FAMILY PROCESS

Culturally Informed and Flexible Family-Based Treatment for Adolescents: A Tailored and Integrative Treatment for Hispanic Youth

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The increasing utilization of evidence-based treatments has highlighted the need for treatment development efforts that can craft interventions that are effective with Hispanic substance abusing youth and their families. The list of evidence-based treatments is extremely limited in its inclusion of interventions that are explicitly responsive to the unique characteristics and treatment needs of young Hispanics and that have been rigorously tested with this population. Some treatments that have been tested with Hispanics do not articulate the manner in which cultural characteristics and therapy processes interact. Other treatments have emphasized the important role of culture but have not been tested rigorously. The value of well designed interventions built upon an appreciation for unique patient characteristics was highlighted by Beutler et al. (1996) when they argued that ''psychotherapy is comprised of a set of complex tasks, and practitioners need comprehensive knowledge of how different processes used in psychotherapy interact with patient characteristics in order to make treatment decisions that will maximize and optimize therapeutic power'' (p. 30). A focus on how treatment processes interact with patient characteristics is particularly relevant in the Hispanic population because of the considerable heterogeneity beneath the Hispanic umbrella. Our new program of clinical research focuses on articulating how the varied profiles with regard to immigration stressors, acculturation processes, values clashes, sense of belonging to the community, discrimination, and knowledge about issues important to adolescent health can be more effectively addressed by a culturally informed treatment.

Keywords: Hispanic; Adolescent; Integrative Drug Treatment; Culture; Adaptive Interventions; Family Therapy

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The importance of establishing the efficacy of culturally informed treatments is highlighted by the substantial number of young Hispanics in the United States and by the severity of symptoms that have been documented in this population. The health of this large cohort of children is significant given that Hispanics make up 15% of the general population in the United States, with 34% of the Hispanic population younger than 18 compared with 25% for the total population (U.S. Census Bureau Estimates, 2007). Most importantly, several health indicators show that this is a segment of the population in need of urgent attention. Alarming indicators include: (1) disproportionately high rates of drug use among 8th grade Hispanic youth (De La Rosa, Holleran, Rugh, & MacMaster, 2005), highest when compared with both White and Black youth (Johnston, O'Malley, & Bachman, 2005), (2) high rates of HIV and STIs (Centers for Disease Control and Prevention [CDC], 2005, 2008), and (3) depressive symptoms and suicide ideation also highest among Hispanic youth (CDC, 2008; Twenge & Nolen-Hoeksema, 2002). Not surprisingly, the likelihood of smoking, binge drinking, cocaine use, and inhalant use have been linked to depressive symptoms (Kelder et al., 2001) and to high rates of HIV and STIs (Guo et al., 2002).

In the work reported in this article, our team sought to create a more intensive treatment with improved outcomes for Hispanic youth who suffered from drug abuse and their families. Our previous research had shown that while conjoint family therapy had been shown to be efficacious, some of the major indicators showed that 50% or more of clients were not yet achieving clinically significant change (Santisteban et al., 2003), a finding that is not unusual for a recalcitrant symptom such as drug use. Beginning with a Stage I treatment development grant designed to encourage innovation, we set out to create a more comprehensive and intensive treatment that would more effectively address the complex needs of substance abusing adolescents and their families. Efforts focused on: (1) evolving from a single component family therapy treatment to a more intensive multicomponent intervention that incorporates individually oriented interventions and psycho-educational modules into our family-based treatment, (2) conducting basic research that helped identify content and themes that were particularly relevant to the lives and experiences of Hispanic youth and families and using these results to create new culturally relevant interventions, (3) creating a flexible manual and decision rules that allowed the treatment to be adapted to improve its ''fit'' with the needs and experiences of Hispanic substance abusing youth and families, and (4) obtaining preliminary feasibility/acceptability data. Work in each of the areas is described below.

MODIFICATIONS TO BECOME AN INTEGRATED MULTICOMPONENT INTERVENTION

Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA's) treatment development work began by challenging many of our assumptions about the optimal components of a treatment for Hispanic substance abusing adolescents and their families, and creating a new integrative treatment. CIFFTA has Structural Family Therapy (Minuchin & Fishman, 1981) as its foundation, including some adaptations (e.g., increased emphasis on parental monitoring, work with the legal system) needed for working with drug using youth. The more innovative aspects of CIFFTA include individual and psychoeducational interventions, more intensity, and more flexibility in its treatment options. In its final form, CIFFTA is delivered over approximately 16 weeks in a two session per week format.

