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❖ **Interview**

History of Evidence-Based Practices: An Interview With José Szapocznik

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This interview with Dr. Szapocznik reveals the importance of building an intervention on the foundation of empirical evidence and family systems theory. Szapocznik is the director of the Center for Family Studies and professor at the University of Miami. He is a chair of the National Hispanic Science Network on Drug Abuse. Szapocznik is also the founder of brief strategic family therapy (BSFT). BSFT is a family-based model for adolescent problem behaviors, such as conduct problems and substance abuse. Throughout the research on BSFT, Szapocznik has been able to show that BSFT is effective and that it can be used with historically difficult populations. Finally, Szapocznik's research has shown that family approaches to adolescent problems are more efficacious than individual and group models of therapy.

Keywords: *evidence-based practice; brief strategic family therapy; adolescent substance abuse*

BIOGRAPHICAL INFORMATION

Dr. Szapocznik is the director of the Center for Family Studies and professor of psychiatry and behavioral sciences, psychology, architecture, and educational and psychological studies at the University of Miami. He is a chair of the National Hispanic Science Network on Drug Abuse. Dr. Szapocznik is the developer of brief strategic family therapy (BSFT; Szapocznik, Hervis, & Schwartz, 2003). BSFT is a family-based model for adolescent problem behaviors, such as conduct problems and substance abuse. BSFT has the endorsement of many public and private sector organizations, such as the Substance Abuse and Mental Health Services Administration, the Office of Juvenile Justice and Delinquency Prevention, the National Institute on Drug Abuse, and BluePrints for Violence Prevention. Throughout his research on BSFT, Szapocznik has been able to show that BSFT is effective, that it can be used with difficult populations, and that family approaches to adolescent problems are more efficacious than individual and group models of therapy (Santisteban, Suarez-Morales, Robbins, & Szapocznik, 2006).

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Distelberg: Dr. Szapocznik, through your work with brief strategic family therapy (BSFT) and in your work with persons living with HIV, you have focused a lot of research and clinical attention on working with families, always tackling difficult issues, most of which has shown a significant difference between family therapy and more individually and group-focused models of therapy. What drives your passion for family therapy versus other models?

Szapocznik: My passion for families comes from the only person I truly consider to have been a great mentor to me, and with whom I have continued to be in contact throughout the past 35 years, Mercedes Scopetta. She hired me into my first job at the University of Miami, and I am still here. She convinced me to take a clinical research position, something that I never expected to do because I expected to be a pure clinician. Mercedes had a passion for families and for culture, which have been my passions as well ever since. I had been trained in the late '60s/early '70s in a very White male conventional psychology program, oriented very individually and "inside the head." As I said, when Mercedes called to offer me a job as a research associate, I didn't want to be in research because I wanted to help people. When I started working, on the very first day of work, I realized that we had an opportunity to work on people's real problems, not the kind of research I had seen at the university, which I felt had not been all that useful. Because of who she was, a person with a devotion to the Hispanic community, she opened my eyes to my roots, to the opportunity of working with professionals and clients of my own culture, Hispanics. While that might not be unusual today, in the early '70s there was nothing like it in Miami. She also taught me the

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important role that families have in Hispanic culture. My passion for the essential role that families and culture play in all of our experience and in all that we are came from my mentor. What a loving, powerful woman she was for me in my first 4 years of work. Psychology had largely disappointed me, but Mercedes exposed me to something I could be passionate about.

I very quickly came to understand that families play such an important role in everything we are and we do in our lives. Families influence us before our birth and for some even after their death, through our whole lifespan. I am very passionate about families, well beyond family therapy. Of course I'm very interested in family therapy, and that's mostly what I do, but I'm broadly interested in how we as a society support families. I think that in addition to treating families when they need treatment, those of us who are family therapists have a unique perspective on what families need to prosper, to do well. As a society, families need support. I've been very interested in how our society supports families. From a family development perspective, I am interested in how to give parents the skills and tools they need to be effective leaders of their families so that they won't grow to need family therapy. We have a line of prevention research in our center where we do just that, where we work with Hispanic immigrant families, developing and testing interventions to give parents tools to be effective parents and to improve the well-being and the adjustment of their kids. So I'm very passionate about families well beyond family therapy. Professionally, family therapy has been my specialty, it's what I know most, and what I've invested most of my career in, but families have always been my central concern.

