

Efficacy of Intervention for Engaging Youth and Families Into Treatment and Some Variables That May Contribute to Differential Effectiveness

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This study reports data on the efficacy of Strategic Structural Systems Engagement (SSSE), which is designed to bring hard-to-reach families into treatment. The study also explores variables that may contribute to differential effectiveness. Participants were 193 Hispanic families, who were randomly assigned to either experimental or control conditions. Several important findings emerged. First, the overall results replicated earlier findings showing the superiority of SSSE: 81% of SSSE families, compared to 60% of control families, were successfully engaged, $\chi^2(1, N = 193) = 7.5, p < .001$. Second, SSSE interventions were more successful with non-Cuban Hispanics (97% successfully engaged) than with Cuban Hispanics (64% successfully engaged), $\chi^2(1, N = 51) = 7.53, p = .006$. Third, an analysis of intervention failures suggests a mechanism by which culture and ethnicity influence clinical processes (resistance to engagement) and may result in differential effectiveness.

Family therapy has become recognized as an effective therapeutic modality in general (Gurman, Kniskern, & Pinsof, 1986), and it has been recognized as particularly effective with drug abusing and behavior problem youth (Bry, 1988; Kazdin, 1987; Liddle, Dakof, & Diamond, 1991; Liddle & Diamond, 1991; Szapocznik, Kurtines, Santisteban, & Rio, 1990). With the increased acceptance and use of family therapy has come a growing recognition of the problem of engaging entire families into treat-

ment and a growing literature concerned with effective intervention strategies for recruiting families into treatment (e.g., Coleman, 1976; Davis, 1977–1978; Stanton & Todd, 1979; Weidman, 1985; Wermuth & Scheidt, 1986).

In our previous work, we have addressed the challenge of effectively engaging entire families by developing and refining an intervention called Strategic Structural Systems Engagement (SSSE; Szapocznik & Kurtines, 1989; Szapocznik et al., 1988; Szapocznik, Perez-Vidal, Hervis, Brickman, & Kurtines, 1990). SSSE is based on the premise that the same dysfunctional family interaction pattern that maintains the presenting symptom will manifest itself during the engagement phase as resistance to entering treatment. The goal of SSSE is to begin the work of diagnosing, joining, and restructuring the family with the very first contact, thereby facilitating the engagement of the entire family into therapy.

In this article, we report the results of the second large-scale study testing the efficacy of SSSE. The original study (Szapocznik et al., 1988) provided strong evidence for the efficacy

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This research was funded by National Institute on Drug Abuse Grant DA03224.

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of SSSE, suggesting that it is possible to develop effective engagement interventions. The present study was designed to provide a more rigorously controlled experimental test of SSSE by using a larger and more multicultural sample, a more stringent criteria for successful engagement, and two control conditions instead of one. The study was also designed to extend our previous work on identifying the variables that may moderate treatment effectiveness (Szapocznik, Kurtines et al., 1990). To address this challenge, we conducted (a) statistical analyses to identify variables that contribute to efficacy and (b) fine-grained, case-by-case analyses to identify the complex mechanisms by which these variables moderate intervention effectiveness. Thus, we sought to address two complementary research goals: an investigation of efficacy and an exploratory articulation of the variables that may moderate intervention effectiveness.

Method

Participants

The sample was composed of 193¹ Hispanic families of adolescents who were suspected of or at risk for drug abuse. These adolescents were identified using a revised version of the Drug Abuse Syndrome List (see Szapocznik et al., 1988), a checklist of behavioral correlates of drug use. The identified patients for the study ranged in age from 12 to 18 years with 89% falling between the ages of 13 and 17 years ($M = 15.6$). Seventy percent of the identified patients were male. Sixty-four percent (108 out of 170) of families on which data were available on this variable were two-parent households.² Using Hollingshead's Educational Scale categories to assess head-of-household education, we found the following: 34% fit in the partial high school or less category, 28% fit in the high school graduates category, and 38% fit in the partial college training category. Families had a broad range of socioeconomic backgrounds.

As was the case in the original study, all families in the present study were Hispanic. Participants for the present study, however, consisted of a more multicultural sample of Hispanics than the original study: Approximately half (54%; $n = 98$) of the participants were Cuban Hispanics, and the other half (46%; $n = 81$) were a diversity of non-Cuban Hispanic families from a variety of nationalities. Of these non-Cuban Hispanics, 41% were Nicaraguan, 23% were Columbian, 15% were Puerto Rican, 12% were Peruvian, 7% were Mexican, and 1% were Salvadoran.

