Change Processes in Family Therapy with Hispanic Adolescents

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Changes in within-session family interaction patterns were examined over the course of Brief Strategic Family Therapy with Hispanic adolescents referred for treatment of behavior problems. Family structure and conflict resolution style were examined at four points in therapy. Participants were 4 Hispanic adolescents and their families that received a full dose of family therapy. Families were selected from a large sample of families that participated in a randomized study. Two cases that showed significant improvement and two cases that showed deterioration on measures of conduct disorder completed at pre- and post-treatment were randomly selected from the larger pool of cases. In-session results demonstrated a linear trend of improvement in family interaction in successful outcome cases, although in unsuccessful outcomes family interactions did not improve or worsened throughout therapy. Findings support the importance of examining in-session therapy processes to shed light on how family therapy is efficacious with behavior problem Hispanic youth.

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A solid research base has emerged documenting the effectiveness of family therapy in reducing adolescent behavior problems, including drug abuse and delinquency (cf. Alexander, Holtzworth-Munroe, & Jameson, 1994; Liddle & Dakof, 1995a, 1995b; Stanton & Shadish, 1997). With respect to Hispanic adolescents, results from nearly three decades of research provide strong support for the efficacy and effectiveness of Brief Strategic Family Therapy (BSFT) (Szapocznik & Kurtines, 1989) with behavior problem youth (cf., Robbins & Szapocznik, 2000). Although there has been an exponential increase in treatment outcome research with minority populations, in a review of minority treatment research by Sue, Zane, and Young (1994), this was the only program of outcome research cited in the section on family interventions. Moreover, this systematic program of research was the only minority-focused program included in a compendium of 21 major programs of systematic research in the country published by the American Psychological Association (Beutler & Crago, 1991).

Through the complex interplay of theory, research, and practice (Szapocznik, Kurtines, Santisteban, & Rio, 1990), BSFT has been developed and refined to include efficacious interventions for engaging and retaining Hispanic youth and family members (Santisteban et al., 1996; Szapocznik et al., 1988) and reducing behavior problems (Santisteban et al., 1996; Szapocznik et al., 1989). Despite this impressive evidence, research has failed to consistently shed light on the mechanisms of change that may underlie the efficacy of BSFT. Thus, the focus of this evaluation was to apply a unique approach for examining interactions in the treatment context to disentangle variables that may be critically important in understanding successful and unsuccessful outcome cases.

Identifying Change Mechanisms

Most theory-driven therapies postulate specific mechanisms of change. In family therapy, family interactions represent an important theoretical mechanism postulated to mediate change (Minuchin & Fishman, 1981; Szapocznik & Kurtines, 1989). As noted above, family interventions targeting family interactions have received considerable empirical support in treatment outcome studies with behavior problem and drug-using adolescents; however, examinations of the mediating role of family interactions in family therapy with these youth have yielded inconclusive results.

This failure to link changes in family interactions to changes in adolescent behavioral outcomes stems, in part, from an overreliance on pre/post and self-report measures of family interactions. In one study comparing the effectiveness of family therapy and child psychodynamic therapy, for example,

pre/post changes in family interaction and child psychodynamic functioning were examined to determine if changes in these postulated mechanisms of action mediated outcome (behavioral and emotional) in their respective conditions (Szapocznik et al., 1989). With regard to the impact of treatment on the proposed theoretical mechanisms of action, family therapy was found to be more effective than child therapy in protecting family functioning, and child therapy was found to be efficacious in bringing about improved child psychodynamic functioning. However, with regard to the relationship between changes in these proposed mechanisms of action and related outcome variables, these results failed to support the assumption that changes in family functioning were necessary for symptom reduction.

In a second study comparing the efficacy of family therapy to a control condition, the mediational role of family interactions in reducing behavior problems was examined (Santisteban et al., 1995). In this study, there was a complex relationship between family therapy, family functioning, and adolescent behavior problems. In the family therapy condition, family functioning showed nonsignificant pretreatment to posttreatment improvement, whereas in the control condition a significant deterioration in functioning was evident.