Approximately half of the work is with the adolescent alone (individual treatment and adolescent-oriented modules) and half is conjoint family treatment and/or work with parents alone (family therapy and some parent modules). In this sense, CIFFTA reflects a substantial departure from the authors' previous work on treatment restricted to conjoint family therapy and typically delivered in a once-per-week format (Santisteban et al., 2003; Santisteban, Suarez-Morales, Robbins, & Szapocznik, 2006). CIFFTA is based on a set of assumptions that make it integrative. First, that family intervention is indeed a powerful foundation for the treatment of adolescents. Second, that adolescents can benefit substantially from motivational interviewing, goal setting, relapse prevention strategies, interpersonal effectiveness skills, and other individually-oriented interventions. Third, that structured psychoeducational modules delivered in a didactic format can complement the more free-flowing family sessions and ensure that key themes are handled systematically and in their full complexity.

Why Add Individual Work?

In working with adolescents who are making daily choices to turn to drugs and deviant peers to cope with emotional turmoil and/or life stressors, it became clear that there are missed opportunities when one-on-one work with the adolescent is not a major component of the treatment. This is particularly true with older adolescents who are struggling to develop effective skills for redirecting their own lives toward healthy outcomes. For this reason, one of the first steps taken to improve the outcomes of our family-based treatment was to carefully integrate individual work into CIFFTA. For example, the majority of youngsters with substance abuse problems are accustomed to being forcefully confronted by adults in the family, school, legal, and treatment systems. It became particularly important to consider evidence-based interventions designed to help the adolescents develop their own goals and motivation for change without triggering the defensive behavior that confrontation tends to elicit. The growing evidence that Motivational Interviewing strategies (Miller & Rollnick, 2002) can be highly successful in lowering resistance so commonly seen in adolescents and that this intervention can be successfully combined with other treatments led to its integration into our work. CIFFTA interventions also sought to strengthen the often weak set of life skills adolescents bring with them into treatment. Interpersonal and crisis management skills training borrowed from the outstanding work of Marsha Linehan (1993) and adapted for adolescents by our clinical team were incorporated into CIFFTA. Interventions aimed at teaching youth about the chemical imbalances brought about by severe drug use and the knowledge and skills needed to avoid risky sexual behavior, STIs, and HIV were also integrated. Finally, the individually focused treatment sessions allowed an exploration of the youths' ethnic and race identity and a full discussion of strategies for handling the stress resulting from the discrimination and alienation they experience. This set of individually oriented additions to our family-based treatment resulted from our assumption that while we worked to improve the family context in which troubled adolescents live, we must also work directly with youngsters struggling through the challenging demands and stressors of the adolescent developmental stage.

Why Add Psychoeducational Modules?

A second step in designing the multi-component CIFFTA treatment was the integration of structured thematic modules. A major assumption behind the development

of this component was that a module: (1) provides clearer guidance on the systematic implementation/delivery of important material, (2) constitutes a highly replicable intervention, and (3) facilitates the mixing and matching that a flexible manual attempts to achieve. Psychoeducational modules were deemed helpful because the free-flowing process of family therapy may not always be the best vehicle to facilitate the family's focused learning of important facts that have accumulated in key areas relevant to adolescent drug abuse (e.g., drug education, STI/HIV risk, parenting practices). Modules were developed that provided a structured and systematic presentation of important topics in a format and at a level that parents and the adolescent could absorb and that could facilitate the behavioral changes targeted by family therapy sessions. Information delivered via psychoeducational modules creates ''therapeutic frames'' for the core presenting problems thereby increasing the family's readiness to achieve the relationship changes they seek.

An additional benefit of having psychoeducational modules that practically stand alone is that they can be selected if and only if the theme of the module is of particular relevance to the family. The set of 11 CIFFTA modules made possible a process in which these thematic modules were available as treatment options within the family-based treatment and used only as needed. Brief modules cover such topics as: parenting practices, drug education (versions for parents and youth), risky sexual behavior (versions for parents and youth), interpersonal effectiveness skills for youth, issues in blended and single parent families, issues that emerge when working with a psychiatrist around medications for children, working through parent-child separations, working with the juvenile justice system, and understanding acculturation-related stressors and their possible impact on the family. The selection of modules became a key component of the ''tailoring'' activity.