Study Design

The basic design for the study included an experimental manipulation for the effects of the engagement intervention. All participant families who called the Spanish Family Guidance Center seeking services were screened, using the Drug Abuse Syndrome List, to determine eligibility. Eligible families were then randomly assigned to one of three conditions, including an experimental condition and two control conditions: (a) engagement family therapy (EFT), that is, family therapy plus SSSE; (b) family therapy (FT) without SSSE, and (c) group therapy (GT) without SSSE, respectively. Because of the expected higher rates of engagement for the experimental engagement condition (as supported by the data from the original study), we used a disproportional random assignment method (25% to EFT, 37.5% to FT and 37.5% to GT) to ensure sufficient numbers of cases engaged and terminated within each condition to permit outcome analysis. This resulted in the following number of assignments to each condition: EFT $n = 52$ (27%); FT $n = 67$ (35%); and GT $n = 74$ (38%). The experimental and control conditions were then implemented as described in the following section.

Intervention Conditions

Engagement family therapy. EFT included Brief Strategic Family Therapy (BSFT; Szapocznik & Kurtines, 1989) plus the SSSE intervention that was developed as part of the original study (Szapocznik et al., 1988). The SSSE procedure is based on the premise that the family's resistance will manifest itself during the engagement phase as it does during treatment. Consequently, the same systemic and structural principles that apply to the understanding of family functioning and to treatment (cf. Minuchin, 1974, 1976; Szapocznik & Kurtines, 1989; Szapocznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1983, 1986; Szapocznik, Perez-Vidal, Hervis, Foote, & Kurtines, 1986; Szapocznik et al., 1991) also apply to understanding and modifying the family's resistance to engagement.

Thus, SSSE is a planned, purposeful way of joining and diagnosing a family from the initial contact to the

¹ Before initiating the formal study, we needed an additional 12 participants to pilot and standardize the procedures. Data from the pilot are not included in this report.

² Because the data set included both families that did and did not engage into therapy, a substantial portion of these families never reached the intake interview. Consequently, despite intensive data collection efforts, complete data were not available for all sociodemographic variables for all families.

first therapy interview. It uses the same diagnostic, joining, and restructuring skills of BSFT (Szapocznik & Kurtines, 1989), but it uses those techniques to overcome the family's resistance to engagement. In the experimental EFT condition, therapists moved beyond empathic concern by doing the following: thoroughly joining; establishing alliances; advising the caller about negotiating and reframing strategies that might help family members attend the intake appointment; joining family members other than the original caller over the phone or in the therapist's office; and conducting out-of-office visits to family members or significant others who were critical of the therapy process (see Table 1 and Szapocznik et al., 1988, for a more detailed description of these techniques).

Family therapy. The FT condition consisted of BSFT without SSSE. The engagement phase of this intervention condition was designed to resemble as closely as possible the kind of engagement that usually takes place in family therapy outpatient centers, and it was modeled after the engagement-as-usual condition in the original study (Szapocznik et al., 1988). For that study, an informal survey was conducted in which five widely used local treatment facilities for drug users were sampled for "initial engagement" strategies. On the basis of this information, the engagement-as-usual control condition was defined.

In the FT condition, during contacts with the family before therapy, the therapist was empathic and supportive. However, the therapist did not attempt to restructure the family's resistance during the engagement process. As is standard practice in most outpatient centers, the therapist provided the family with the opportunity to enter therapy, but the responsibility for mobilizing its members remained with the family. When a client failed to show up for an appointment, the therapist continued to contact the family to offer services and schedule appointments as long as there was a possibility that the family would come in.

Group therapy. The GT condition was a group process-oriented intervention designed for the identified patients and conducted without SSSE. As in the FT control condition, the engagement component of the GT control condition was designed to resemble the kind of engagement that usually takes place in outpatient centers and was modeled after the engagement-as-usual condition in the original study (Szapocznik et al., 1988).

