Preface

We are grateful that with this book we can share what we have learned over decades of serving youth and families. The first reason for the gratitude comes from having had the opportunity to conduct and publish considerable research that supports the use of family therapy, and to share findings on family processes that are key to the well-being of underserved children and adolescents. We acknowledge the generous funding we received from the National Institutes of Health for development and outcome research. This allowed us to provide free and top-quality treatment to thousands of diverse youth and family members, to learn from families about what works and what does not, and to develop innovations. We have used this knowledge to train the next generation of therapists, researchers, and scholars. We have integrated the voices and perspectives of these thousands of family members into the treatment model we call Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA). Together we have over 80 years of experience in family processes, family therapy, training, and the role of culture-related processes in adolescent symptoms and treatment. Throughout these years, we have had extraordinary colleagues in centers such as Encuentro, the Spanish Family Guidance Center, and the Center for Family Studies. The pursuit of excellence, passion, and commitment of our colleagues has been inspiring. Although the book is written from the perspective of the clinician, and each chapter is highly practice-oriented, the foundation of our work rests on adolescent, family, and treatment processes that have been supported by rigorous research.

In this book, we make the case for the value of evidence-based treatments (EBTs). It should not be a difficult case to make. If we were

considering the use of a powerful medication or undergoing an intensive medical procedure, we would always want to know that the evidence on effectiveness, unintended consequences, and side effects are known and factored into the equation for whether to proceed. No one wants to waste time with ineffective treatments that can make a problem worse, or that leave a patient hopeless because the problem continues a harmful course. The same argument holds for the treatment of mental health problems, such as depression, substance misuse, self-harm, and suicide, especially in children and adolescents. No therapist or parent wants these serious problems to persist and interfere with healthy development. And it would make sense that we do not want to try unproven methods, even if they may be popular. It is a benefit to society that funding agencies are increasingly requiring EBTs for youth and families.

One can argue that the use of treatments proven effective is particularly important in the Latine population (we will say more below about the selection of the term *Latine* instead of *Latino* or *Latinx*), in which many longstanding health disparities have been identified (Alegría et al., 2016). Research has shown that self-harm and suicide risk are high in female/Latina adolescents (Zayas & Gulbas, 2012; Gulbas et al., 2019); that for male/Latine youth, substance use has historically been high in middle school ages (Szapocznik et al., 2007); that severe behavior problems may have particularly harsh legal consequences for Latine youth; that Latine youth and families face difficult conditions due to powerful immigration and acculturation stressors (Cervantes et al., 2014); and that Latine families are less likely to seek and remain in services for their youth (Alegría et al., 2014). It is hard to argue with the premise that Latines and other minoritized populations deserve the best that science has to offer (i.e., EBTs) when treating mental health issues. (In this book, we use *minoritized* to mean a group that is treated as distinct from and less important than the dominant population.) There is no reason why the treatment of depression, self-harm, or substance use should be based on science and evidence any less than the treatment of cancer, hypertension, or diabetes. And yet, the field of Latine youth treatment has been the stage for an intense debate regarding the pros and cons of using EBTs. This is the important *context* in which we present this book, and it is important to acknowledge the best arguments on both sides of this debate.

We must not look upon EBTs with rose-colored glasses. Research methods have limitations, and we should continue to try to improve them and combine different methods (e.g., quantitative and qualitative) to obtain increasingly useful answers. There are two additional well-substantiated problems with EBTs that this book will attempt to

address. The first is that manualized treatments have been criticized for being rigid, inflexible, overly restrictive, and prescriptive, and unable to adequately provide guidance in complex clinical situations. The second problem, one even more central to the purpose of this book, is that too many of our current EBTs fail to incorporate what we know about the role of culture and unique life experiences in Latine and other minoritized families. This is the reason for the debate regarding EBTs and the treatment of Latine and other minoritized populations. Treatment manuals in widespread use fail to articulate the precise role of these factors (e.g., worldview and systemic discrimination) *and their impact* on the treatment mechanisms at the core of the manuals. This is particularly problematic given a growing body of evidence on the positive impact of treatments that include culture-related factors within the core of the treatment. These findings suggest that without an integration of cultural factors, even EBTs may not be reaching their optimal outcomes when used with Latine and other diverse clients.

This brings us to a second reason for the gratitude the three of us feel. It comes from being immigrants, or the child of first-generation immigrants, who were welcomed to a generous country that provided us the opportunities to be the first college graduates in our families, leaders in the family therapy field, and the authors of this book. Just as important as our research training and National Institutes of Health–funded research is the fact that our lives were shaped by culture, immigration, and acculturation-related experiences that are described in these pages. We know firsthand that these experiences have powerful impacts on families (i.e., both risk and protective influences), and they helped to shape our sensibilities to these issues. Our parents took great risks, worked harder than anyone should be expected to work, and showed the scars that come from leaving everything behind in their country of birth (often including their parents and other family members whom they never saw again) to begin from scratch in an unfamiliar land.

These experiences helped us to appreciate their role in the process of treatment for Latine and other immigrant groups. When we realized that much of the literature on cultural factors was separate and disconnected from much of the outcome research on adolescent treatment and the manuals for EBTs, we saw the urgent need to share our perspectives on the importance of bridging these two worlds. Too often an EBT that makes no mention of culture when describing its mechanisms expects that the therapist is trained in cultural sensitivity and adds that layer to the treatment in their own idiosyncratic way. We do not believe this is the best approach for the field. We can help therapists be more effective and responsive to the needs of diverse families if the treatment manual

itself bridges culture, unique life experiences, and mechanisms. What does this look like concretely? It is a therapist who understands both the power of strong parents who can guide and nurture the youth, and the specific way they may have to do that when the youth is the victim of racism or a traumatic event. The therapist may even have to acknowledge that because the parents continue to experience this same stressor each day, their ability to lead with confidence may be negatively impacted. This is what it looks like to be aware, sensitive, and prepared to tackle therapy mechanisms, culture, and life events simultaneously and in an integrated fashion. When we train and prepare to treat families, we must know as much as possible about family dynamics, family subsystems, and communication so that we are prepared to see clearly and take appropriate steps to help. The same is true of culture, discrimination, immigration, and acculturation—the more we know about how these processes work in a systematic and structural way, and how they negatively impact family relationships, the more prepared we are to help the families we work with.