INCREASING CONTENT AND THEMES RELEVANT TO HISPANIC YOUTH AND FAMILIES

The treatment literature on Hispanic families has documented many special stressors and immigration/acculturation experiences that shape their lives and that should be considered in treatment (Falicov, 2007; La Roche & Christopher, 2008; Santisteban, Muir-Malcolm, Mitrani, & Szapocznik, 2002). Stressors include, but are not limited to, acculturation and immigration stress, intrafamilial conflicts around acculturation, and being the target of discrimination based on ethnicity and race. The use of treatments that fail to incorporate findings on culture-related variables ignores the individual differences and differences in life experiences that define ethnic minorities (Bernal & Scharron-Del-Rio, 2001). Just as one would expect that treatments used with adolescents should incorporate the findings of developmental research (Liddle et al., 2000) and findings on family processes (Alexander, Sexton, & Robbins, 2002), we believe that state of the science interventions with minority groups must be explicitly informed and enhanced by findings on important culture-related processes. We do not believe that the onus should be solely on a culturally competent therapist to deliver a manualized treatment that makes only passing reference to issues of culture. The optimal situation is that treatments for Hispanics integrate specific content relevant to the experiences of Hispanic families, show the connection of these themes to well known family processes, and lend themselves to rigorous testing with this population. By successfully addressing these issues, the treatment becomes more relevant

and timely for Hispanics and has the potential to improve the engagement, retention, and outcomes of this population. In all of the family, individual, and psychoeducational components, CIFFTA attempts to incorporate culturally relevant material. In family therapy, for example, we seek to help a hopeless and frustrated parent to stay engaged in treatment by helping her/him to perceive the conflict with the son as partly due to complex and normative acculturation processes during which adolescents change their values, beliefs, and behaviors, rather than simply as a personal rejection or disrespectful behavior. In psychoeducational modules such as parenting practices, we highlight the differences in parenting practices often seen in more hierarchical versus egalitarian families and how these can sometimes be more prominent in some ethnic cultures than in others.

A Basic Research Study to Generate New Culturally Relevant Material for CIFFTA

To generate new empirical findings regarding how Hispanic values, beliefs, and behaviors might interact with key family processes and that would help us develop new interventions for the CIFFTA treatment, we conducted a cross-sectional study as the first phase of the CIFFTA treatment development grant. Basic research can serve as an important part of treatment development efforts when the knowledge derived is used to design and/or refine treatments for specific populations. This separate study focused on investigating the links between immigration and acculturation-related factors, clinical processes, and adolescent behavior. Because of space limitations, in this article we limit ourselves to two issues that emerged in our previous clinical work with drug abusing Hispanic youth, namely immigration-related parent-child separations and adolescent risky sexual behavior. Other issues that we continue to investigate but that are not reported here include: (1) the links between Hispanic-specific stressors within the family and disruptions in family relations and (2) the links between certain values (e.g., egalitarian and nonegalitarian preferences) and comfort with commonly used family therapy interventions. By using structured interviews and psychometrically sound self-report measures within a systematic assessment process, we sought to use the empirical findings as the foundation for the development and/or refinement of treatment themes and psychoeducational modules. Instruments that were available in English and Spanish and that have been successfully used with Hispanic populations were used. Interviewers were fully bilingual in English and Spanish and conducted the 90 minute assessment in the family's language of choice.

In this cross-sectional study 110 Hispanic adolescents and their parents participated in the assessments. Adolescents were 14–17 years of age and had been admitted to an assessment facility due to severe behavior problems and substance abuse. Sixty-four percent of the adolescents were male and there was substantial variability in the Hispanic groups represented within this sample (e.g., Cuban, Honduran, Puerto Rican, Dominican, Nicaraguan, Colombian, Venezuelan, Mexican, Ecuadorian, Peruvian, and Panamanian). In our study, mother assessments were much more common than father assessments and we used those assessments whenever possible. Eighty-one percent of parents reported an educational level of high school or less and the median family income range for the sample was between $20,000 and $24,999. Seventy-four percent of Hispanic parents preferred the questionnaires and interviews in Spanish while 90% of the adolescents expressed a preference for English.

Extended parent-child separations and their impact on adolescents

Extended parent-child separations can occur for many reasons and often contribute to disruptions in healthy family processes (Mena, Mitrani, Muir, & Santisteban, 2008) and unhealthy adolescent functioning. Although this issue was not present in the majority of immigrant Hispanic families, when it did occur in a family with a behavior problem youth, it was a powerful experience that was often linked to the persistence of the problem. Our clinical experience with Hispanic adolescents and their families led us to appreciate the power of immigration-related separations and to want to learn more about how these important family events (Falicov, 2007; Suarez-Orozco & Suarez-Orozco, 2001) could impact adolescent functioning. In our sample we also found that there were substantial numbers of youth with extended separations for nonimmigration related reasons, such as when parents are unable to care for the children due to their own financial, mental health, or substance abuse issues or when the child's behavior is deemed to be beyond parental control. For all separated families, improvement in family functioning was difficult to achieve if therapists missed or avoided these separation themes.