Intervention Integrity

In this section, we describe the method for assessing compliance with the engagement protocol for each condition. Table 1 presents specific engagement efforts permitted within each condition. The specific

Table 1
Descriptions of Engagement Levels Used

Engagement effort level	Description
Level 0	Expressing polite concern; scheduling of intake appointment; establishing that case fits inclusion criteria; identifying caller; making clear who must attend intake.
Level 1	Minimal joining; encouraging caller to involve family; inquiring about depth and breadth of identified patient's problems; inquiring about what family members exist.
Level 2	More thorough joining; inquiring about family interactions; inquiring about problems, values, and interests of different family members; supporting the caller and establishing an alliance with the caller; beginning to establish leadership; asking if all family members are willing to keep intake appointment.
Level 3	Restructuring for engagement through caller; advising caller regarding negotiating, reframing, and tracking in order to have family members keep intake appointment (either over the phone or personally with caller at therapist's office).
Level 4	Lower level Ecological Engagement Interventions; joining family members or doing intrapersonal restructuring (with family members other than original caller) over the phone or in the therapist's office; telephoning significant others for purposes of gathering more information only.
Level 5	Higher level Ecological Interventions; out-of-office visits to family members or significant others; using significant others to help in doing restructuring.

Note. Therapists in the two control conditions (family therapy and group therapy) were only permitted to use levels 0 and 1. Only therapists in the experimental condition (engagement family therapy) were permitted to use levels 2–5.

behaviors carried out by the therapist were measured by levels 0–5. Levels 2–5 were permitted in the engagement condition, and EFT therapists were expected to use the highest level needed to engage their families. Levels 2–5 reflect increasing deviation from engagement-as-usual therapist behaviors. In contrast, only levels 0–1 were permitted in the control conditions (FT and GT). The control condition therapists were expected to be understanding and sympathetic, but they were not permitted to go beyond level 1. In all three conditions, the therapist could make as many

contacts as needed within the 4-week period allowed for engagement by the research protocol.

All engagement contacts were monitored by having the therapist document in writing the nature and content of engagement interactions. The therapist then assigned each contact a numeric value representing the highest level of engagement effort (as per Table 1) implemented for that case. For purposes of a reliability check, an independent rater reviewed the written documentation of the contact and assigned the contact a numeric value using the same scale. The independent rater was blind to the condition and to the therapist's rating. Intervention and treatment integrity findings and reliability data are presented in the section titled *Results*. Human participants restrictions did not permit us to tape family contacts before we obtained their signed consent to participate in treatment.

The data reported in this article were based on the work of four child psychiatry fellows, six clinical psychologists, and a master's-level counseling professional.³ Cases in the GT group were treated by two child fellows, a clinical psychologist, and a master's-level group therapist. Cases in the EFT and FT groups were treated by two child fellows and six clinical psychologists (one of the psychologists treated cases in all three conditions). Clinicians were thus assigned to conditions in which they were deemed to have expertise (i.e., either to the family condition or group conditions alone, or to both family and group conditions). Clinicians conducting family therapy were randomly assigned cases in both the EFT and FT conditions.

Measures

The basic measures of the effectiveness of the engagement intervention consisted of ratings of the following: (a) engagement in therapy and (b) maintenance in therapy.

In the original study, *engagement* was defined as having the family attend the intake session. Although all family members were encouraged to attend, a minimum of the identified patient and all adult caregivers that lived in the household were required to be present at intake. When there was only one adult living in the household, older siblings living there were also required to attend. For the present study, the criteria were revised to include the more stringent standard of attending the intake session and one in-office therapy session within a 4-week period following initial contact. This revision was done so that our condition would more closely approximate actual clinical practice.

Maintenance was included as an indicator of outcome because of our concern that families successfully engaged through the use of the specialized procedures might prove difficult to maintain in treat-

ment. If SSSE was more effective in engaging clients, but dropout rates in this condition were higher, the overall value of the interventions would have been diminished. *Maintenance* was defined as completing at least 8 therapy hours and completing the termination assessment battery.

Results

Engagement Intervention Integrity

The analyses reported in this section were conducted to assess the faithfulness with which therapists adhered to the interventions (as assessed from each therapist's written documentation of the engagement contacts). Pearson product-moment correlations were calculated on a randomly selected subset of contacts with both the therapist's and the independent rater's scores in order to estimate the interrater reliability of the therapist and independent ratings of the levels of engagement effort during the contacts. The analyses yielded a correlation of .87, (1, 36) $p = .000$.