EVOLVING PERSPECTIVES ON IMMIGRATION

We cannot leave this topic without briefly mentioning the immigration dialogue taking place in many societies. The welcoming of immigrants is never a straight line. Our society goes through peaks and valleys in terms of how receptive it will be to immigrants, and the reception for different groups varies depending on political, social, and economic factors, as well as the history of politics with the country of emigration. Some groups are welcomed with open arms while others are not welcomed at all, even when immigration occurs in the same historical period and for similar reasons. Presently, the mature and informed conversation that should be taking place regarding the most effective processes and rates of planned immigration and naturalization has been replaced by fear, anger, posturing, hostility, and warring factions. It is not something that makes sense, given that the United States continues to need planned immigration to fill positions at all levels of industries and science. This is true because without immigration, the birth rate in the United States continues to decline similar to what is happening in many other countries. In fact, in the most practical terms, we all need more workers contributing taxes on their earnings if we want to have a chance of receiving, when we retire, the benefits we felt we paid for throughout our employment years. There are good points on all sides of the debate, but what is truly needed is a rational and mature conversation.

We share this perspective not to take a political position, but to acknowledge that this is the background, the noise, and the distress that families are experiencing when entering treatment, even as their description of the problem is focused on symptoms such as behavior problems, substance use, or self-harm. As practitioners, we cannot look away from these truths because families that feel they must stay in the shadows will not avail themselves of the services we feel they need to promote well-being. We must also be sensitive to the fact that some individuals who strongly oppose even planned immigration are going through their own difficulties, occupational and culture-related losses, and disillusionment. This distress also goes unacknowledged, though it is quite evident—just look at the increasing suicide rates across race, ethnicity, and economic status profiles. Treatment for individuals and families must also take these painful truths into account. These life experiences are not disconnected from the work of treatment. One cannot treat the presenting problem without understanding the lived experience and the stressors that are impacting symptoms and the family's sense of well-being. We hope that our book shares a perspective on what humane treatment of vulnerable people and their families should look like. We hope it conveys a celebration of all diversity so that the beauty and strength of differences can be better appreciated and mobilized in treatment. We also hope what we share will help you *see* your client more clearly. It is certainly a wise adage that "If we see clearly, we will know what to do."

TERMINOLOGY

In this final section, we would like to share our thoughts on terminology and labels that we use throughout the book. We begin with a brief overview of the individuals included under the Hispanic and Latine umbrella, including the terminology of *Hispanic*, *Latino*, and *Latinx*. One of the most popular umbrella terms to be used widely in the United States was *Hispanic*. Hispanic came into widespread use in the 1970s and was included in the 1980 census. The term was welcomed in large part because it brought together a large group of individuals claiming roots in Spanish-speaking countries. The considerable size of the group under this umbrella had important implications for the group's political power and led to an appreciation of the group's growing influence in American culture.

In the decade of the 1990s, a sense arose that *Hispanic* overemphasized links to Spain (and the problematic parts of Spain's history of conquest) and descendants from Spanish-speaking countries. Use of the

term *Latino* gained more widespread appeal. *Latino* was considered to accentuate important roots in the countries of Latin America. Its emphasis was on the history and experiences of people who had been in Latin America long before the arrival of Spaniards. For the past decades, the terms *Latino* and *Hispanic* have tended to be used interchangeably, and they appeared together for the first time in the 2000 census. The fact that the terms are often used interchangeably does not mean that there are not strong emotional arguments for the use of one over another.

One of the more recent terms to hit the scene is *Latinx*. It has been recommended as a more inclusive term that refers to individuals of Latin American descent without placing emphasis on issues of gender (especially male gender, as in *Latino*) and excluding individuals who prefer not to be identified by traditional gender status. This gender-neutral term has not yet caught on among the population it is meant to represent. Only 25% of individuals of Latine descent are familiar with the *Latinx* term, and only 3% use *Latinx* to describe themselves (Noe-Bustamante et al., 2020). Perhaps the reluctance to accept the terms should not be surprising given that the population tends to be more on the conservative and traditional side of the continuum, and that Spanish is a "gendered" language. For example, the words *el libro* and *el capítulo*, meaning the book and the chapter, respectively, are linked to male gender, while *palabras*, meaning the words, are linked to female gender. This may contribute to a reluctance to see the need for a gender-neutral term. Perhaps it is just too soon in the life of the new terminology. Indeed, according to a Pew 2020 survey (Noe-Bustamante et al., 2020), even the term *Latino* is not as commonly endorsed as the original *Hispanic*. This brings us to the term *Latine*, which we have chosen for this book. It is akin to the gender-neutral term for a student, which is *estudiante*. As we were reaching a decision on whether to use Hispanic, Latino, or Latinx, we found a compelling set of arguments for the use of *Latine*. This term is being widely used in Spanish-language literature and is more in tune with a gender-neutral term a Spanish-speaking person might use. We chose to use this term, but we also acknowledge that we are unsure about whether it will stand the test of time.

In general, Mexicans, Puerto Ricans, Cubans, Spaniards, and Nicaraguans will typically want to be called by their identity as relates to the name of their home country. They identify most with their country of origin and not really with any of the umbrella terms. Of course, some may prefer Mexican American or Cuban American. Many would not be happy with a hyphenated label such as Mexican-American, which can convey that they are not fully American. Individuals acknowledge the similarities they share, but they also appreciate the substantial differences

in the reasons for and route of historical and current migration, reception in the United States, traditionalism, social class, education, and other life experiences (marginalization and immigration-related separations). The experience of a Mexican American whose family has been in New Mexico for three generations, or a Puerto Rican whose family has been living on the island for the same amount of time, may differ across myriad dimensions from that of a Venezuelan or a Honduran who has been in the United States for 4 months. While it is common to use such general categories as *Hispanic* or *Latino* or *Latine,* for the sake of convenience and to attempt to point to commonalities shared by a larger group of people, it is important to keep in mind the substantial limitations of any such categorical label.