That is only an answer to half your question. The other part of the question is "What drives my passion versus other models?" I want to start by saying that I don't have anything against individual- or group-based models. I myself have been in individual therapy and have had some great and some not-so-great therapists. There are good and bad therapists in any model. It is a best practice in research to use a comparison intervention that might typically be practiced with a particular population. For example, in my child study, I did a survey of what was being used at that time. What was being used with Hispanic kids in Miami at the time was mostly individual psychodynamic therapy. For this reason, I used individual psychodynamic therapy as a comparison in the child study because I wanted it to be something that had generalizability and validity as to what was really going on in the community. It was totally surprising to me that the individual condition had an adverse or negative effect on the family. Then when we did the BSFT adolescent study, we used group counseling as a comparison because that was something that was used a lot of for these kinds of problem-behavior kids. Especially in schools, they tended to use counseling groups. I wanted to have something that had external validity. I didn't want to use something artificial. So I developed a group counseling condition like these kids might actually receive elsewhere in the community. I was very surprised with the findings that group counseling did so poorly. By the time we published those findings, there were other people who had published findings about group interventions having negative effects on antisocial adolescents. When we started that study we did not expect those results. Then when I did the study with HIV-positive African American women, we were looking for the right kind of condition to be an active control to our family intervention. In that case, it was not so much external validity; we were really looking for an active control that was a real therapy, but at the same time as different as possible from our family ecological therapy, which is why we chose a person-centered approach. And again I was totally surprised that the individual person-centered approach had a negative impact on the women's family functioning. I didn't set out to have anything against the individual and group conditions we used in our studies, but the evidence has taught me that some of these alternate interventions appear to have negative effects on our minority families.

I am a firm believer that when one is a scientist, there are things that one sets out to find, like whether a family intervention is more effective then an alternative intervention, and there are many things that we don't set out to find but we have to be alert to what our data tell us. An example I often use when I teach is Madame Curie. She had some photographic plates in a drawer, and when she went to use them they were exposed. If she had not been curious about what caused it she wouldn't have discovered the radioactive material. For me, having discovered that individual and group interventions have a negative impact on family functioning was not what I expected, but it has been important to pay attention to the negative impact of these interventions on our families.

Distelberg: You are considered one of the key if not the developer of BSFT. I'm going to ask you a question that will be difficult to answer in a short answer: Could you give me a brief overview of what you think it is about BSFT that makes it so effective?

Szapocznik: I think that there are some important and unique aspects of BSFT. At the core of BSFT is our attention to family process, to the patterns of behaviors linked together in an interaction that repeat overtime, some of which are strengths of the family that can be supported, and some of which are not getting the family

what the family wants. For example, if they are not helping the family to get rid of the symptom that they would like to get rid of, they need to be corrected. Another important aspect of BSFT is a very clear focus on what needs to be supported or corrected in a particular family. Now, to identify those family interactional patterns, we have developed a diagnostic approach, which is very much based on the work of Minuchin. We look at families in terms of the family organization or structure, who's in charge of leadership in the family, who's aligned with whom, how successful are parents or adults in executive functions, are children responsive to parents' leadership, and others. So that's the structural organizational dimension. Another dimension is resonance. What is the emotional and psychological distance between family members? Sometimes family members can be overinvolved and sometimes they're underinvolved. There is a lot that's cultural about resonance. So in some cultures, we are typically more involved with each other in the family than in other cultures. Regardless of what your culture might be, sometimes being overly close or overly distant can create problems for the family. So even though it's cultural, the family may need help with it. We are interested in what the developmental stage of the family is, what the developmental stage for each family member is, and if everyone is functioning in the family appropriate to the developmental stage of the family and each family member. We're interested in how families resolve conflict, and of course we help families prioritize conflicts; those conflicts that are of high priority that need to be resolved. We help them develop the skills to resolve these conflicts. And finally we are interested in the centrality of the IP-hood [the role that identifying a problem individual plays in the family]. To what extent does the family blame one person for all the problems of the family, versus seeing that the family has multiple problems.