Post hoc analyses were conducted to determine whether intervention effects on the mediator were moderated by intake levels of family functioning. The assumption was that by pooling and analyzing the data for all of the subjects in the sample, the potential effects of the intervention would be masked. Consequently, cases were partitioned into two groups based on a median split: *good family functioning* at intake and *poor family functioning* at intake. Results indicate that in the poor family functioning group, cases in the family therapy condition showed significant pretherapy to posttherapy improvement in family functioning, whereas in the control condition, no significant change was observed. In the good family functioning group, however, cases in the family condition showed nonsignificant deterioration in family functioning, whereas cases in the control condition showed statistically significant deterioration. Thus, family therapy had resulted in a significant improvement in family functioning; however, this effect was only observed in cases that had poor family functioning at intake. These results argue for potential ceiling effects in cases with good family functioning at intake.

To examine the mediational role of family interactions on the primary outcome of behavior problems, analyses were restricted to cases in the family condition with poor family functioning at intake. In this group, pre/post changes in family functioning were shown to have a marginal effect on outcome (Santisteban et al., 1995).

A Focus on In-Session Process

The purpose of this article is to suggest that a focus on linking changes in family interactions as they are observed in-session over the course of treatment to changes in behavioral outcomes may yield more fruitful results than traditional examinations of pre/post changes in behavioral outcomes for Hispanic youths. Examination of in-session processes may prove particularly useful because a process focus is specifically concerned with identifying patterns of family interaction that the therapist is actually working on in treatment. As such, process strategies may yield information about changes in those patterns of family interaction that are most closely linked to the youth's behavior problems and provide insight about those aspects of treatment that are most salient to the ethnic context in which the family exists.

Family researchers have relied heavily on observational measures to understand family and family therapy processes (Alexander et al., 1994; Friedlander, Wildman, Heatherington, & Skowron, 1994; Patterson & Forgatch, 1985) and have developed sophisticated strategies for identifying family interactions as they occur naturally, in the laboratory, and in the treatment context. Obtaining a pure assessment of family interactions in the treatment context, however, is a very difficult task. The complex relationships between therapist and family member behaviors, the process and content of interactions, and the context in which these interactions occur create numerous challenges for identifying critical family processes that may be related to the ultimate outcome of therapy.

In view of the need to further refine observational strategies in the context of treatment for behavior problem adolescents, including Hispanic youth (e.g., Szapocznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1983, 1986; Szapocznik et al., 1988), the Structural Family Systems Ratings was developed (SFSR) (Szapocznik et al., 1991) to assess aspects of family interaction that are critical to the structural family theory of family dysfunction. The original work on the SFSR was based on family responses to the Wiltwick family tasks (Minuchin, Rosman, & Baker, 1978). Codes are organized into the following five dimensions that tap into important structural family theoretical constructs: structure, resonance, developmental stage, identified patienthood, and conflict resolution.

Modeling after the strategy used in developing the Core Conflictual Relationship Theme (CCRT) for use in rating core conflictual relationships, both within therapy as well as outside of therapy (Relationship Anecdotes Paradigm) (Luborsky, 1990), the SFSR was adapted to assess family interactions in the treatment context. In this study, family interactions were assessed at four different time points (early, early-middle, late-middle, and late). In this

fashion, it was possible to examine the evolution of family interactions over the course of BSFT in successful and unsuccessful cases with Hispanic youth. It was expected that successful outcome cases would show improvements in family interactions over the course of therapy, whereas unsuccessful outcome cases would not show improvements in family interactions.