In the analyses of this separation process we conducted regression analyses on the assessment data of 145 youth and parents (for this analysis we were able to combine the sample of 110 with an additional comparable sample of 35 youth). Assessment data consisted of a demographic form that included descriptions of parent-adolescent separations (e.g., for how long, at what age, and from whom), and adolescent internalizing disorders (all anxiety disorders and major depressive disorder) as reported by the mother using the Diagnostic Interview Schedule for Children—Predictive (Lucas et al., 2001), which assesses the likelihood that a person will meet Diagnostic and Statistical Manual of Mental Mental Disorders (4^{th} ed.) (DSM-IV) diagnostic criteria for a number of different psychiatric disorders. For these analyses we chose those separations that were primarily from the mother because in every instance, this represented a child that was left with no biological parent. Separations from fathers were much more frequent and in many cases the mother was still present in the child's life. Fifty-three percent of all adolescents had experienced either an immigration-related (11%) or nonimmigration-related (42%) separation from their mother. Separations typically occurred between the ages of 7 and 10 and lasted for 2–3 years.

One of the most important findings in this investigation related to interactions between gender and the type of separation experienced. Although there was a significant relationship between separations and internalizing symptoms for all youth with substance abuse problems, further exploration of these relationships showed that: (1) immigration-related separations appeared to be more strongly related to depression than nonimmigration separations, $\Delta R^2 = .050$, $F\,(2, 141) = 3.90$, $p < .05$, (2) females tended to show a much stronger relationship than males between depression and both immigration-related separations, $b = -3.704$, $t(138) = -3.27$, $p < .01$, and nonimmigration-related separations, $b = -1.653$, $t(138) = -2.36$, $p < .05$, and (3) females showed a clearer relationship between length of the separation and internalizing disorders, $b = .405$, $t(139) = 2.16$, $p < .05$ (Mena et al., 2008). Taken together, these data suggest that while all separations may be potentially detrimental, immigration-related separations can be particularly powerful and that female adolescents may be particularly susceptible to these particular harmful effects. These findings were incorporated into our psychoeducational module focused on parent-child

separations and into the family discussions designed to ameliorate the negative impact of the extended separations.

Hispanic family process and adolescent risky sexual behavior

Family factors such as high levels of parental involvement and good parent-adolescent communication about risky sexual behavior have been consistently linked to promoting healthy youth behavior including engaging in less unprotected sex (Hutchinson, Jemmot, Jemmot, Braverman, & Fong, 2003). We also know, however, that a number of factors make open and honest conversations about sexuality particularly difficult in more traditional Hispanic families (Villarruel, 1998). With this research question we wanted to move beyond our anecdotal and clinical evidence that this conversation is not an easy one for more traditional Hispanic parents to empirically identify specific barriers and create intervention strategies that could help therapists handle this issue more effectively.

Our second set of analyses therefore focused on adolescent and parent/family factors that are associated with communication about birth control among Hispanic substance abusing adolescents and their families and explored possible adolescent gender differences in these family factors. For these analyses, measures were selected that addressed demographic information, parent and adolescent report of acculturation, which includes a separate dimension for Hispanicism (i.e., the degree to which the individual endorses Spanish language usage, radio, music), and a similar Americanism dimension (Bicultural Involvement Questionnaire—Szapocznik, Kurtines, & Fernandez, 1980), adolescent report of parent-adolescent attachment quality (Inventory of Parent and Peer Attachment (IPPA)—Armsden & Greenberg, 1987), parent and adolescent report of parenting practices including level of parental involvement (Parenting Practices Questionnaire—Gorman-Smith, Tolan, Zelli, & Huesmann, 1996), and parent perceptions of barriers to talking to their adolescent about sex (items taken from the National Longitudinal Adolescent Health Questionnaire—Bearman, Jones, & Udry, 1997). These measures had strong psychometric properties and Cronbach alphas for the sample ranged from .73 to .95. This set of analyses focused on the prediction of talk of birth control between Hispanic parents and their adolescent. To understand the factors that influenced these types of parent-adolescent communications, we investigated the overall level of parent-child communication, parental barriers to discussing sex, and adolescent reports of levels of parental involvement utilizing multiple regression analyses.