REASONS AND ROUTES OF MIGRATION TO THE UNITED STATES

As we describe in more detail in Chapter 2, there are myriad reasons for migration. Of course, any such discussion must begin with a subset of Latines of Mexican descent, for whom the question is not "How did they come to the United States?" but "How did the United States come to them?" Before the early 19th century, most of the people of Mexico were of mixed Spanish and Indigenous background. After approximately 300 years of Spanish rule, Mexico won its independence in 1821. For the inhabitants of Northern Mexico, however, everything changed when war erupted between Mexico and the United States in 1846. When Mexico lost the war, they also lost land that is now Texas, California, and other sections of the Southwest. With that, and with a later land sale by Mexico to the United States, one-third of Mexico became the United States and *close to 100,000 Mexicans were suddenly living in the United States without ever leaving their homes*. These Mexican families were now susceptible to being called foreigners by anyone who did not understand history, territorial expansion, land conquest, and land sales. This history and its consequences continue to be the roots of present-day tensions.

TYPE OF IMMIGRANTS

John Berry (2006), one of the foremost writers on migration and acculturation, describes different types of migrants including voluntary immigrants, refugees, asylum seekers, and sojourners. It is beneficial to think

about the difference between individuals in these categories, but the overlap is considerable, and people placed in one category may argue that they belong elsewhere.

Voluntary immigrants are those individuals who migrate away from their country of origin by choice. They are said to be in search of improved educational, economic, and employment opportunities. There is a great deal of variability in terms of how these immigrants are received and welcomed in the United States.

Refugees do not leave their countries voluntarily or by choice but are displaced by violence and persecution. Refugees are often welcomed into the host country, and their entry is documented in agreements that invite the refugees to stay. Refugees are often characterized by a desire to return to their country of origin when it becomes safe to do so.

Many people who are said to have come *voluntarily* will point out the great turmoil, danger, and persecution that they were fleeing. Whether or not government agreements were in place does not change the danger that the family experienced and that led them to leave everything they owned, everyone they loved, the land, the town squares where families cared for each other, and the community that gave their lives meaning.

Asylum seekers also request refuge in a new country due to fear of persecution and violence. Again, you see that the boundaries between these categories of immigrants are quite vague and susceptible to interpretation. And yet, they are important because the categorization leads some groups to feel they have more of a right to be in the United States than others, and they may become unsupportive of immigrants who they feel do not have a "good enough" reason to want to enter the United States.

Those immigrants who are made to feel unwelcome may forever feel separate and may be less likely to incorporate themselves into society. There may be an important difference between immigrants who do not see a return to their homeland in their future, that is, those who are said to "burn their bridges behind them," and those who either return regularly or never fully disconnect from their families back home. The latter group can often be described as transnational, with their identities connected to more than one nation.

To know a Latine family fully, one must be able to distinguish these different lived experiences and be open to the stories that a family shares about themselves, the life-changing decisions they have made for their families, and their place in the world. These subtle differences in life experiences are often connected to strong emotions and pain or pride in the client. This book is written for those who are willing to truly prepare themselves to be as effective as possible with their clients no matter what

background they come from. Although the research began with Latine clients and the need to integrate culture and science, it is now about a template for integrating the lived experience of many diverse clients and the science on family and treatment process.

OUR USE OF PRONOUNS

We should also mention our approach to the use of pronouns and our attempts to ensure that our writing is as gender inclusive as possible. Guidelines on language (e.g., American Psychological Association, the *Chicago Manual of Style*, and the Modern Language Association) support the movement away from gender-restrictive terms such as *he* and *she* and toward the use of the singular *they*. Whenever we must use a pronoun and the correct one is unknown, we use the singular *they*. Some will argue that this usage is not grammatically correct but as the rules on grammar have evolved, experts have argued that this usage is grammatically correct. This of course does not guarantee that our grandchild will not one day pick up the book and still say, "What were they thinking?", because new and more useful and inclusive guidelines have evolved.

ROADMAP FOR THE BOOK

This book can be broken down into three main parts. In the first part, consisting of Chapters 1 through 3, we summarize the diverse literature that has created a foundation for our work. In the second part, Chapters 4 through 8, we provide a deep dive into each of the CIFFTA treatment components, details on the *nuts and bolts* of delivery, and a clearer sense of the available tools that CIFFTA offers. We also present a chapter including case studies that bring clinical situations and interventions to life. In the third part of the book, consisting of Chapters 9 and 10, we document the strategies we have used to expand our work beyond Latine families to include other diverse populations. We also document the strategies we have used to address the challenges the field faces regarding family intervention training, adoption, implementation, and sustainability.

This book is not a treatment manual and does not provide all the requisite training and materials needed to generate optimal outcomes and high fidelity when implementing CIFFTA. The book does provide a strong foundation for family-based work with Latine adolescents, a general description of the CIFFTA components, and guidelines for implementation. Access to the full array of CIFFTA tools, including

the treatment manual and psychoeducational modules, is available as part of a training contract with Training and Implementation Associates. (Follow this link for details about our training program: *www.guilford.com/santisteban-materials*.) Trainees receive online access to a treatment manual, dozens of downloadable psychoeducational modules in PDF form on different treatment topics and in English and Spanish, animations that help demonstrate effective intervention delivery, and implementation and fidelity tools. Training can typically be completed in 12–15 hours, and a 6-month period of expert consultation and coaching is highly recommended as therapists begin CIFFTA implementation.

1

The Treatment of Latine Youth and Families

Behavioral treatments make a significant difference in the lives of children and adolescents by reducing disruptive behaviors, depression, anxiety, substance misuse, self-harm, and suicide-related behavior. These approaches can reduce presenting symptoms, increase child and adolescent well-being, and minimize disruptions to their healthy development. Ameliorating emotional and behavioral problems during an already complex child and adolescent stage of development can have a long-lasting impact on a youth's well-being.

Many successful treatments that ameliorate presenting symptoms have also focused on identifying and modifying the underlying factors that contribute to the emergence and maintenance of the symptoms. Family-based interventions focus on reducing underlying family risk factors while enhancing protective factors. Family therapy has been found to be particularly efficacious for treating a variety of disorders including attention-deficit/hyperactivity disorder (ADHD), depression, disruptive behaviors, and substance use (Kaslow et al., 2012; Hogue et al., 2021; Van Ryzin et al., 2016; Vermeulen-Smit et al., 2015; Mena et al., 2023; Santisteban et al., 2011, 2017, 2022; Sheidow et al., 2022). Family interventions can have an effect long after the therapist is gone by transforming maladaptive family-level conditions (e.g., family conflict, ruptured relationships) and mobilizing protective family factors and relationships (e.g., support, validation, and nurturance). Once an entire family is strengthened and made healthier, even other siblings/youth and family members not currently in treatment can reap the benefits of a better-functioning family. Furthermore, when a therapist succeeds

at engaging family members as allies in treatment, the work becomes easier. It strengthens the caregiver's leadership role, and they work collaboratively to effect change for the family system both in sessions and at home.