Method

Participants

Participants were four Hispanic, Spanish-speaking families that participated in a family therapy treatment study for drug-using, behavior problem adolescents (Santisteban et al., 1995). The four families were selected from the pool of participants in the treatment study on the basis of intake family structure scores (SFSR) (Szapocznik et al., 1991; Szapocznik & Kurtines, 1989) and pre/post changes on the Conduct Disorder (CD) scale of the Revised Behavior Problem Checklist (RBPC) (Quay & Peterson, 1987; Rio, Quay, Santisteban, & Szapocznik, 1989). For the purpose of participant selection, cases were classified as improvers if they demonstrated significant improvement on the CD scale of the Revised Behavior Problem Checklist, or as deteriorators if they showed deterioration on the CD scale. A median split on the structure scale of the SFSR score at intake was used to classify families into good and poor family functioning. Families were then assigned to four categories: improvers in conduct disorder with good intake family functioning; improvers in conduct disorder with poor intake family functioning; deteriorators in conduct disorder with good intake family functioning; and deteriorators in conduct disorder with poor intake family functioning. One family was randomly selected from each group.

Case 1. A 15-year-old Nicaraguan female was referred for the treatment of behavior problems. This case was selected from the improvers in conduct disorder with good intake family functioning group. Pre-SFSR structure score was 5 (excellent structure) and pre/post CD scores were 24 and 3, respectively.

Case 2. A 16-year-old Cuban male was referred for the treatment of alcohol use and behavior problems. This case was selected from the improvers in conduct disorder with poor intake family functioning group. Pre-SFSR structure score was 3 (average structure), and pre/post CD scores were 40 and 29, respectively.

Case 3. An 18-year-old Cuban female was referred for the treatment of behavior problems. This case was selected from the deteriorators in conduct disorder with good intake family functioning group. Pre-SFSR structure score was 4 (good structure), and pre/post CD scores were 30 and 33, respectively.

Case 4. A 13-year-old Cuban male was referred for the treatment of alcohol and drug use and behavior problems. This case was selected from the deteriorators in conduct disorder with poor intake family functioning group. Pre-SFSR structure score was 2 (average structure), and pre/post CD scores were 26 and 36, respectively.

Therapists

Therapists were two (one male and one female) doctoral-level psychologists. Both therapists were experienced in the implementation of brief strategic family therapy with behavior problem adolescents (20 years and 5 years experience for the male and female therapists, respectively). BSFT is a time-limited family systems intervention that has been shown to significantly modify family interactions and reduce adolescent drug use and behavior problems (Szapocznik et al., 1983, 1986). Each therapist treated one male and one female client and one improver and one deteriorator. The improver case treated by the male therapist was Case 1 (female adolescent), and the improver case treated by the female therapist was Case 2 (male adolescent).

Measures

Revised Behavior Problem Checklist (RBPC). The RBPC (Quay & Peterson, 1987; Rio et al., 1989) is an 89-item instrument that was administered to parents at pretreatment and posttreatment. The RBPC consists of 89 problem behaviors that are rated on a 3-point scale from 0 (*not a problem*) to 1 (*mild problem*) to 2 (*severe problem*). The RBPC contains six scales representing related but distinct dimensions of adolescent behavior problems. For this project, the 22-item Conduct Disorder (CD) scale was used to assess pre/post changes in parent reports of adolescents' disruptive, disobedient, and impertinent behaviors at home.

The RBPC has been found to be sensitive to behavior changes resulting from family treatment (e.g., Santisteban et al., 1995; Szapocznik et al., 1989). The internal consistency reliability (α) coefficient for the CD scale is .93 for the participants from which these four cases were drawn.

Structural Family Systems Ratings (SFSR). The SFSR (Hervis, Szapocznik, Mitrani, Rio, & Kurtines, 1991; Szapocznik & Kurtines, 1989; Szapocznik et al., 1991) was designed for evaluating family interaction patterns along the following five dimensions: structure, developmental stage, resonance, identified patienthood, and conflict resolution (a brief description of these scales is presented under the FTSSR). The standardized procedure for eliciting family interaction consists of the administration of the Wiltwick family tasks (Minuchin et al., 1978) and includes instructions to plan a menu, discuss likes and dislikes about each other, and discuss a recent family argument. A trained rater observes videotapes of the family's performance on these tasks, recording specific categories of interaction on a rating form. These clinical ratings are then scaled (on a 5-point Likert-type scale) for each of the five dimensions, ranging from 1 (*very maladaptive*) to 5 (*highly functional*). These scores are summed to yield a total SFSR score. Interrater reliability for the total score is .89. One-month interval reliability checks range from .83 to .98 along the five scales (Szapocznik et al., 1991). Mean correlation coefficients (Pearson) are reported as .74 for the five dimensions of the SFSR, and .94 for total score. An intraclass correlation of .74 is reported for the total score.