We make a diagnosis that helps us to focus on what are the patterns of interactions that may be functional and which are the patterns of interactions that may be maladaptive and linked to the family's symptoms that may need to be changed. What our diagnostic approach allows us to do is to be very strategic in understanding what needs to be the focus of our work with the family. Although we diagnose, our actual work with the family is 100% collaborative with the family, but when families, as typically happens, have multiple views, the diagnosis helps us to make choices about what to emphasize. That's one aspect.

Another aspect is the way we engage families into treatment. We've conducted three major research studies to develop and test strategies for engaging families into treatment, redefining resistance to enter treatment not as something that we blame the family with but rather as something that is a function of how a family responds to the therapist behavior, in recognition that therapist behaviors and families' resistance to enter or stay in treatment is interactional. When we change the therapist's behavior in relationship to the family's patterns of interactions, we are able to increase dramatically engagement into treatment and retention in treatment. We use reframes liberally to reduce the negativity in family interactions; particularly for families of problem-behavior adolescents, there tends to be a lot of negativity. We transform that negativity into an opportunity for families to communicate at a more profound affective level.

A therapist always works through a collaborative process with the family. We never take an adversarial role. That allows families to be more open, more relaxed, and more accepting of the therapist. And finally, the strategic aspect of BSFT is important. We are very practical, planned, and problem focused in the way we go about helping the family to change its troublesome interactional patterns.

BSFT has become well known because we have conducted a great deal of research on BSFT for more than 30 years, both BSFT clinical trials and BSFT clinical process. We've done a lot of work in clinically observing the intervention, explaining it and trying to improve it. We have done a larger number of clinical trials that have shown its strengths and its weaknesses. When we learn about what doesn't work in BSFT, then we're able to improve it in a future study. So over time, in a process of doing the clinical work, understanding the theoretical framework for BSFT, and doing research on it, we have taken an intervention and we've developed and improved it, and tested it, and retested it until it is a fairly well-tuned intervention.

Now we haven't by any means finished improving it. There is always a lot of room for improvement in any intervention in any field. We are continuing to learn from our research and continuing to refine the intervention to identify, for example, client groups for whom it works well and for whom it doesn't work well. As we have identified for whom it doesn't work well, we work to understand how we would change BSFT to work more effectively with that particular group. So BSFT is always in the process of development, as it should be. We should not at this point say that we've learned everything that we have to learn. Rather, we recognize that we've learned a great deal, and we want to continue to learn and improve the intervention.

Distelberg: One of the very impressive things about BSFT is the research on engagement, which you've mentioned. BSFT handles engagement from a different point of view; BSFT encourages engagement from the first phone call.

Szapocznik: Right.

Distelberg: Can you talk about what engagement means and how that would be carried out through BSFT?

Szapocznik: What we came to understand is that when a family comes to therapy, we see certain patterns of interactions that are not working for the family. Let's take for example the adolescent population that we work with; these are pretty powerful, rebellious, and typically antisocial adolescents. These are kids that are typically not responsive to their parent. Many have strong peer groups that are deviant and that give them a lot of support. These are kids that if their parents said, "I want to go to treatment for you to help you get better," these kids are going to bolt. They're not interested, they don't think they need help. The problem is that if you say, "I'm going to help that family," that family cannot get itself to treatment, unless that kid gets arrested, and they are mandated to treatment, because the kid is not interested and the parents don't have the leverage or the skills to bring the youth into treatment. What we realized is that there are a number of patterns like this that occur in these families. These are the same kind of patterns that are keeping these families from coming into treatment. So if we have a case, like the powerful adolescent, often it is the parent who calls and says, "I need help," but the parent is powerless to bring the kid into treatment.

The therapist has to be the one who brings that youngster into treatment, recognizing that it is the powerful member of the family that is going to bring the family into treatment. In that case, from the first phone call, when it's clear that the adolescent is not going to come, because the parents don't have the power or the skills to bring them, then the therapist will ask the caller's permission to contact the adolescent directly, to try to establish a relationship with the adolescent, to understand the adolescent's perspective of the family conflict, and to present to the adolescent a perspective of family therapy that can be interesting to the adolescent.