A great strength of family therapy models is that they take a contextual or relational approach. This means that the therapist attempts to understand an individual's behavior, at least in part, as a result of the relationship dynamics that surround it. The relationships can elicit or constrain certain behaviors (e.g., family members can restrict the discussion of past traumatic experiences), and the behavior can send an important relational message (e.g., cry for help or a refusal to accept constraints). The therapist will use the relationship context to better understand and even modify individual behaviors. Throughout this book, the relational approach also guides us in reflecting on the complex contexts (i.e., schools, neighborhoods, and health systems) that directly impact the behaviors of both adolescents and families.

When working with Latine and other diverse families, we also appreciate the value of *culturally centered* treatments. Such approaches put culture-related material at the core of the treatment and have been associated with superior outcomes (Hall et al., 2016; Soto et al., 2018) when used with diverse populations. Such treatments integrate assumptions, metaphors, and worldviews that are consistent with those endorsed by the diverse clients and may be better able to address such factors as trauma, discrimination, immigration and acculturation stress, and other culture-related stressors (Bernal & Domenech Rodriguez, 2012; Cervantes et al., 2018). The contextual perspective used in family therapy facilitates the identification of systemic and structural inequities that work against youth and family well-being. Approaching the presenting problem from this perspective also provides thoughtful ways of helping the family to address these stressors. The ability to incorporate cultural values and worldviews into the therapy process has been a hallmark of family therapy (Boyd-Franklin, 2010; Falicov, 2014; McGoldrick & Hardy, 2019) though we have argued that this strength has not always filtered into the more formal evidence-based treatments (EBTs; Santisteban et al., 2013). Treatments that integrate cultural domains may better address the unique life experiences that contribute to hopelessness, stressors, symptom emergence and maintenance, and poor service utilization, retention, and treatment outcomes (Abraído-Lanza et al., 2016). These experiences should be a starting point in the conceptualization of both symptom emergence and return to more adaptive functioning. Treatments designed to identify and work through the powerful everyday stressors experienced by Latine and other minoritized clients will be perceived as more relevant and helpful by the client. Working from

this perspective means that culture-related experiences and mechanisms of change are two threads running through the same discussion and therapeutic work.

This position is vastly different from those who argue that it is best to focus primarily on the mechanisms of action of the therapy and to separately add a layer of cultural competence or cultural sensitivity in the delivery of the services. The latter argument assumes that culture-related factors are peripheral to the principal targets of treatment and change. We argue, in contrast, that culture is always present in therapy, but it is often unacknowledged. The worldview of the dominant culture is already (quietly and subtly) the foundation of the generic treatments and arguments for "culture-free" treatment mechanisms. The cultural assumptions behind the generic treatments are a perfect fit for the dominant group. From that perspective, *cultural competence* is easily seen as an added layer that must later be placed atop an established clinical approach, to address the treatment of the patient or family from a minority or nonmainstream culture. Traditionally, in manuals that delineate generic clinical approaches, there is little mention of how the main components and mechanisms central to how the treatment works (e.g., cognitions, interpersonal relationships, definition of family, communication, hierarchy, ecological/contextual processes) are directly impacted by diverse cultural factors. The only way to explain how cultural nuances can be left out of the core explanation of these treatments is that nuances of the dominant, mainstream culture were *assumed*, as a foundation of the treatments' driving theory and associated practices, but never acknowledged as such.

An example of these subtle assumptions became evident when Latine families were found to fall short in their mission to support the autonomy and individuality of a child and were prematurely labeled *enmeshed* or *overinvolved*. A Latine would consider it impossible to talk about family mechanisms of action without talking about what *familia* means. These parents did not get the memo on the urgency of successful *launching* by a certain age, often around 18 years. It was taken as a given that families should prioritize the separation and autonomy of teens as they move toward young adulthood. That was an assumption of the dominant culture so widely accepted as to not require discussion. This prioritization of autonomy sometimes led therapists to emphasize the need for individual therapy that excluded family members who were not allowing timely separation and individuation. Yet we often heard Latine families who endorsed the priority of family involvement and other aspects of familism complain that the therapy approach was misguided. A similar conflict can arise when therapists encourage adolescents to speak their minds in therapy, and express whatever things they dislike about their

families. In traditional Latine and even Haitian families in which hierarchy is important, parents may feel a therapist who encourages such behavior (which they view as disrespectful) is misguided. Suggesting that the teen speak freely goes against the expectation of *respeto* (respect) in the family.

Interestingly, because values, beliefs, and cultural norms are not static, we might be able to detect changes in mainstream thinking that are likely to influence what we as therapists convey is a new normal. For example, now that more *mainstream* families are struggling with inflation, housing shortages, and high student loans, more individuals are living with their parents well into their 20s and even 30s. This may be contributing to a change in mainstream dialogue, which now includes the term *emerging adults*. This term helps to normalize what might once have been labeled a failure to launch.

To provide a balanced view, we should also look at the other side of the divide—scholars and clinicians who highlight the rich and diverse experiences and culture-bound aspects of Latine clients but may prematurely disregard EBTs. Many in this camp can correctly point out the substantial limitations of EBTs that fail to account for culture. However, when taken to an extreme, the ill-advised response is to pay lip service to the value of available EBTs while promoting less proven treatments that highlight only the role of culture. These may be treatments that are culturally sensitive but totally lacking in evidence of their efficacy, effectiveness, or impact on established mechanisms of change. Discarding the benefits of EBTs because they fail to incorporate cultural considerations is the proverbial "throwing out the baby with the bath water." Alternative non-EBTs may provide a good fit with the expectations and preferences of Latine clients, but they have not done the work of integrating accepted knowledge on the best-established change mechanisms and therapeutic processes. We argue that a therapy that fits with the client's cultural worldview is *necessary but not sufficient*. Optimally, we should integrate advances in treatment, findings from process research, and insights from ethnic psychology (Foxen, 2016)—and avoid the vilification or disregard for one side or the other.