An analysis of the therapist contacts in all three conditions revealed that in 97% of cases in the control conditions (FT and GT), the engagement effort did not go beyond the highest level of contact allowed by the protocol (level 1; see Table 1). In 3% ($n = 4$) of the cases in the control condition, the therapist did not follow the protocol (i.e., the therapist used level 2, 3, or 4). More specifically, for the control conditions (FT and GT), 27% of engagements were level 0; 70% were level 1; and only 3% deviated from the protocol by reaching above level 1. In contrast, families assigned to the experimental condition (EFT) received a higher level of engagement (level 2–5) in 60% of the cases. In the EFT condition, levels 0, 1, 2, 3, 4, and 5 were applied

³The cases ($n = 11$) of one additional therapist were not included in the data for this study. Treatment integrity checks indicated that this therapist was not implementing the full range of engagement procedures in some of his cases—a violation of the research protocol. Hence, all cases for this therapist were excluded from the analyses. Six of his cases had been assigned to the experimental family condition and five to the control family condition. Additional analyses conducted to determine whether these cases would have substantially changed the results reported in this article showed that inclusion of these cases would not have significantly changed the major findings.

4%, 36%, 14%, 18%, 22%, and 6%, respectively. We computed a one-way analysis of variance (ANOVA) to test the significance of the differences in average level of engagement among conditions. The results indicated that the differences were highly significant, $F(1, 188) = 115, p < .0001$. The mean level for the control condition was .8 ($SD = .6$), and the mean for the experimental condition was 2.4 ($SD = 1.4$). Thus, as established by the protocol, more intensive engagement strategies were used in the EFT condition than in the control conditions.

We made comparisons to assess whether or not there were significant differences among the three conditions on the number of engagement contacts between client and therapist. ANOVA testing revealed that there were significant differences in the average number of contacts between the therapist and the families in the experimental condition versus the control conditions, EFT $M = 5.3, SD = 3.8$; FT + GT $M = 3.4, SD = 2.1$; $F(1, 75) = 7.8, p = .01$.

Intervention Effectiveness

The analyses reported in this section were conducted to test the intervention effectiveness relative to the control conditions. As can be seen in Table 2, there were highly significant differences between the experimental engagement condition and the two control conditions for rates of engagement. In the EFT condition, 81% of the families assigned to the condition (42 of 52) were successfully engaged. In contrast, in the control conditions (FT and GT combined), 60% (84 of 141; FT = 57%, GT =

Table 2
Rates of Engagement Into Therapy
by Condition

Condition	Engaged		Not engaged	
	<i>n</i>	%	<i>n</i>	%
Experimental condition (EFT)	42	81	10	19
Control conditions (FT and GT)	84	60	57	40

Note. EFT = Engagement family therapy; FT = family therapy; GT = group therapy. There were significant differences between the experimental condition and the two control conditions for rates of engagement, $\chi^2(1, N = 193) = 7.53, p < .006$.

Table 3
Maintenance Rates by Condition

Condition	Maintained in therapy		Dropped out of therapy	
	<i>n</i>	%	<i>n</i>	%
Experimental condition (EFT)	29	69	13	31
Control conditions (FT and GT)	56	67	28	33

Note. EFT = Engagement family therapy; FT = family therapy; GT = group therapy. There were no significant differences in the maintenance rates between the experimental and control conditions, $\chi^2(1, N = 126) = .07, p = .78$.

62%) of the families assigned were successfully engaged, $\chi^2(1, N = 193) = 7.5, p < .006$.

The next analysis tested the termination and drop out rates among those cases that had successfully engaged. As can be seen in Table 3, there were no significant differences in the maintenance rates between the experimental and control conditions. In the EFT condition, 69% of the cases that were engaged (29 of 42) were successfully terminated. In the control conditions (combined), 67% (56 out of 84; FT = 71%, GT = 63%) were successfully terminated, $\chi^2(1, N = 126) = .07, p = .78$.

These primary outcome analyses provided strong evidence for the efficacy of the engagement intervention. The following sections provide additional findings concerning the efficacy of the intervention.

Replication analysis. We conducted an analysis to test the degree to which the results of the present study replicated the findings of our original study on SSSE (Szapocznik et al., 1988). We compared the rates of engagement in the present study with those of the original study using the original criteria (attending intake). The results indicated that there were no significant differences between the two experimental engagement conditions (original and present studies) on the rates of engagement. As Table 4 shows, in the experimental engagement condition of the original study, 93% of families assigned to the condition (51 of 55) were successfully engaged. In comparison, in the experimental engagement condition of the present study using the original criteria, 88% of families assigned to the condition (46 of 52) were successfully engaged, $\chi^2(1, N = 107) = .57, p = .44$.