As you can see, that's a family that could not bring itself into treatment. There are other types of families. There's a type of family where you may have a parent–child alliance against another parent (also known as a coalition). The parent who has an alliance with the child calls and asks for help and when you ask, "Can you bring in your whole family?" that parent with the alliance with the child is not going to want to bring in the other parent because they want that other parent out of the relationship. When you identify this on the call, you have to engage the parent who's calling in allowing you to contact the other parent and engage that other parent to come into treatment. You get the parent who calls you to allow you to call the other parent because the parent who calls wants to help her/his child, and as a therapist you use the love and concern for the child as the leverage to engage the calling parent in allowing you to bring the other parent, because that is the only way that the child can be helped, which by the way is absolutely true in our view. Otherwise, if you, the therapist, just engage the caller and the child, you are strengthening the isolation of the already isolated parent and possibly the overinvolvement of the caller and the child; so that you are basically contributing to the problem that the family came to you with. Obviously, there are times when the other parent is truly undesirable and should not be included in therapy, but in most cases the other parent should be included in the therapy because the conflict between the parents is hurting the so-called problem child. So to do good work with these family members requires reaching out to those family members who either wouldn't come or are not wanted in therapy by other family members.

Distelberg: It sounds like a lot of responsibility is placed on the therapist to be active in engaging everyone.

Szapocznik: Yes! There are different models of family therapy. One model of family therapy is what I call the medical model. You come to my office and I treat you. I believe in the public health model. In the public health model, there is a problem, there is a child or family with problems, and it's our responsibility to give that help. That characterizes all of the work I have done. You can say it's to help that family but it's also a societal responsibility. In other public health fields, for example tuberculosis, the same thing is done. If you know someone who has tuberculosis, the public health system is required to find that person and treat them. I believe that everyone chooses what they want to do, and there's plenty of room and need for therapists who work out of their office, and if you work in private practice, that's the only way you can do it, you have to work out of your office because it's typically not financially viable to do anything but work in your office. However, if you're fortunate enough to have funding flexibility as occurs in publicly or philanthropically funded programs, then you have the opportunity to help families who otherwise would not be helped.

Distelberg: It sounds like it would be difficult to implement some of the things that you see as helpful in changing a family system when you're operating independently from a private practice situation.

Szapocznik: I am afraid that is correct, at least with typical private practice fee-for-service funding. Most family therapists in private practice have to make a living, and you can't make a living on an hourly rate if you're going to do this extensive outreach, unless families will pay you for the outreach, which only wealthy families are likely to do. You could do some engagement work on the phone. It's easier to do some things on the phone with parents that cannot be easily

done with teens. It's hard to engage powerful teens through the phone.

Let's look again at the medical model/public health model perspectives. From a public health or societal perspective, antisocial kids are costing society a great deal through their involvement with police, in the juvenile justice system (such as courts, public defense, probation officers, jails), through their disruption and failure in schools, getting drunk or doing drugs, and getting injured or engaging in HIV-risky behaviors such as unprotected sex. For example, the greatest growth in HIV infections is among the young. These are kids who are expensive to society, so for society to invest in an aggressive and assertive treatment approach for these kids is highly cost effective (and, perhaps more important, it would also be the right thing to do), whereas it wouldn't be cost effective for a therapist in private practice. The work we've done has tended to be more focused on the public sector than the private sector. Although we all use BSFT with private cases, the engagement work in particular has been developed with the public sector in mind.

Distelberg: You've mentioned a couple of characteristics that might be helpful for therapists if they are going to engage in this type of work, and it sounds like being active is one of those characteristics that you would hold up.

Szapocznik: Yes.

Distelberg: Are there other characteristics that make for a quality therapist in this situation?

Szapocznik: Yes. A BSFT therapist is like a choreographer or a director of a play. There is a very clear distinction between active and central. We don't want therapists who are driven to be central in their relationship with their clients. We want the therapy to focus on the family, the interactions to stay within the family, for the therapist to be choreographing new and more functional interactions within the family. Thus, the therapist is active but not central. I don't know if you capture the difference between active and central.

Distelberg: Can you explain it further?

Szapocznik: Central means that communications are going through the therapist. That mom is talking to the therapist and then the teen talks to the therapist, and then the therapist talks to the teen and then to the mom. In that case, the therapist is central to the communication of the family. The therapist functions like a switchboard. What we want is for the therapist to be facilitating a conversation between/among family members. When the family member attempts to speak solely to the therapist, the therapist redirects the conversation to occur between/among family members. Our emphasis in maintaining a focus on family interactions is because the skill of parents/youth talking to the therapist is not a valuable skill in life, but the valuable skill is that father and daughter learn to talk with each other in effective ways, that parent and teen are able to communicate their love, their disappointments, their fears, their concerns, and from this communication a different set of more adaptive interactions can emerge. Thus, for the interactions to occur in the family, therapists must be active but not central.