CULTURALLY INFORMED AND FLEXIBLE FAMILY-BASED TREATMENT FOR ADOLESCENTS

The treatment set forth in this book, Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA), is designed to achieve a high level of integration of knowledge pertaining to adolescent, family, and cultural processes. It is an EBT that depends on

well-established therapy mechanisms (e.g., family systems, motivation enhancement, adolescent skills) while also integrating cultural complexity and nuance at its core. We make the case that to focus on the more generic "melting-pot" concoction is to disregard some of the most powerful risk factors at work on adolescents and families. Also disregarded are powerful protective factors that a therapist can use to help Latine families. We contend that treatment manuals that disregard culture and lived experience are not the most effective tools, because they ignore the unique circumstances and events that are most real in the daily lives of many minoritized groups. It also reminds us that there is no "one-size-fits-all" Latine either. The therapist must be attuned to the uniqueness of the experiences of each individual and family.

CIFFTA was developed with the goal of taking the best that EBTs and Latine psychology have to offer and creating a comprehensive family-based approach for Latine youth and families. CIFFTA recognizes and incorporates the advances and innovations achieved by dedicated researchers and theorists on both sides of the aforementioned debate. And in fact, CIFFTA has been criticized for being too "research-based" as well as being too "focused on Latine cultural factors"—an indicator that it may be lodged in exactly the right space. At its best, research serves to amplify the voices of the diverse populations we serve and to ensure that their life experiences and worldviews are integrated into systems that are designed to serve them in the most effective way possible. If the reader can analyze CIFFTA and discern both the generic mechanisms that are well established in family systems theory *and* the way that the life experiences of Latine youth and families are intertwined with theoretical individual and family mechanisms, then this book will have served its purpose.

CIFFTA encompasses three major innovations: (1) creating a multicomponent treatment and creating synergy between its family treatment, child/adolescent treatment, and psychoeducational components; (2) making cultural themes central to the treatment manual, training, and coaching while linking them to core therapy mechanisms; and (3) creating a flexible and adaptive modular framework that allows the treatment to be tailored to the unique clinical and cultural characteristics of youth and families. In the next section, we explain each in a bit more detail.

The Family Component

CIFFTA has *family work* at its core because the family is one of the most powerful contexts in which child and adolescent development takes place. Risk factors, protective factors, guidance, socialization, and the nurturance of healthy child and adolescent development occur

in families. Family processes can mobilize, constrain, shine a light on, or conceal individual strengths and weaknesses. There is an impressive amount of research on family processes, and research has supported the efficacy of family therapy when addressing adolescent symptoms such as conduct and behavior problems and substance use. The family is the context in which a vast number of life's most intense behavior-shaping experiences occur, and even as autonomy and differentiation processes can become prominent in a youth's life, the family continues to be highly influential. CIFFTA answers the question "Who is family?" with a flexible definition of family that includes traditional, extended, and elected families. CIFFTA includes the entire network of support and resources that can be utilized during treatment. We are free to mobilize the pastor, the coach, the godmother, the neighbor, and the school counselor who can stand by and support healthy change. Chapter 6 will provide further information on the "nuts and bolts" of family intervention delivery. CIFFTA zooms in on specific techniques and strategies for mobilizing family support, validation, and protection while reducing negativity, disengagement/neglect, and other risk factors.

The Individual Therapy Component

CIFFTA reflects a substantial departure from the senior authors' previous work on a different family treatment model (Brief Strategic Family Therapy), which was restricted to conjoint family therapy and typically delivered in a once-per-week format (Santisteban et al., 2003, 2006). Although family intervention is indeed a powerful foundation for the treatment of adolescents, we believe adolescents also benefit from an individually oriented treatment component that can help them with the complex tasks that emerge during the adolescent stage of development. Developmentally appropriate interventions include motivation enhancement, goal setting, working through sexual orientation and gender identity questions, and teaching interpersonal effectiveness and emotion regulation skills. In our work with adolescents who turned to substance misuse to cope with emotional turmoil and life stressors (Santisteban et al., 2011) or turned to self-harm due to the marginalization that comes from coming out as an LGBTQ+ youth (Mena et al., 2024a), it became clear that there is a need to contribute to healthy adolescent development using one-on-one sessions with the youth. This is particularly true with older adolescents who are struggling to develop effective skills for leading their own lives in a healthy direction. It is overly limiting to reach the adolescent only through the family and not directly. As we show later in this book, this does not preclude the issues that emerge in individual therapy from being processed within the family, when the timing is optimal.

For these reasons, our effort to improve the outcomes of our family-based treatment included the integration of *individual* work into CIFFTA in a way that complements and enhances the family work. For example, most youngsters with substance abuse problems are accustomed to being strongly confronted by adults in the family, school, legal, and treatment systems in a disempowering way. It became particularly important to consider EBTs designed to help adolescents develop their own goals and motivation for change without triggering the defensive and *stonewalling* stance that confrontation tends to elicit. The growing evidence that Motivational Interviewing (MI) strategies could be extraordinarily successful in lowering adolescent resistance (Miller & Rollnick, 2023) and that MI could 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 into treatment. Interpersonal effectiveness and emotion regulation skills (Linehan, 2014a, 2014b, in press-a, in press-b; Santisteban et al., 2015) are critically important when working with struggling youth. Individual sessions can facilitate the generalization of psychoeducational material, teaching them emotion modulation or interpersonal effectiveness skills that can make a difference in the youth's daily challenges in multiple settings (e.g., peers, family). Finally, the individually focused treatment sessions allowed an exploration of the youth's identity on issues such as ethnicity, race, sexual orientation, and gender identity. It is common for second-generation immigrant teens (those born in the United States) to have perspectives on the traditions of their country and culture of origin that are quite different from those of their first-generation parents and grandparents. The same can be true with feelings and attitudes about gender identity and sexual orientation, which may not be accepted by their parents and grandparents and the larger Latine culture.

Sometimes an adolescent must explore parts of themselves before they are ready to explain them to family members. These topics may be avoided in the early stages of family therapy because of the intensity of the conflicts and the hurtful attacks that may result. Some therapists see these attacks and decide they must exclude the family completely. That is a mistake. Individual sessions with teens allow them a chance to discuss and explore all these issues, and the therapist can then plan with the teen on how best to process these issues effectively in family sessions. Individual sessions with teens can also include a full discussion of strategies for handling the stress resulting from the discrimination and alienation they experience. In short, our assumption is that therapists can work to improve the family context in which adolescents find themselves, while also working directly with youngsters struggling with the challenging demands of the adolescent developmental stage. Chapter

5 provides a more detailed discussion of the delivery of individual treatment in CIFFTA.