The regression analysis revealed that the overall set of predictors were highly related to birth control talk, $F\ (11, 107) = 11.15$, $p < .0001$. Not surprisingly Hispanic parents who had older adolescents, $\beta = .17$, $p = .02$, and whose children reported more parental involvement, $\beta = .31$, $p = .0001$, reported greater frequency of Birth Control Talk. After controlling for those factors, there were still additional significant predictors of this type of communication. Hispanic parents were less likely to have these conversations when they were concerned with possible negative reactions from their adolescent, $\beta = .38$, $p = .0001$, and when they felt they were not knowledgeable and confident regarding the facts of sexually transmitted infections and the role of birth control, $\beta = .41$, $p = .0001$(Mena, Dillon, Mason, & Santisteban, 2008).

From the point of view of a family-based intervention, these findings were highly meaningful because family interventions can target all of these factors (e.g., level of

parent-youth involvement, quality of communication, handling negative reactions). Furthermore, for Hispanic parents who have not had a history of these types of conversations and who felt that they lacked the breadth of knowledge regarding safer sex practices and who needed to feel confident in such discussions, our program developed a psychoeducational module for parents. This parent version included the facts about STIs, HIV/AIDS, the added risks for drug abusing youth, the high rates of HIV/AIDS found in Hispanics, and information on safer sex practices—all parallel to those offered to the adolescents. This strategy of strengthening a potential protective factor within the family at the same time that we build the needed skills in the adolescent is consistent with the overall philosophy of our integrative family-based CIFFTA. This level of communication between parents and adolescents regarding sexually related topics may not be welcomed by all Hispanic families but may be particularly needed in the families of substance abusing youth who are at very high risk of STIs and HIV.

Our third set of analyses focused directly on the clinical and cultural correlates of condom use among sexually active substance abusing adolescents. Hispanic adolescents have been shown to engage in riskier sexual behaviors when compared with non-Hispanic youth (CDC, 2005) and substance abusing youth are particularly prone to risky sexual behavior (Guo et al., 2002). These facts alone, however, tell us little about how culture-related factors might contribute to risky sexual behavior among Hispanic substance abusing youth and whether these culture-related effects are equally salient in males and females. Therefore, we investigated whether adolescent age, gender, acculturation, and psychiatric variables could predict sexual activity and risky sexual practices (i.e., sexual intercourse without condom use) among those adolescents who were already sexually active. For these analyses, measures were selected that addressed demographic information, parent and adolescent reports of acculturation (Bicultural Involvement Questionnaire—Szapocznik et al., 1980), adolescent reports of their own sexual behaviors (questions assessing sexual behaviors asked about frequency of risky sexual behavior, including number of partners and number of times having engaged in the behavior), and the adolescent report of co-occurring psychiatric symptomatology (Diagnostic Interview for Children—Predictive; Lucas et al., 2001). The diagnoses included in the analyses were Anxiety Disorders, Major Depressive Disorder, ADHD, Oppositional Defiant Disorder, and Conduct Disorder.

The findings from the logistic regression analysis pointed to the fact that among Hispanic females lower adolescent Americanism, $b = .092$, $\chi^2(1) = 4.546$, $p = .033$, and higher parent Americanism, $b = -.048$, $\chi^2(1) = 3.740$, $p = .053$, were associated with greater likelihood of engaging in sex over the past 30 days. Relative to females, the effects of both adolescent and parent Americanism in males were small. More importantly, when we investigated the predictors of frequency of condom use during the past 30 days among the subset of Hispanic adolescents who reported being sexually active, we found that adolescent females whose parents reported high Americanism, $\beta = -1.088$, $t(47) = -2.998$, $p = .004$, were more likely to report using a condom during sexual activity. In contrast, adolescent males reported overall higher levels of condom use, but use did not differ depending on the level of Americanism of the parent. Taken together we find that as parents endorse more ''American'' values and activities on traditional acculturation measures, females tend to be more sexually active but do so in a much safer manner (Mena, Santisteban, Mason, & Dillon, 2008).

While parent acculturation did not appear to be as predictive of safe sex practices for Hispanic males, there was an equally interesting and clinically significant finding for males. Specifically we found that for Hispanic adolescent males, those who reported more co-occurring psychiatric diagnoses also reported less condom use when engaging in sexual activity, $\beta = -0.672$, $t(48) = -2.203$, $p = .032$. The same was not true for female adolescents. That is, in identifying processes and clinical profiles that are particularly problematic for Hispanic males, clinicians must keep an eye on psychiatric symptoms that coexist with substance abuse and can become obstacles to safer sex practices (Mena et al., 2008).

