
Key Findings	In one study, adolescents who participated in BSFT showed a significantly greater reduction in conduct problems than adolescents in the comparison condition, who received a participatory- learning group intervention ($p < .01$). In another study, adolescents receiving BSFT showed a significant reduction in conduct problems ($p < .001$).
Studies Measuring Outcome	Study 2, Study 3
Study Designs	Experimental, Pre-Experimental
Quality of Research Rating	3.4 (0.0-4.0 scale)

Outcome 3: Socialized aggression (delinquency in the company of peers)

Description of Measures	The Socialized Aggression subscale of the RBPC was used to assess adolescents' delinquent behaviors in the company of peers. The subscale consists of 17 items that focus on conduct--membership, stealing, and lying. For each adolescent, an informed observer, such as a parent or guardian, rated the severity of each behavior on a 3-point scale (0 = no problem, 1 = mild problem, 2= severe problem).
Key Findings	In one study, adolescents who participated in BSFT showed a significantly greater reduction in socialized aggression than adolescents in the comparison condition, who received a participatory- learning group intervention ($p < .01$). In another

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	study, adolescents receiving BSFT showed a significant reduction in socialized aggression ($p < .001$).
Studies Measuring Outcome	Study 2, Study 3
Study Designs	Experimental, Pre-experimental
Quality of Research Rating	3.4 (0.0-4.0 scale)

Outcome 4: Substance Use

Description of Measures	Alcohol and other drug use was measured using the following instruments: • Items from the Addiction Severity Index (ASI) measuring the number of days respondents used various drugs during the month prior to assessment • The Alcohol and Drug Use scale of the Adolescent Drug Abuse Diagnosis (ADAD), a 150-item structured interview instrument with a 10-point severity rating for each of nine life problem areas • The Drug Use subscale of the Adolescents' Risk-taking Behavior Scale (ARBS), with scores ranging from 0 to 4 on each scale, 4 indicating the most marked risk-taking behavior
Key Findings	In one study, adolescents who participated in BSFT showed significantly greater reductions in marijuana use than adolescents in the comparison group, who received a participatory-learning group intervention ($p < .05$). In another study, adolescents receiving BSFT showed a significant reduction in overall substance use ($p < .05$). In a third study, adolescent girls who participated in BSFT showed significantly greater reductions in substance use at posttest ($p < .001$) and at the 1-year follow-up ($p < .05$) than adolescent girls in the comparison group, who received an intervention consisting of structural, detailed question sessions.
Studies Measuring Outcome	Study 2, Study 3, Study 7
Study Designs	Experimental, Pre-Experimental
Quality of Research Rating	3.0 (0.0-4.0 scale)

Outcome 5: Family functioning

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Description of Measures	Family functioning was measured using the following instruments: • The adolescent- and parent-reported Cohesion and Conflict scales from the Family Environment Scale (FES). The Cohesion scale measures the extent to which the adolescent and parent view the family as harmonious and close. The Conflict scale measures the extent to which the adolescent and parent view the family as characterized by frequency of quarrels and disagreements. • The General Scale of the Family Assessment Measure, which consists of 50 items focusing on the family as a system and provides an overall score of family functioning, rated by any member of the family. • The Structural Family Systems Rating (SFSR), a measure of family interactions as reported by an observer (i.e., a clinical psychologist or other trained staff). It consists of five scales: structure (the family's organizational system and flow of communication), resonance (closeness, distance, and boundaries between family members), developmental stage (age appropriateness of family members' behaviors), identified patient-hood (the extent to which a family member, usually the adolescent, is labeled as the family's "problem"), and conflict resolution (the extent to which the family is able to resolve differences of opinion).
Key Findings	In one study, adolescents who participated in BSFT reported significantly better family functioning on the FES Cohesion scale than adolescents in the comparison group, who received a participatory-learning group intervention ($p < .05$). Families in the BSFT group also showed significantly greater improvement on overall SFSR scores than families in the comparison group ($p < .05$). In another study, reports by both parents and adolescents who received BSFT showed significant improvements in family functioning on the General Scale of the Family Assessment Measure ($p < .001$ for both parents and adolescents). The effect sizes were medium for the parent report (Cohen's $d = 0.58$) and small for the adolescent report (Cohen's $d = 0.42$). In a third study, families receiving BSFT demonstrated significantly better family functioning on the SFSR at the 1-year follow-up than families assigned to either an individual psychodynamic child therapy group or a recreational control condition ($p < .02$).