The Psychoeducational Component

The third CIFFTA component consists of structured psychoeducational modules delivered in a didactic format. A major assumption behind the development of this component is that there is a great deal of material on such issues as substance use, self-harm, social media, discrimination, acculturation processes, parenting practices, family acceptance following LGBTQ+ disclosure, and legal system involvement that may be highly relevant to certain families, but that is also complex and difficult to digest. Psychoeducational sessions are helpful because the free-flowing process of therapy does not always allow time to focus on the family's learning and integration of these important facts. Psychoeducational sessions provide a structured and systematic presentation of important topics in a format and at a level that parents and the adolescent could more readily absorb. This information serves to normalize the issues because it shows that they emerge in many families. Families can sit back and hear the information and decide whether it relates to them and how. Furthermore, the modular structure of this material facilitates the specific family *tailoring* approach that is important to CIFFTA. Only those modules that address an important content area for a given family are selected and integrated into their treatment plan. Based on individual sessions with the teen, certain modules may be selected as relevant (for instance, trauma or self-harm). Using the modules is a less emotionally evocative and personal way to introduce issues that are of high relevance to the youth. Youth and families can also participate in the selection of the module using a shared decision-making approach. Chapter 7 provides more information on the module's details and delivery process.

Creation of Synergy between Treatment Components

Each of CIFFTA's components can stand alone, but the full effect of the treatment is achieved only when you actively and intentionally create synergy and bridges among them. An example of bridging the components is the *generalization* work that follows any didactic psychoeducational module. Generalization helps clients with the difficult task of integrating new knowledge and skills into their daily lives. For example, in CIFFTA's psychoeducational work, a family may learn about the multifaceted and predictable impact that acculturation or immigration-related separations can have on family relationships. The processes are normalized, discussed as they happen across many families, and can be

absorbed with less defensiveness. In therapy sessions, the family returns to this topic and processes how these dynamics play out in their own home and how they can use what was learned to relate to each other differently. A family that learns in psychoeducational sessions that it is normal for a child who has been separated from parents to experience sadness, resentment, a sense of loss and abandonment, and to have a need to ask difficult questions, gets to explore and validate all these feelings with their own child in a family session. The therapist helps shape the family interactions to facilitate the healthy processing of the issue. An adolescent who learns interpersonal effectiveness skills in a psychoeducational session can be coached on how to use them effectively with peers in individual therapy sessions and can be coached *in vivo* on how to use the skills with the parents and siblings in family therapy sessions. A family therapy session can be the arena in which parents can be taught to support (rather than dismiss or challenge) new and emerging adolescent behaviors and new skills learned via psychoeducation (e.g., communication, emotion regulation). Conversely, a family session in which an adolescent blows up and hurts their own cause can be a learning opportunity and can lead to an extension of a skills session that focuses on why the skill (e.g., interpersonal effectiveness skills) did not work within that family session and how to handle the incident more effectively in the future. This is what we call bridging the work between the complementary treatment components to achieve CIFFTA's optimal effect.

Integration of Cultural Themes into CIFFTA's Therapy Mechanisms

CIFFTA sets culture-related content and issues alongside established treatment mechanisms. We seek to avoid the mistakes of the past that allowed two bodies of information (on culture and on family therapy mechanisms) to exist in separate silos that a competent therapist must struggle to bridge in their own idiosyncratic way. Keeping these two bodies of knowledge separate and apart deprives the therapist of some of the richest and most useful tools available (Santisteban et al., 2013). The richness of family system concepts is most evident when considering the variety of experiences and relationships encountered by individuals of diverse backgrounds. Likewise, the complex relationships and contextual interactions that occur in minoritized individuals' lives can be better appreciated by looking at them through the lens of systemic principles and mechanisms.

When treating a Latine family with its unique and powerful life experiences, values, beliefs, behaviors, and help-seeking patterns, one of the first questions that emerge is about the fit between the assumptions,

tools, content, and processes that define that model and those that define the culture of the client and family. The challenge is to articulate the relevance and precise links between culture-related factors and established family concepts and processes. The CIFFTA therapist is trained to ask questions such as:

- How does acculturation impact parenting practices and communication?
- How does an immigration-related parent–child separation impact the relationship quality in the recently reunited family?
- How do the norms regarding *respeto* (respect) and adherence to hierarchy in a traditional family dictate how disagreements can be handled at home and in a therapy session?
- How might a therapist who encourages an adolescent to confront his traditional and hierarchical father be violating the expectations and norms of the father and family?
- How does an expectation that a couple *must* have an egalitarian relationship violate the norms of some very traditional and non-egalitarian couples? How do we strengthen each member's voice in this context?
- How can a healthy family, strong parenting practices, and socialization help to buffer youth from racist experiences in the world?

These types of questions link culture and diverse worldviews to established family processes and mechanisms. They are how we determine which cultural factors to highlight when seeking key changes. Falicov (2014) reminds us that in considering cultural differences, it is critically important to identify *those differences that make a difference*. That is, the therapist will be able to identify many culture-related issues but must focus on those differences between people that are particularly relevant to understanding differences in treatment relevance, processes, and outcomes.

For example, Latine families are said to highly endorse *familism* or the obligation to protect, support, and always consider the family (Sabogal et al., 1987). A family that highly endorses familism may be less likely to connect with a treatment that is highly individually oriented, that excludes family members, and that does not interpret behaviors in relation to their impact on the family. The advice of a provider that the client *do what is right for them as an individual, without worrying about the family's reaction,* may not hit fertile ground without more processing of how family obligation and guarding the family name is a deeply ingrained value in that client. The work of healthy differentiation must take the client's ingrained perspective on familism into account.

And no, the individual's continued orientation to the family is not necessarily a sign of immaturity and lack of individuation.