Levels of engagement analysis. We conducted an exploratory analysis to investigate the efficacy of specific SSSE levels that would complement the findings of the overall intervention package. In interpreting these findings, it should be noted that the levels used in the analyses are the highest levels implemented with the family and do not indicate whether higher level interventions were offered. In other words, families that received levels 2–4 and were not successfully engaged into treatment were most likely offered higher level interventions (e.g., the therapist offered to speak to another family member or visit the home) but refused further participation.

In the EFT condition, 30 families received the specialized engagement techniques (levels 2–5). As Table 5 indicates, level 2 SSSE interventions were the highest level of engagement techniques received in seven cases. Of these seven cases, six (86%) were successfully engaged, and one failed to engage.

Level 3 SSSE interventions were the highest level of engagement techniques received in nine cases. Of these nine cases, seven (78%) were successfully engaged, and two failed to engage.

Level 4 SSSE interventions were the highest level of engagement techniques received in 11 cases. Of these 11 cases, eight (73%) were successfully engaged, and three failed to engage.

Finally, level 5 SSSE interventions were the highest level of engagement techniques received in three cases. Of these three families, none (0%) was successfully engaged; all three failed to engage.

The results indicate that engagement activities in levels 2–4 were very effective whereas level 5 activities (leaving the office and visiting

Table 5
Levels of SSSE Engagement and Their Effectiveness

SSSE effort level	Not Engaged		Engaged	
	<i>n</i>	%	<i>n</i>	%
Level 2	1	14	6	86
Level 3	2	22	7	78
Level 4	3	27	8	73
Level 5	3	100	0	0

Note. SSSE = Strategic Structural Systems Engagement.

family members) were not. The apparent lack of success of level 5 interventions should be interpreted with caution, however, because of the small number of cases receiving this specific intervention.

Variables Moderating Intervention Effectiveness

The analyses reported in this section were conducted to identify variables that contribute to or moderate efficacy. Toward this end, we investigated specific client–family variables that could potentially play a role in determining the effectiveness of the intervention. The variables included the following: socioeconomic status, years in the United States, single- versus two-parent families, status of identified patient drug use⁴ at pretest, and culture–ethnicity.

Of these variables, only culture–ethnicity was significantly related to the efficacy of the experimental intervention. More specifically, an analysis of the intervention failures and successes revealed that there was a striking difference in treatment effectiveness for Cuban and non-Cuban Hispanics.

As Table 6 shows, the effects of culture–ethnicity on the efficacy of specialized engagement procedures, as measured by the rate of engagement, were dramatic. Among the non-Cuban Hispanics assigned to the EFT condition, the rate of intervention failure was extremely

Table 4
Rates of Engagement Into Therapy by Study (for Experimental Conditions Only)

Study	Engaged		Not engaged	
	<i>n</i>	%	<i>n</i>	%
Present	46	88	6	12
Original	51	92	4	7

Note. There were no significant differences between the two experimental engagement conditions (original and present studies) on the rates of engagement, $\chi^2(1, N = 107) = .57, p = .44$.

⁴For these analyses, drug use was measured by percentage of youth classified as drug users on the basis of composite measures of drug use derived from a number of variables, including both self-reported drug use and hair and urine analyses at pretest.

low: 3%. Fully 97% of the non-Cuban Hispanic families (28 of 29) were successfully engaged. In contrast, among the Cuban Hispanic sample assigned to the EFT condition, the rate of intervention failure was relatively high: 36%. Only 64% of the Cuban Hispanic families (14 of 22) were successfully engaged, $\chi^2(1, N = 51) = 9.33, p = .002$.

An analysis of the intervention failures and successes in the two control conditions, conducted to test whether this effect of culture-ethnicity was evident in the control conditions as well, indicated that there was no significant effect for culture-ethnicity on the engagement rates of control condition families. Among the non-Cuban Hispanics assigned to the two control conditions, the rate of intervention failure was 35%. Thus, 65% (34 of 52) of the non-Cubans Hispanic families in the control conditions were successfully engaged. Similarly, among the Cuban Hispanic sample assigned to the two control conditions, the rate of intervention failure was 36%. Thus, 64% of the Cuban Hispanic families (49 of 76) were successfully engaged, $\chi^2(1, N = 128) = .011, p = .916$. The finding that there was a significant effect for culture-ethnicity for the experimental condition but not for either of the control conditions suggests that the relationship between culture-ethnicity and the intervention conditions is complex; that is, the relationship is more analogous to an interaction between the experimental intervention and the culture-ethnicity variable than a main effect for either.