Another quality that is very important in a BSFT therapist is abstract thinking. The therapist has to be able to observe the interactions in the family, conceptualize what's going on in the family, conceptualize what the appropriate intervention would be, and then behave with great attention to family and individual sensibilities. The therapist has to be able to do this in a very short period of time (with high speed of information processing). Individuals who are concrete or slow thinkers are unable to do BSFT well.

Distelberg: It sounds like focusing on process rather than content.

Szapocznik: Absolutely, totally, and fully process oriented.

Distelberg: Are there any other qualities of the therapist?

Szapocznik: Organized. Someone who is "planful," because the therapy is very planful. [Therapists go] into a session, having thought about the prior session, with some plans about what they want to accomplish in the next session in terms of interactional patterns to target. You need to be someone who is planful and somewhat organized in the way you go about your work. There are also the usual good interpersonal skills, the ability to relate to different family members. We typically screen trainees for interpersonal skills and their ability to relate to adolescents as well as mother and father. That's the kind of maturity that is essential for someone to be able to work with whole families. We also pay attention to conceptual ability and the ability to think on one's feet. We believe that we can teach everything else.

Distelberg: When you talk about engagement, and you talk about the ability to relate with adolescents and different members of the family, do you need that same level of engagement from every family member or is it possible to create change and have differing levels of engagement across different members of the family?

Szapocznik: That's really a complex question. If you look at the research on what causes dropout in BSFT, the therapist has to have a balanced alliance between the adolescent and the parents. In a way, one might say, that would suggest that you need to engage parents and the target adolescent equally. Even though in any one family you may need to do more to join a particular individual because at the onset one parent may be more interested in therapy than another parent or the teen.

Distelberg: Is there a difference between engagement and alliance?

Szapocznik: Yes. Alliance is a trajectory, it's a process, which starts with engagement. From the time when you get the first phone call, you are beginning to work on your client–therapist alliance with that family member who's calling. From the time you reach out to an adolescent or distant family member, you're beginning to work on your alliance with that family member. If you have a powerful adolescent at the time of engagement, your strongest engagement may be with that adolescent because that's the powerful person you have to make an effort to bring in, but in the course of treatment you'll have to balance the alliance to keep everyone involved.

Distelberg: So you might have a stronger alliance with the powerful adolescent at the beginning, but the end goal would be to have an equal alliance with everyone?

Szapocznik: Yes, you are right, but you have to move very quickly in therapy to a balanced alliance. You might have a family member who is very committed to treatment, and you may not have to work as hard at establishing an alliance with that person immediately and that person is going to wait you out. But you may also have another family member who, if you don't attend to, you're going to lose in the first session. Some times you don't know that ahead of time. You have to make an effort to reach out to every one in the session, and to use interventions that do not compromise your alliance with one family member more than the other. There are interventions like reframing that are very useful, particularly early in therapy. Mike Robbins's process research has shown that reframing is the only intervention that doesn't cause you to lose your alliance with the adolescent in the early stages of therapy. But in the course of treatment when you're restructuring, when you're trying to bring about a different pattern of interactions, and you try to encourage a family member toward a new behavior, you lose some of your rapport and possibly your alliance, which means that very quickly you have to rebuild it. It's a dance. In restructuring, you're constantly using up some rapport, debilitating your alliance, and quickly rebuilding it.

Distelberg: There are a number of models that align themselves with the same population, the same family format or base. I am wondering if you see any differences or commonalities between BSFT and functional family therapy (FFT), multisystemic therapy, and multidimensional family therapy (MDFT)?

Szapocznik: I think each one has its uniqueness. Multisystem family therapy probably is more ecological or ecosystemic than any of the others, and it probably does a little less within family therapy than the others. MDFT does a lot more individual work, particularly with the adolescent, than the other models. And that can be a strength when you have more disengaged systems. I think FFT and BSFT are the most family systemic in their orientation. We're both very "within family" systemic oriented. That doesn't mean that we're not interested in ecology or individual, we are, but the balance is different. FFT places a great deal of emphasis on reframing and changing the meaning of interactions. BSFT gives more emphasis on actually changing interactions, not just changing the meaning of existing interactions.