Our previous research on culture and family processes led to interesting findings that impact the therapy process. These include:

- How the level of acculturation of parents can impact the way they conduct their parenting and the efficacy of those parenting practices in helping youth to stay away from behavior problems (Santisteban et al., 2012). We found that parents who endorsed more of the *Hispanic culture from their country of origin* reported more involvement as part of their parenting practices and lower behavior problems in their youth.
- How Latine parents reported discomfort with the concepts, terminology, and lack of information concerning sexual behavior and safe sex, and that this was in large part associated with their discomfort in having these conversations with their kids (Mena et al., 2008a). This is particularly important given that prevention specialists have shown that having this conversation is one way parents can be helpful in reducing risk in youth.
- How immigration-related parent–child separations can be associated with relationship difficulties during reunification (Mena et al., 2008b), how this process can lead to depressive symptoms in youth, especially Latina youth (Mena et al., 2023), and how it can be addressed in treatment (Santisteban et al., 2013).
- How Latine culture and religiosity, both of which are considered powerful protective factors, can make it even more difficult for many Latine parents to validate and accept their LGBTQ+ youth (Mena et al., 2024a).

These are all examples of how treatment can make itself truly relevant to the reality of the Latine family by ensuring that the therapist has specialized content ready to address these types of situations.

An Adaptive and Flexible Framework

Youth and families enter treatment with different strengths and areas for growth, varied presenting problems and co-occurring disorders, myriad family constellations and structures, and diverse culture-related characteristics and experiences. Given this reality, there is no one-size-fits-all approach to treatment, no matter how comprehensive the treatment manual is. There should be no question that the process of adaptation and tailoring the generic techniques to the specific family will take place in one form or another. The question is whether the adaptations and

tailoring will occur out in the open in a way that is replicable, or behind closed doors in a way that is very idiosyncratic. CIFFTA's approach is to spell out within the manual as much of the adaptation and tailoring process as possible. *It seeks to place as much attention on the tailoring process as it does on the main therapy mechanisms*.

Any treatment can claim to be flexible by allowing individual therapists to make adaptations or enhancements in idiosyncratic ways. The problem is that such adaptations can later be criticized for undermining the fidelity needed to achieve an optimal outcome. Any unplanned and nonsystematic changes made by a therapist make it difficult to know what was really delivered to a client, and these hidden modifications make the complete treatment package difficult to replicate. The benefit that comes with an adaptive treatment is flexibility guided by decision rules that can be clearly articulated in the manual and, if followed, can simultaneously create flexibility and facilitate replication. CIFFTA's adaptive approach resembles what Sue (2006) called *dynamic sizing*. The important caveat is that CIFFTA seeks to provide decision rules for the sizing and tailoring so that it can be done in a systematic and replicable fashion.

CIFFTA's use of an adaptive framework is facilitated by our group of approximately 20 (to date) psychoeducational modules that can be delivered to youth and parents in English or Spanish, and that include information on prominent issues that have emerged in our 30 years of working with Latine youth and families. Flexible treatments with well-defined options seek to include in a manualized treatment the wisdom of the highly qualified and culturally competent clinician.

One important result of the flexible framework is that it facilitates a *transdiagnostic* approach. It helps CIFFTA avoid the pitfalls related to being an approach that focuses on only one symptom and facilitates the process of addressing many different symptoms within a broader category of problems roughly described as a "youth behavior problem syndrome" (Jessor & Jessor, 1977). Transdiagnostic treatments seek to address "maintaining mechanisms" that may underlie several, often co-occurring disorders (McHugh et al., 2009). In CIFFTA these maintaining mechanisms include family maladaptive relationship patterns, invalidation, high conflict, and emotion dysregulation. A transdiagnostic approach allows for flexibility to make systematic adjustments for prespecified conditions (Kendall et al., 2008) and begins to address the concern that manualized EBTs are overly rigid manuals and narrow in their focus. EBTs that can only be shown to work with one narrow type of diagnosis or presenting problem are unlikely to be attractive or sustainable in the front lines of practice given that comorbidity and co-occurring disorders are the rule and not the exception.

Evidence of CIFFTA's Efficacy and Effectiveness

A program of research funded by a series of National Institute of Health grants led to the development and rigorous testing of CIFFTA for minoritized adolescents and families. We are indebted to the National Institute on Drug Abuse (NIDA), the National Institute on Minority Health and Health Disparities (NIMHD), and the National Institute on Mental Health (NIMH) for their leadership and funding to help effective treatments reach our communities. An early NIDA study (Santisteban et al., 2011) helped to develop the CIFFTA components and provide a preliminary test of its efficacy. The study used an "add-on" design to isolate the effects attributable to the enhancements, so it compared participants assigned to a family therapy-only condition and a family therapy plus CIFFTA components. The study included Latine adolescents who met criteria for substance abuse disorder as outlined in the fourth edition, text revision of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association [APA], 2000). Most youth had substantial marijuana and alcohol use and to a lesser extent cocaine use when they entered treatment. Change was investigated between baseline and an 8-month follow-up assessment.

Santisteban et al. (2011) Study Details

Twenty-four adolescents and their families were randomly assigned to either the experimental treatment (CIFFTA) or traditional family therapy (TFT). Below are findings from the study.

- Adolescents in CIFFTA showed a significantly greater reduction in self-reported drug use (marijuana + cocaine), $F(1, 22) = 10.59$, $p < .01$, $\eta^2 = .33$, compared to the TFT condition.
- Self-reported change in drug use was consistent with urine analysis results.
- Adolescents in CIFFTA reported a significantly greater improvement in parenting practices, $F(1, 22) = 9.01$, $p < .01$, $\eta^2 = .29$.

These results showed the promise of an adaptive and culturally informed treatment for substance misuse in Latine adolescents.

A second study funded by NIMHD (Santisteban et al., 2017) was designed to test a computer-assisted version of the CIFFTA model. As

part of an ongoing program of treatment improvement, our team investigated the possible benefits of integrating technology-assisted intervention into the existing CIFFTA approach. Technology-assisted treatments can enhance the attractiveness of an intervention, particularly for youth, and can aid in the intervention process by (1) requiring fewer hours of counselor contact (which lowers cost and stress on agency system resources); (2) increasing the client's therapeutic work between sessions; (3) reducing the logistical barriers (e.g., travel time, public transportation) that often plague low-income clients; (4) offering key treatment components delivered via videos in a standardized manner to maintain fidelity; and (5) providing variable information formats (e.g., multimedia) that make the intervention more engaging. These features appeared particularly promising in the context of CIFFTA because technology could support an adaptive and modular framework (e.g., facilitating the selection of only modules that are relevant to the unique needs of an identified adolescent and family).