The analyses of the intervention failures and successes clearly indicated that, for our population, culture-ethnicity was a significant moderator of intervention effectiveness in the experimental condition. Our next challenge then, was to identify the mechanism through which cul-

ture-ethnicity might moderate intervention effectiveness. Exploration of this mechanism involved a two-step process. The first step was to identify specific clinical processes that resulted in intervention failure; the second was to identify the relationship of culture-ethnicity to these clinical processes.

The clinical process relevant to the first step involved the processes by which the therapists attempted to bring families into treatment and the processes by which families resisted entering treatment (i.e., the mismatch between families' behaviors and therapists' interventions). Because the experimental design of the study controlled for therapist interventions, our efforts to identify clinical processes that resulted in intervention failures focused on exploring the specific processes by which families resisted entering treatment and how therapist interventions failed to overcome these resistances. To identify these processes, we conducted a case-by-case structural examination of the patterns of resistance to the intervention of the Cuban and non-Cuban Hispanic families. A team (consisting of the project investigators and clinicians) carefully examined the written clinical notes and, using the criteria developed and reported in the original study (Szapocznik et al., 1988), defined the following four patterns of resistance to engagement: (a) powerful identified patient, (b) ambivalent mother, (c) distant or disengaged father, and (d) family with secrets.

The results of our efforts to identify specific clinical processes that resulted in intervention failures indicated that 9 of the 10 failures had some type of identifiable pattern of resistance.⁵ Even more revealing, the analyses identified the specific type of resistance pattern that resulted in the largest number of the intervention failures: families with resistant parents. In fact, eight of nine intervention failures involved some form of parental resistance. Thus, although families with resistant parents made up 68% of the experimental condition,⁶ they comprised fully 89% of the engagement failures. Conversely, the intervention was extremely ef-

Table 6
Rates of Engagement Into Therapy by Ethnic Group (for Experimental Condition Only)

Ethnic group	Engaged		Not engaged	
	<i>n</i>	%	<i>n</i>	%
Cuban	14	64	8	36
Other Hispanic	28	97	1	3

Note. There was a significant difference in treatment effectiveness for the Cuban and non-Cuban Hispanics, $\chi^2(1, N = 51) = 9.33, p = .002$.

⁵The one intervention failure that was categorized as "other" involved transportation problems and had no identifiable resistant family member.

⁶Of this 68%, the detailed breakdown is as follows: 21% ambivalent mothers, 18% distant and disengaged fathers, 25% more than one family member (one of these involved a family secret), and 4% other.

fective with resistant identified patients (only one of the nine resistant intervention failures were of this type). Thus, although families with powerful identified patients made up 32% of the experimental condition, they comprised only 11% of the engagement failures.

The second step was to identify the relationship of culture–ethnicity (Cuban versus non-Cuban) to these clinical processes of resistance. The case-by-case analysis indicated a very clear relationship between culture–ethnicity and type of resistance. All eight failure-to-engage cases with parental resistance were Cuban Hispanic families. The only non-Cuban Hispanic family who failed to engage showed the powerful identified patient pattern of resistance.

Taken together, the results of the analyses of the intervention failures indicated that the specialized engagement procedures were effective across the board, with the specific exception of Cuban families in which there was parental resistance. Among these families, there appeared to be a special type of parental resistance that was not effectively addressed by the intervention procedures.

Discussion

The growing recognition of the usefulness of family interventions with adolescents who have problem behaviors (Kazdin, 1987) has resulted in an increased interest in identifying and overcoming difficulties in engaging families into family therapy. Given these difficulties, we have been interested in developing effective engagement interventions. The present study reports a number of critical findings that make an important contribution toward meeting this challenge.

In our original study, we developed and experimentally tested an engagement intervention, SSSE, that proved to be very effective. The data from the present, more rigorous study replicated our earlier findings concerning the superiority of SSSE in bringing into treatment hard-to-reach drug abusing youth and their families, as the experimental condition had a significantly higher rate of engagement than did the control conditions. Moreover, a comparison of the data from the present and original studies (using the original criteria) yielded engagement rates that showed the specialized engagement interventions to be equally effective in the two studies.