Distelberg: Is it accurate to say that the families that you engage in clinical research are involved in multiple systems such as courts and schools?

Szapocznik: Yes. In fact, in our current multisite study of 480 families in eight cities around the country in which we compare BSFT to treatment as usual in each of the participant community-based drug treatment agencies, 72% of the adolescents were referred by the juvenile justice system.

Distelberg: What are some of the strategies you use to help balance the sometimes competing needs of a research agenda, clinical issues, and legal and school protocols?

Szapocznik: BSFT is based on a multisystemic theoretical model in which youth are influenced by their families, and youth and families are influenced by the social and cultural context. Our job is to work with all that is relevant to the problems we are addressing in the teen and the family, including the legal and school issues. Obviously from a clinical perspective, it is all done with the family's permission; as part of the therapy, we facilitate families learning to effectively interact with these systems.

In thinking about working with a juvenile justice system, let's say that a kid has a probation officer. Well, I think what is critical is that all the adult figures or the adult systems collaborate. So whether it's the school, the juvenile justice, or the parents, what is critical is that they all send the same message, and they all collaborate and support each other. We might, for example, invite the probation officer to come into a family therapy session and try to develop the same kind of teamwork between parents and probation officers as we might develop between two parent figures, in the sense that they all have to be on the same page. What becomes problematic is when the probation officer is trying to impose some rules that the parent resents and undermines. This is going to hurt the child because the probation officer will blame the child even though the parent supported the youth in her/his rebellion against the probation officer. A conflict (or lack of collaboration) between a parent and a probation officer is like the conflict between two parent figures, resulting in a youth who is triangulated in that

conflict. What we want to foster is for the parents to form a collaborative team with those other adult figures in the kid's life. I don't know if that helps.

Distelberg: No, it does, and it sounds like, again, that responsibility rests on therapist leadership?

Szapocznik: Right. And that leadership does get communicated to the parents/parent figures. That responsible leadership gets communicated to the parents so that the parent is empowered to take that leadership role in the life of their teen; to be responsible, to reach out to the probation officer, to reach out to the schools, to get involved with the kid's friends and the kid's friends' parents, and to create a context that is functional for the kid. We do place a lot of responsibility on parents to the extent that they are able. And it is our responsibility to give the parents the tools and help them develop the social support that carries them through their considerable parental responsibilities.

Distelberg: It sounds like there is a balance between therapist leadership and parent leadership.

Szapocznik: Right. The therapist leadership gets communicated to the family in such a way that the family takes on the leadership and the therapist can step back. You know, these teens and these families live in a very complex world, with a lot of complex messages, a lot of systems that are involved that sometimes are in conflict with each other. On a daily basis, among all the players in the teen's world, the parents are the only ones that can see that whole world of the child developmentally and with continuity. Sometimes a parent cannot do it; not all parents have the same level of competence. Some single parents are extremely competent and do better as single parents than when they were married and had a spouse that undermined them, so I don't think it's about one- or two-parent families, but when you have one parent, you have half the chance of having a parent with a lot of skills.

More often when it is a single parent, you may need to bring in another family member to support the parent. It's tough to be a single parent in such a complex world. I think single parents need a support system. We always look for these support systems, first with their families, but we build them where we can. As you know, *family* is a very fluid term, and so a family is a functional term, it's who functions in those roles and it's not always a biological person who does.

Distelberg: One final question I have for you is that a lot of the effectiveness or efficacy research that is being done and placed into top-tier family research journals is not being done by individuals who have come from family-accredited programs such as an AAMFT-accredited program. Do you have any goals that you would like to see happen in the field in terms of family research?

Szapocznik: Yes, let's be structural about it. Either the MFT programs need to hire someone who can do that kind of research and bring it to the MFT program and teach it to the students, or it needs to align itself with a program in which the students can do graduate assistantships. For example, our center works with a program that has a strong focus in marriage and family therapy; it's a program that comes out of the School of Education's counseling psychology program. Many of their graduate students have their graduate assistantship with us, so they do their research here. They get trained in doing family therapy outcome and process research.

Distelberg: I want to thank you very much for time. I really appreciate it.

Szapocznik: I appreciate your serious interest in the field of evidence-based family therapy. Good luck in your work.

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