Santisteban et al. (2017) Study Details

Eighty Latine and African American youth and families were randomized to either immediate computer-assisted CIFFTA or delayed computer-assisted CIFFTA. The findings below represent significant between-groups effects showing the superiority of the immediate computer-assisted CIFFTA condition when compared to the delayed condition that received no treatment during the same period. Compared to families in the delayed condition, families receiving treatment immediately showed superior outcomes. More specifically, for immediate CIFFTA:

- Parents reported significant reductions in youth conduct disorder ($B = -5.17$, $SE = 1.73$, $p < .01$, confidence interval = [−8.55, −1.79]).
- Parents reported significant reductions in youth socialized aggression (or peer-based delinquency) ($B = -2.04$, $SE = 0.83$, $p < .05$, confidence interval = [−3.67, −0.41]).
- Parents report significant improvements in family cohesion ($B = 1.34$, $SE = 0.50$, $p < .01$, confidence interval = [.36, 2.32]).
- Youth reported significant reductions in externalizing problems ($B = -4.22$, $SE = 1.40$, $p < .01$, confidence interval = [−6.95, −1.48]).
- Youth reported significant improvements in family cohesion ($B = 1.31$, $SE = 0.46$, $p < .01$, confidence interval = [0.41, 2.21]).

Baseline to 6-week posttreatment (T1–T3) analyses showed that these significant within-subject effects were sustained for the treatment group. When the delayed-condition families received the computer-assisted CIFFTA, they also showed improved outcomes. Results highlight that adolescent behavior problems can be significantly impacted by a computer-assisted intervention that replaces some face-to-face meetings with computer-delivered psychoeducational modules.

A third and larger trial funded by the NIMHD (Santisteban et al., 2022) tested CIFFTA with youth reporting behavior problems and sought to expand knowledge on culturally sensitive treatments with a randomized controlled trial. Specifically, we investigated CIFFTA's ability to engage and retain Latine youth and families, to modify family functioning, and to reduce adolescent internalizing and externalizing symptoms. The study also sought to investigate the role that acculturation may play in treatment outcomes. Assessment occurred at baseline prior to treatment and then again after 16 weeks of intervention.

Santisteban et al. (2022) Study Details

The study in which 200 Latine adolescents 11–14 years of age were randomly assigned to CIFFTA or individual treatment as usual (ITAU) showed that:

- CIFFTA had significantly higher retention (83%) than the comparison condition (71%), odds ratio = 2.05, $p = .036$.
- Youth in both conditions had significant reductions in child- and parent-reported externalizing and internalizing behaviors and no significant differences between conditions.
- Parents in CIFFTA reported significantly greater reductions in family conflict, $d = 0.38$, $p = .025$, than in the comparison condition.
- In CIFFTA, children of less acculturated Latine parents showed more improvement than the children of more acculturated parents.

CIFFTA's superior impact on retention and reduction of family conflict was a significant finding even though both conditions show treatment effects on youth behavior problems. This evidence of differential effects depending on cultural

values and behaviors may have strong implications for the field of Latine psychology, family treatment, and the tailoring that may be necessary when working with diverse Latine clients.

Following its record of testing in the research arena with diverse populations, CIFFTA was selected for implementation by community agencies in the South Florida area. This allowed us to evaluate the effectiveness of implementing CIFFTA for the treatment of 232 Latine and Black youth and families in community settings (Mena et al., 2024b). Utilization of services offered, changes in youth presenting problems, and family functioning were used to evaluate the program. As we discuss in Chapters 9 and 10, there are many factors that determine whether an EBT is successfully transported to the community, and there is as much of a need for an *evidence-based approach to implementation and sustainability* as there is for EBTs.

In the community setting for this program evaluation, care coordinators and natural helpers (*promotoras*) formed part of the team. After they learned about what an intervention such as CIFFTA has to offer youth and families, they were able to reach parts of the community that are typically highly underserved and that do not always trust community programs. Natural Helpers are often members of the community who were connected and trusted long before the EBT was offered. The evaluation results showed a program with great retention of families as shown by the percentage of families completing treatment, strong participation in the program as shown by number of sessions (average of 15 sessions) received per family, improvement in youth behavioral and emotional presenting problems, and improvements in family functioning.

Mena et al. (2024b) Study Details

This project that included 232 Latine and Black youth and families, allowed us to evaluate the effectiveness of implementing CIFFTA in community settings. Findings revealed that:

- Adolescents reported a significant reduction in symptoms of *depression* ($N = 147, Z = -3.63, p < .001$).
- Adolescents reported a significant reduction in symptoms of *anxiety* ($N = 147, Z = -3.01, p = .003$).

- Caregivers reported significantly lower *overall adolescent difficulties* ($N = 147$, $Z = -4.45$, $p < .001$) as did the adolescents ($N = 147$, $Z = -5.06$, $p < .001$).
- Caregivers reported a statistically significant reduction in *family conflict* ($N = 146$, $Z = -4.68$, $p < .001$) and a significant increase in *family cohesion* ($N = 145$, $Z = -2.53$, $p = .011$).
- Caregivers reported a statistically significant reduction in *parental stress* ($N = 145$, $Z = -3.69$, $p < .001$).
- Caregivers reported a significant decrease in *frustration with their relationships with their children* ($N = 146$, $Z = -4.40$, $p < .001$), improved *parent–adolescent communication* ($N = 147$, $Z = -3.43$, $p < .001$), and improved *confidence in parenting* ($N = 146$, $Z = -2.93$, $p = .003$).

SUMMARY

In this chapter, we have argued for the important role that EBTs can play in optimally serving Latine youth and families, pitfalls that must be avoided, and why we believe that CIFFTA offers a unique set of tools that can be particularly effective with this population. We gave the reader a feel for CIFFTA's unique interventions and how it creates synergy between the three components to lead to more effective treatment. Finally, we provided some evidence to show that a therapy that seeks to integrate cultural and established therapy mechanisms can be tested in rigorous randomized trials and show its efficacy and effectiveness with diverse and complex problems.

The experience of these trials has led to the development of expertise in training clinicians to implement family-based interventions and the development of innovative training platforms (see Chapter 9). Most of the work on CIFFTA has been done with Latine youth and families, but more recent implementations of CIFFTA with African American and Haitian youth are leading to the articulation of unique stressors that can be considered for tailoring within the CIFFTA framework (see Chapter 10). Our CIFFTA team has dozens of published articles, book chapters, and treatment guides focusing on treatment outcomes, family interventions, cultural competence, the training of family therapists, and the real-world problems of implementing EBTs.