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Studies Measuring Outcome	Study 2, Study 3, Study 5
Study Designs	Experimental, Pre-experimental
Quality of Research Rating	3.2 (0.0-4.0 scale)

5. Cost effectiveness report (Washington State Institute of Public Policy – if available)

Benefits minus cost, per participant Source: Return on Investment: Evidence-Based Options to Improve Statewide Outcomes - *July 2011 Update. Washington State Institute for Public Policy, http://www.wsipp.wa.gov/rptfiles/11-07-1201.pdf.* Benefits and Costs of Prevention and Early Intervention Programs for Youth – *2004 update. Washington State Institute for Public Policy, http://www.wsipp.wa.gov/pub.asp?docid=04-07-3901.* Costs and Benefits of Prevention and Early Intervention Programs for At-Risk Youth: *Interim Report – 2003. Washington State Institute for Public Policy, http://www.wsipp.wa.gov/pub.asp?docid=03-12-3901*.	**According to the Washington State Institute for Public Policy, the program/strategy returns** **$4,151 per individual** in savings that would otherwise be associated with education, substance abuse, teen pregnancy, child abuse and neglect, or criminal justice system.

6. Washington State results (from Performance Based Prevention System (PBPS) – if available)

7. Where is this program/strategy being used (if available)?

Washington Counties	Oregon Counties

8. Study Populations

The studies reviewed for this intervention included the following populations, as reported by the study authors.

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Study	Age	Gender	Race/Ethnicity
Study 1	6-12 (Childhood) 13-17 (Adolescent)	70% Male 30% Female	100% Hispanic or Latino
Study 2	6-12 (Childhood) 13-17 (Adolescent)	75% Male 25% Female	100% Hispanic or Latino
Study 3	6-12 (Childhood) 13-17 (Adolescent)	66.4% Male 33.6% Female	84.4% Hispanic or Latino 15.6% Black or African American
Study 4	6-12 (Childhood) 13-17 (Adolescent)	75% Male 25% Female	76% Hispanic or Latino 24% Black or African American
Study 5	6-12 (Childhood)	100% Male	100% Hispanic or Latino
Study 6	6-12 (Childhood) 13-17 (Adolescent)	67% Male 33% Female	100% Hispanic or Latino
Study 7	13-17 (Adolescent)	100% Female	Data not reported/available

9. Quality of Research

The documents below were reviewed for Quality of Research. Other materials may be available. For more information, contact the developer(s).

Study 1

Santisteban, D. A., Szapocznik, J., Perez-Vidal, A., Kurtines, W. M., Murray, E. J., & LaPerriere, A. (1996). Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. Journal of Family Psychology, 10, 35-44.

Study 2

Santisteban, D. A., Coatsworth, J. D., Perez-Vidal, A., Kurtines, W. M., Schwartz, S., LaPerriere, A., et al. (2003). The efficacy of Brief Strategic Family Therapy in modifying Hispanic adolescent behavior problems and substance use. Journal of Family Psychology, 17(1), 121-133.

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Study 3

Santisteban, D. A., Coatsworth, J. D., Perez-Vidal, A., Mitrani, V., Jean-Gilles, M., & Szapocznik, J. (1997). Brief Structural/Strategic Family Therapy with African American and Hispanic high-risk youth. Journal of Community Psychology, 25(5), 453-471.

Study 4

Coatsworth, J. D., Santisteban, D. A., McBride, C. K., & Szapocznik, J. (2001). Brief Strategic Family Therapy versus community control: Engagement, retention, and an exploration of the moderating role of adolescent symptom severity. Family Process, 40(3), 313-332.

Study 5

Szapocznik, J., Rio, A., Murray, E., Cohen, R., Scopetta, M., Rivas-Vazquez, A., et al. (1989). Structural family versus psychodynamic child therapy for problematic Hispanic boys. Journal of Consulting and Clinical Psychology, 57(5), 571-578.

Study 6

Szapocznik, J., Perez-Vidal, A., Brickman, A. L., Foote, F. H., Santisteban, D., Hervis, O. E., et al. (1988). Engaging adolescent drug abusers and their families in treatment: A strategic structural systems approach. Journal of Counseling and Clinical Psychology, 56(4), 552-557.

Study 7

Nickel, M., Luley, J., Krawczyk, J., Nickel, C., Widermann, C., Lahmann, C., et al. (2006). Bullying girls--Changes after Brief Strategic Family Therapy: A randomized, prospective, controlled trial with one-year follow-up. Psychotherapy and Psychosomatics, 75(1), 47-55.