Family Therapy Structural Systems Ratings (FTSSR). The FTSSR (Robbins, Alonso, Hervis, Szapocznik, & Mitrani, 1995) is an observation-based measure that assesses family interactions as they occur in the therapeutic context. Based on the operationalizations and scoring decisions of the SFSR (Hervis et al., 1991), the FTSSR was developed for this project to assess the following four dimensions of structural family functioning: structure, resonance, identified patienthood, and conflict resolution. Structure assesses the organization of the family system and includes codes for leadership, subsystem organization, and communication flow. Resonance assesses the degree of emotional and psychological connectedness between family members and contains codes for enmeshed and disengaged family member behaviors. Identified patienthood (IP) assesses the degree to which the adolescent is centralized within the family system and contains codes for negativity about the IP, IP centrality, nurturance of IP, and other IP. Conflict resolution assesses the family's characteristic style of resolving conflicts, ranging from denial to emergence with resolution.

Table 1 presents the coding categories for the structure and conflict resolution dimensions.

Similar to the SFSR, family interactions in each dimension are rated on a 5-point Likert-type scale, ranging from 1 (*very maladaptive*) to 5 (*highly functional*). These scores are summed to yield a total score indicative of the

Table 1. Family Therapy Structural Systems Ratings

Structure	Conflict Resolution	Resonance	Identified Patienthood
Balanced leadership	Level of conflict in family in adult subsystem	Enmeshment-emotional/ psychological	Negativity about Identified Patienthood
Collaborative leadership	Conflict avoidance	Disengagement-emotional/ psychological	Centrality of Identified Patienthood
Guidance or nurturance	Conflict diffusion	Enmeshment-physical control	Nurturance/protection of Identified Patienthood
Behavior control	Conflict negotiation/ resolution	Disengagement-physical control	
Alliance			
Hierarchy			
Communication Flow			

family's general level of adaptive functioning. In this study, an expert coder, reliable with the SFSR, used the FTSSR to rate family interactions in the treatment context (see procedure).

Procedure

Family therapy was divided into four quadrants (early, early-middle, late-middle, and late), and one session from each quadrant was randomly selected. Thus, each family had four sessions in the data set, one from each quadrant. For each of these sessions (n = 16), family interactions were assessed on four dimensions of family functioning and a total score was computed. Case 1 was seen for 12 therapy sessions; sessions 2, 4, 8, and 10 were selected. Case 2 was seen for 15 therapy sessions; sessions 1, 8, 12, and 14 were selected. Case 3 was seen for 18 sessions; sessions 3, 8, 13, and 16 were selected. Case 4 was seen for 12 therapy sessions; sessions 2, 6, 8, and 11 were selected.

Rating. A master's-level rater, fully proficient in Spanish and with more than 2 years of experience coding family interactions using the SFSR (approximately 200 SFSRs), rated all 16 sessions using the FTSSR. The rater

was blind to both the outcome of the case as well as the session being coded (i.e., quadrant of therapy). To complete the clinical ratings on the FTSSR (Robbins et al., 1995), the rater focused on family interactions that occurred in the session. The FTSSR manual includes detailed operationalizations and examples of the categories that compose four dimensions of family functioning. All rating decisions were based exclusively on overt family interactions. For example, to rate effective behavior control, the rater attended to interactional sequences in which a parent successfully controlled a child's uncooperative or inappropriate behavior.

Rater inference was kept to a minimum; however, in instances in which the rater was expected to estimate the degree to which a family process was evident some inference was required. For example, when rating the appropriateness of parental behavior control on a 0 (*inappropriate*) to 3 (*appropriate*) Likert-type scale, the rater based her score on the degree to which she perceived that the parents' behavior control was appropriate given the interactional context in which behavioral control occurred and given children's developmental capabilities. Procedures for rating are presented in the FTSSR rating manual (Robbins et al., 1995).