The data on the efficacy of the specific levels of engagement (levels 2–5) also led to some interesting findings. The results of our exploratory analyses suggest that engagement activities in levels 2–4 were very effective whereas level 5 activities (leaving the office and visiting family members) were not. Although the finding concerning the efficacy of level 5 interventions is tentative (because of the small number on which it is based), it suggests that most, if not all, of the benefits of the SSSE techniques tested were obtainable through strategic, in-office telephone calls to key family members. The finding also suggests that the more time-consuming activities of going out to the home or turf of the family was not particularly effective.

The finding that SSSE intervention was effective across the board, with the specific exception of Cuban Hispanic families in which there was parental resistance, allowed us to begin articulating, in an exploratory way, the mechanism by which culture–ethnicity (and other contextual conditions) may moderate intervention effectiveness. This finding takes on additional significance in view of the fact that the same intervention was successful in engaging resistant Cuban parents in the original study. Together, these findings raise some intriguing questions concerning the possible effects of culture–ethnicity and other subtle contextual factors on clinical process (cf. Szapocznik & Kurtines, 1993) related to engagement.

By comparing the clinical experiences of our original Cuban sample, of our present Cuban sample, and of our present non-Cuban sample, we saw a possible framework emerge for understanding the mechanism by which culture–ethnicity influences clinical processes that, in turn, moderate intervention effectiveness. Our hypotheses concerning the mechanism by which culture–ethnicity moderates efficacy draws on our more than two decades of clinical and research experience in working with Cuban and non-Cuban Hispanic families in the greater South Florida area. Our experiences suggest that the Cuban families in the present study were more fully integrated into the economic and political life of the community than either Cubans families in the original study or the non-Cuban families in the present study. Cuban Hispanics now living in Dade County have been extremely successful in adapting to and functioning within its political, economic, educational, and mental health systems. In the pro-

cess, Cuban Hispanics have become more acculturated to the individualistic orientation of the mainstream culture and have also become adept at maneuvering within the mental health system. Systematic case reviews indicated that the clinical consequence of this process was a substantial number of families who insisted on hospitalization or individual therapy for their adolescent, rather than family-oriented therapy, and who were willing to work the mental health system to obtain it.

Although our intervention for engaging families was highly effective, our hypothesis concerning the mechanism by which culture–ethnicity influences clinical processes (i.e., patterns of resistance) that, in turn, moderate intervention effectiveness provides some insight into the potential for further enhancing the intervention. Our hypothesized mechanism indicates that the enhancement of the specialized intervention could be facilitated by the early diagnosis and restructuring of parental resistance. Moreover, our hypothesized mechanism suggests that the most effective strategy for overcoming parental resistance is by tracking and joining parents in their individually oriented perspective before attempting to restructure this perspective. Thus, our hypothesized mechanism not only provides a plausible explanation of the variables that may moderate intervention effectiveness, it also highlights the importance of being responsive in adapting interventions to subtle, changing contextual conditions (cf. Szapocznik & Kurtines, 1993).

In summary, the overall pattern of results of the study provide strong support for the effectiveness of our specialized engagement interventions. The pattern of results also indicates that contextual variables, such as cultural–ethnic characteristics and a population's role within a community network, can have significant effects on the efficacy of therapeutic processes. Therapeutic interventions must be responsive to these constantly evolving population–contextual conditions.

Limitations

We acknowledge that the effects reported here might be caused by variables other than those that were experimentally manipulated. Such unknown variables constitute threats to the study's internal validity. One rival hypoth-

esis is that differential engagement rates between conditions may be caused by differing numbers of contacts, because families in the experimental condition tended to have more contacts than did those in the control conditions. In analyzing this further, however, it is noteworthy that clinicians in the control conditions encountered a natural limit or ceiling to the number of contacts that could be made with a family without implementing therapeutic interventions. In other words, after an average of 3.4 calls per family, during which the therapist was empathic and warm and gave the family repeated appointments, there was no more to be done short of violating protocol by intervening therapeutically. In this sense, we suggest that more contacts of the same type would not have been incrementally effective.

Another rival hypothesis is that the effects may have been caused not by the number of contacts but by the quality of the contacts, which was not built into the guidelines. More specifically, the therapists in the experimental condition may have appeared more friendly, empathic, caring, or warm. Although we attempted to avoid this by supervising the therapists and by building the importance of joining and showing polite concern into the control condition guidelines, the study did not quantify the empathy and warmth of the therapist.

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Received June 16, 1994

Revision received October 17, 1994

Accepted December 3, 1994 ■