CREATING A FLEXIBLE MANUAL MECHANISM WITH REPLICABLE DECISION RULES

Findings that suggest that there may be improved outcomes resulting from tailored or adaptive interventions when working with minority populations (Griner & Smith, 2006) contributed to our goal of creating a treatment approach that delivers a manualized therapy in a way that is flexible and that incorporates decision rules that can be replicated. In the case of Hispanics, the highest level of complexity occurs with the realization that there is considerable heterogeneity both between and within groups that are clumped together under the Hispanic umbrella. Even a treatment designed primarily for Hispanics is unlikely to have a ''one size fits all'' solution. For a treatment manual to truly be of service to a therapist wishing to increase her/his level of clinical and cultural competence, the manual must incorporate a level of flexibility that makes specific intervention options available based on the identification of issues that are important to individual families. Efforts toward creating flexibility in a manner that is also replicable are particularly well articulated in the prevention arena where ''adaptive'' interventions are described and where there are serious efforts to delineate the decision-rules that are at the core of the tailoring processes (Collins, Murphy, & Bierman, 2004). In this work, the focus is on ''tailoring variables'' that can typically predict better or poorer outcomes to generic interventions. If these tailoring variables can be accurately defined, measured, and linked to decision rules that lead to the utilization of specific interventions, then one can hope to achieve enhanced outcomes. In the treatment realm, Rohrbaugh, Shoham, and Racioppo (2002) have focused on Aptitude $\times$ Treatment interactions, a similar way of describing the need for a good fit between client needs and characteristics and the specific interventions that can best meet these needs.

Once multiple CIFFTA components and psychoeducational modules were available as treatment options, the next challenge was to delineate a set of procedures for identifying those unique characteristics and needs that serve as tailoring variables, and describing steps for using this information to select modules and interventions. A systematic decision-making process would help not only counselors but also researchers who wish to rigorously test an adaptive intervention. Because the treatment package is flexible and changing, one must test the entire model that includes treatment options and its replicable set of procedures for tailoring. The emphasis on the measurement of the tailoring variables and the articulation of the decision-rules for finalizing the treatment package that will be offered to the family is an important recent advance in the field (Collins et al., 2004).

In our work we began by creating a comprehensive semistructured interview that was conducted by the therapist with the adolescent and parents during the initial

family sessions. We consider this interview an integral part of the manualized treatment and the tailoring process rather than as a separate procedure. One important component of this interview consists of asking family members to share their immigration history with the therapist—including such information as where the family is from, when and why the family came to the United States or for those who had been in the United States for many years, how much they felt a sense of belonging in their communities, whether family members were separated due to crossing the borders, and if so, what were the conditions of the separations. This discussion allowed us to probe whether there were current conflicts around issues of acculturation (e.g., clashing values). Our interview also gathered information about how and when mental health or substance abuse symptoms emerged and how the family attempted to deal with them (e.g., family-based strategies, psychosocial treatment, medications). This information was used in conjunction with intake data on comorbid diagnoses, to understand the full clinical picture. We also asked parents the extent to which they felt comfortable with the amount of information they had about drugs, alcohol, co-occurring psychiatric symptoms, sexually transmitted infections, and safer sex options.

The profiles resulting from this interview allowed us to identify interventions and modules that could be offered to the family and that would be perceived as relevant and timely. Based on this information the therapist—together with the family—formulated a treatment plan. We should point out that for this population we considered the modules on parenting practices for parents, drug education for youth, and HIV/STI risk reduction education for youth as core interventions for every family. Each of these included information about the profiles of Hispanics in these areas or issues that are highly prominent in Hispanic families. Additional modules were optional and selected based on the needs identified in the initial clinical interview. Those dyads that had been separated for extended periods were offered the ''separations module.'' Those whose children suffered from co-occurring psychiatric disorders were offered the ''co-occurring disorders module'' as well as the ''medication information and adherence module'' when appropriate. Families that felt that there was stress due to marked differences in levels of acculturation could have had that issue addressed by an ''acculturation process module.'' Parents who were dissatisfied with the amount of information they had on drugs, alcohol, or sexually transmitted infections were offered modules with this information.