Rating decisions were also based on the content of family members' communications. For example, to rate negativity about the IP, the rater was required to identify negative statements (i.e., content) about the IP and other members of the family (e.g., "Since she (IP) began hanging out with those friends, she has turned into a nasty person.") In addition, the rater focused on statements containing information about the way in which the family typically interacted (i.e., how they interacted outside of therapy). For example, a mother stating that she does not feel supported by her husband was rated as a disturbance in the parental/adult subsystem.

Results

Examinations of family interaction profiles yielded several results (see Table 2). First, as shown in Figure 1, families evidenced difficulties in functioning in the first quadrant of therapy regardless of their intake family functioning scores. In other words, in the first quadrant of therapy all four families demonstrated maladaptive family interactions. It should be noted that in Case 1, the family was rated as adequate on the conflict resolution dimension; however, difficulties in family structure were present.

Second, results indicate that for families that showed reliable improvement in CD (Cases 1 and 2), positive changes in each of the four dimensions of family functioning were observed; however, for families that showed deterioration in CD (Cases 3 and 4), no changes or a slight deterioration in each of

Table 2. Total Family Therapy Structural Systems Ratings Scores by Quadrant of Therapy

	Quadrant of Therapy			
Case Number	1	2	3	4
Case 1	12	15	17	20
Case 2	5.5	17.5	13	18
Case 3	7	6.5	8.5	7
Case 4	7.5	7	7	6.5

the four dimensions of family functioning were observed. For ease of presentation, only results for structure and conflict resolution dimensions are presented in Figure 1. Scores for resonance and IP demonstrated a similar pattern. In Cases 1 and 2, family structure was noted as problematic in the first quadrant of therapy; however, by the final quadrant of treatment, no problems in structure were noted. Moreover, in Case 2, conflict resolution changed from 1.5 in the first quadrant to 5 in the last quadrant. Conflict resolution for Case 1 was also 5 in the last quadrant; however, conflict resolution was less problematic throughout treatment for this case.

In the poor outcome cases, family structure and conflict resolution remained steady (Case 3) or worsened (Case 4) over the course of treatment.

Third, improvements in family functioning, when they occurred, were evident by the second quadrant of therapy. In Case 1, family structure scores improved slightly by the second quadrant, and in Case 2, both family structure and conflict resolution increased sharply from the first to second quadrant. In Case 2, there was a slight decline in family functioning between the second and third quadrants; however, family functioning improved again during the fourth quadrant.

Discussion

These results highlight the importance of examining treatment processes in successful and unsuccessful cases in greater detail (Stiles & Shapiro, 1995; Strupp, 1980). In particular, these results illustrate that improvements in family interactions during therapy sessions may be associated with successful outcomes. By examining family process at multiple points, a consistent pattern of improvement over the course of therapy for good outcome cases is evident. Although these findings support the hypothesis that family interactions mediate family therapy outcome, they must be reconciled with the results of a previous study in which differential mediational effects of family interac-