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating

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1: Engagement in therapy	3.5	3.5	3.5	3.5	3.0	3.5	**3.4**
2: Conduct problems	4.0	3.8	3.3	2.8	2.8	3.8	**3.4**
3: Socialized aggression (delinquency in the company of peers)	4.0	3.8	3.3	2.8	2.8	3.8	**3.4**
4: Substance use	3.3	2.8	3.0	3.3	2.5	3.4	**3.0**
5: Family functioning	3.5	3.5	3.3	2.8	2.5	3.5	**3.2**

Study Strengths

Most of the studies were well designed and involved random assignment of subjects to the study conditions. Attrition was minimal, and there were few compelling confounding variables that could reasonably account for the overall positive pattern of findings. For most of the studies, the investigators sufficiently addressed the psychometric properties of the measures, the analyses, and the study limitations.

Study Weaknesses

Results might have been more compelling if the authors had used an intent-to-treat model and more sophisticated methods to document engagement strategies. One of the studies used a weak design. Another study did not provide enough detail regarding the psychometric properties of the instruments or the fidelity of implementation.

10. Readiness for Dissemination

The documents below were reviewed for Readiness for Dissemination. Other materials may be available. For more information, contact the developer(s).

Dissemination Materials

BSFT for Adolescents--Adherence Form (ADH), Version 2.15

BSFT for Adolescents--Clinical Supervision Checklist (CSC), Version 2.15

BSFT for Adolescents--Overall Supervision Evaluation Checklist (OSC), Version 2.15

BSFT for Adolescents--Videotape Certification Rating Checklist (VRC), Version 2.15

Robbins, M. S., Perez, G. A., Hervis, O., & Santisteban, D. (n.d.). Overall supervision evaluation checklist: Procedure and rating manual. Miami, FL: University of Miami Center for Family Studies.

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Robbins, M. S., Perez, G. A., Hervis, O., & Santisteban, D. (n.d.). Weekly clinical supervision checklist: Procedure and rating manual. Miami, FL: University of Miami Center for Family Studies.

Robbins, M. S., Perez, G. A., Mayorga, C. C., Hervis, O., & Santisteban, D. (n.d.). BSFT adherence checklist: Procedures and rating manual. Miami, FL: University of Miami Center for Family Studies.

Robbins, M. S., Perez, G. A., Mayorga, C. C., Hervis, O., & Santisteban, D. (n.d.). Videotape certification rating checklist: Procedure and rating manual. Miami, FL: University of Miami Center for Family Studies.

Szapocznik, J., & Hervis, O. E. (2004). Brief Strategic Family Therapy training manual. Miami, FL: University of Miami Center for Family Studies.

Szapocznik, J., Hervis, O. E., & Schwartz, S. (2003). Brief Strategic Family Therapy for adolescent drug abuse (NIDA Therapy Manuals for Drug Addiction, Manual 5, and NIH Publication No. 03-4751). Rockville, MD: National Institute on Drug Abuse.

University of Miami Center for Family Studies. (2004). Brief Strategic Family Therapy: An empirically validated therapy [PowerPoint slides]. Miami, FL: Author.

University of Miami Center for Family Studies. (2004). BSFT curriculum. Miami, FL: Author.

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
3.3	3.0	3.5	**3.3**

Dissemination Strengths

The clinical manual presents a clear theoretical and conceptual base for understanding the clinical components and sequencing of intervention phases. Guidance is provided for using the intervention with diverse and complex family systems. A detailed training curriculum is provided and is supplemented by ongoing weekly clinical supervision to support implementation. Four highly detailed instruments with manuals are available to document clinician competency.

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Dissemination Weaknesses

The intensive supervision and clinical consultation components necessitate additional guidance for assessing and bolstering organizational readiness for implementation. The required level and sequence of training is unclear. The training manual is very dense, and its content and sequencing do not clearly correspond with training slides. It is unclear who administers some quality assurance instruments. No guidance is provided to implementers for clinical outcomes measurement.

11. Costs

The information below was provided by the developer and may have changed since the time of review. For detailed information on implementation costs (e.g., staffing, space, equipment, materials shipping and handling), contact the developer.

Item Description	Cost	Required by Program Developer
Licensing fee	$4,000 per site per year	Yes
Three 3-day, on-site staff training workshops (includes program manuals and handouts)	$16,200 per site for a team of four therapist trainers	Yes
Annual 2-day booster workshop	$5,000 per site plus travel expenses	Yes
Site readiness assessment	$5,000 per site plus travel expenses	Yes
Supervision package	$15,600 per site	Yes
Monthly supervisory consultation	$7,200 per site per year	Yes
Quarterly fidelity ratings	$2,400 per year	Yes

12. Contacts

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