The material and process presented in each of the modules created the ''therapeutic frames'' for continued work in the family and individual therapy sessions. For example, following the parenting and acculturation modules, it was expected that a family had new information to integrate into their family interactions around parenting and values that impact their relationships. Family sessions focused on shaping adaptive interactions using that material. Individual sessions that utilize a motivational interviewing strategy focused on eliciting from the adolescent a goal of avoiding the dangers discussed during the drug and HIV/STI modules and specific strategies for achieving this goal.

Although a therapy manual by definition focuses the efforts of the therapist on certain types of interventions and problems, a flexible manual facilitates a treatment that more closely resembles what a clinically and culturally competent therapist might do to creatively integrate his/her knowledge of family process, drug treatment, and culture with the unique nuances of the family. An expert clinician does not deliver a treatment package (all he/she knows about clinical work) in the same format to each

family as most therapy manuals appear to prescribe. They select from their knowledge that which is called for by the family and situational needs. We believe that the possibility of tailoring the treatment makes a manualized therapy not only more effective but also more attractive to clinicians who often feel that manuals impede flexibility, clinical judgment, and therapeutic alliance, and fail to specify the adjustments needed for clinically complex problems (Moras, 2002).

It is worth noting that the work described in this article could not have been achieved without first bringing together a team of culturally competent expert family clinicians and researchers. Clinical expertise led to the development of clinically meaningful research questions and the results led to the development of strong therapeutic components. For example, the team attempted to specifically lay out how family therapy interventions would address the fears of some Hispanic parents that family interactions would go poorly during conversations about sexual behavior, risk, and protection. The team identified the specific type of psychoeducational information that might satisfy the needs of Hispanic parents who did not feel competent to have these discussions with their youth. We attempted to go further in the work we had already initiated (Mitrani et al., 2004) in terms of specific adolescent symptoms that could emerge following extended parent-child separations. In integrating individual interventions such as Motivational Interviewing into our family-based work, the team challenged itself on apparent contradictions or conflicts in messages between psychoeducational, family, and individual treatment messages. For example, Morgenstern, Morgan, McCrady, Keller, and Carroll (2001) highlight the importance of how and when counselors may experience a conflict between the theoretical underpinnings of distinct treatment approaches that are being integrated. When integrating approaches these types of conflicts experienced by clinicians should not be underestimated. In CIFFTA we concentrated on whether it was possible to provide the psychoeducational information in a manner that conveyed the message that ''this approach appears to work for many people and you may want to consider it'' rather than ''I know best and this is what you need to do.'' The former message is more consistent with a motivational interviewing approach than the latter and creates more consistency between the newly integrated approaches.

For each of these areas, a major focus was on articulating the very close relationship between these newly formulated themes and the types of family mechanisms (e.g., parent-child attachment, parenting practices including leadership and guidance, conflict resolution, adolescent developmental stage issues) that prior research and clinical theory have shown to be at the core of good family work. A major part of the work of the clinical team was to describe the way therapists should create synergy between the different treatment components (i.e., family work, individual work, and psychoeducational modules). For example, in the manual we articulate the benefits of practicing during family sessions, the skills learned in psychoeducational modules, and how individual sessions can be used to plan for more effective family interactions. Although components appear able to stand alone, they really achieve their full impact only when they are used together strategically.

CIFFTA PRELIMINARY INDICATORS OF ACCEPTABILITY AND FEASIBILITY

In piloting the impact of a new Stage I treatment, indicators of acceptability (e.g., retention, therapeutic alliance) and feasibility of treatment delivery with the proposed

types of therapists, interventions, patients, and treatment settings are crucial (Rounsaville, Carroll, & Onken, 2001). This is particularly true for a multicomponent treatment such as CIFFTA that increases the intensity of office visits and raises the question of whether substance abusing youth and their families will actually attend. To test CIFFTA's impact on outcomes our team conducted a randomized trial that compared the three component—two sessions per week CIFFTA model to a more traditional one time per week family treatment. Participants were Hispanic adolescents between the ages of 14–17 years of age who met DSM-IV criteria for substance abuse. Therapists in the two conditions were master-level social workers and mental health counselors and all treatment sessions were conducted in a clinic. Although the analyses of the outcome data are still underway, in this article we can report data on retention and working alliance of the participating youth and parents. In all, 28 adolescents and their families were randomly assigned to either the more intensive CIFFTA ($N = 14$) or the once per week Traditional Conjoint Family Therapy ($N = 14$).

Were Youth with Substance Abuse Problems and Their Families Willing to Attend the More Intensive CIFFTA Treatment?