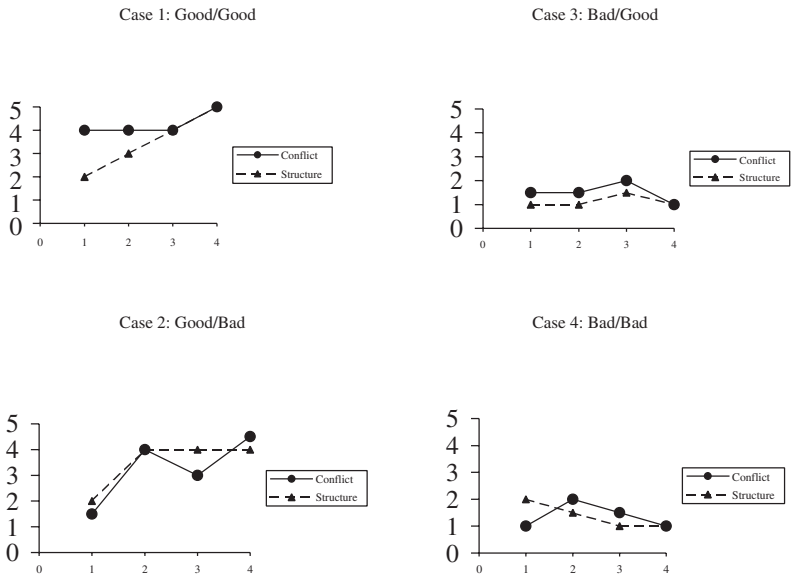

Figure 1. Results of structure and conflict resolution dimensions.

tions were demonstrated based on families' pretreatment SFSR scores (Santisteban et al., 1995). It is possible that previous results underestimated the importance of family interactions due to an absolute reliance on pre/post changes in family interactions (which may have overestimated pretreatment levels of family functioning for some families). For example, in the first quadrant of therapy, all four families demonstrated some difficulties in family functioning, regardless of their pretreatment SFSR scores. By examining family interactions throughout treatment, the mediational role of family interactions in therapy became more apparent.

These results also suggest that changes in family functioning in successful outcome cases become apparent early in therapy. In fact, by the second quadrant of therapy, notable improvements were evident in both of the successful outcome cases. In brief strategic family therapy, therapists target maladaptive family interactions from the beginning of therapy (Szapocznik & Kurtines, 1989), and as these results suggest, in successful cases, these changes may be reflected very early in the treatment process. In the unsuccessful outcome cases, family interactions did not improve at any point throughout treatment. This lack of improvement may have resulted from several factors, including

characteristics of the family (e.g., highly rigid interactions), characteristics of therapy (e.g., the therapist fails to implement interventions appropriately), or characteristics of the therapeutic relationship (e.g., a failure to establish an alliance with multiple family members). Additional research is needed to examine the role of these factors in successful and unsuccessful cases.

This study also has important implications about assessing family interactions in the treatment context. The fact that the therapist is present in therapy creates numerous challenges for obtaining an accurate assessment of the family's characteristic style of interaction. In this study, the rater focused primarily on interactions between family members; however, some rating decisions were based on the content of communications of family members to one another and to the therapist. Thus, to obtain a more accurate assessment of family functioning, rating occurred at several levels. In brief strategic family therapy, therapists encourage family members to interact directly with one another (i.e., enactments); consequently, there were numerous opportunities for the rater to observe family interactions directly. It is possible that coding family interactions in the treatment context may prove to be more difficult for other models of family therapy in which the therapist may be more centralized. Additional work is necessary to examine the reliability and validity of the FTSSR rating scales.

Limitations of the Current Study

One of the biggest limitations of this study is the small sample size. Clearly, generalizations to the full data set from which these cases were drawn as well as to the general treatment population cannot be drawn from this small sample. Nevertheless, these findings point to the potential utility of investigating in-session changes in family therapy process and outcome research with Hispanic and non-Hispanic clients.

A second major limitation has to do with the FTSSR rating measure and procedure. For example, although the FTSSR is based on an established observational measure of family interaction, reliability and validity were not compiled during this study. Thus, even though the rater was blind to the outcome and session number, it is not possible to disentangle a rater effect from the findings that were observed. Nonetheless, the strength of these findings has prompted additional efforts into refining the FTSSR. At present, a thorough rating manual for the FTSSR has been completed. This rating manual contains specific operational definitions, rating anchors, and decisions rules for rating family structure (leadership, subsystem organization, and communication flow) and conflict resolution (level of conflict and resolution strategy). Raters are currently being trained to use this measure to identify in-

session family processes in three family-based intervention modalities that may predict dropout/retention in treatment (NIDA P50 11328, Howard Liddle, principal investigator, Study 2, James Alexander, principal investigator). Preliminary data for the combined structure and conflict resolution scales show that raters demonstrated exact agreement (76%) or within one point of agreement (22%) on 98% of the observations. Intraclass correlations and factor analyses are currently under way.

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