Three of the 28 cases (2 TFT and 1 CIFFTA) received five or fewer sessions and did not provide complete information for outcome analyses. This is the first indicator that CIFFTA did relatively well in retention of youth and families and that it was not substantially worse than the once per week treatment. A second way to explore the issue of acceptability was to assess whether CIFFTA participants who were offered a higher number of sessions were actually attending those additional sessions. The preliminary data suggest that adolescents and families were successfully and fully retained in all components of the more intensive CIFFTA treatment. CIFFTA participants who were offered psychoeducational and individual sessions in addition to the family sessions did indeed attend approximately three times as many outpatient treatment sessions as did the TFT condition families (CIFFTA: $M = 35.14$, $SD = 12.89$; TFT: $M = 11.93$, $SD = 4.71$).

Did Adolescents and Parents Report High Levels of "Working Alliances" with the CIFFTA Therapists?

Data from the ''Working Alliance Inventory'' showed a high level of alliance with the therapist as reported by both adolescents and parents for both CIFFTA and TFT. The Working Alliance Inventory is a self-report measure (Horvath & Greenberg, 1986) using a 1–7 scale, in which $1 = \textit{very low alliance}$ and $7 = \textit{the highest possible alliance}$. From the adolescent's perspective, the working alliance was high and not significantly different in the two conditions (TFT: $M = 5.44$, $SD = 1.28$; CIFFTA: $M = 5.96$, $SD = 0.95$), $\chi^2(df = 1) = 1.60$, ns. Similarly, mothers reported very high levels of alliance with their respective therapists and no significant differences between the two conditions (TFT: $M = 6.75$, $SD = 0.42$; CIFFTA: $M = 6.56$, $SD = 0.51$), $\chi^2(df = 1) = 2.64$, ns.

These preliminary data reflect a low number of premature terminations, a willingness to attend a relatively high number of in-office sessions despite the time and effort required, and a relatively high level of perceived total alliance with the therapist

as reported by both adolescents and mothers. Taken together these indicators suggest a highly promising level of acceptability and feasibility for a more intensive integrated CIFFTA treatment.

CONCLUSIONS AND FUTURE DIRECTIONS

The shortage of evidence based treatments for Hispanic youth that integrate information about culture-related strengths and stressors can be seen as both a crisis and an opportunity. In designing treatments for this important population, clinical researchers have the opportunity to utilize state of the science strategies and create adaptive/tailored treatments that become prototypes of this new movement. In this article we attempted to show how basic research was used to inform the development of themes that became central to CIFFTA by identifying relationships between family (e.g., communication and attachment) and culture-related processes (e.g., acculturation, immigration stress) and adolescent symptoms (e.g., depression, risky sexual behavior). We have also presented our thinking on how flexibility can be built into a manual and the continuing challenge to the field of improving the specification and standardized measurement of possible tailoring variables that can lead to decision rules designed in a replicable manner. By making treatment manuals responsive to the issues Hispanic families report as being important and central to their lives, these manuals can facilitate treatment delivery in a clinically and culturally competent manner. Clearly a treatment manual that emphasizes the links between culture-related variables and important drug addiction and family processes is not sufficient to produce clinically and culturally competent therapists. What a manual can do is to sharpen the focus on how these variables can interact and in doing so facilitate the process of delivering a manualized treatment in a culturally competent manner. Our presentation of how immigration related separations can impact a core family process such as attachment, and our inclusion of interventions to address this phenomenon in a flexible manual, are good examples of how we believe a manual can draw attention to unique immigration-related processes and culturally informed interventions. In this process a manual becomes a vehicle for making a strong statement about the importance of linking cultural knowledge and clinical practice and in giving examples of the role that cultural competence can play in treatment. Clinical researchers wishing to expand on these ideas can make major contributions to the field by making explicit these close relationships between treatment targets, family processes and specific cultural factors.

It is our challenge to make manualized treatments more attractive to clinicians who sometimes feel that manuals are rigid and fail to specify the adjustments needed for clinically complex problems. Manuals that do not prominently include discussions of heterogeneity among patients and how clinicians can work with a variety of clinical and cultural profiles are unlikely to win over the majority of clinicians. Our program of research continues to extend the work described in this article by creating decision rules that lead to different family and individual interventions that may be more appropriate for (1) younger adolescents and children, with (2) different symptom profiles (e.g., Conduct Disorder, Depression, and Attention Deficit Hyperactivity Disorder), and (3) youth with more limited resources available to be mobilized during the treatment process.

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