CHAPTER 1

Navigating through Complex High-Risk Adolescent Mazes

> We are continually faced with great opportunities
> which are brilliantly disguised as unsolvable problems.
> —MARGARET MEAD

Across the country, economic hardship and state and federal funding cuts for services to high-risk youth and families have forced social service and child protection agencies, mental health clinics, addictions programs, residential treatment programs, and even specialized hospital-based programs to reduce their staff sizes, or even to close down. As a result, clinicians still working in such settings are being inundated with many challenging and complex adolescent cases. These kids arrive at their programs with extensive treatment histories and past traumas, and come from multiproblem families, which for even the most seasoned family therapist can be very difficult to work with. Furthermore, because of administrative productivity requirements, health insurance limitations, and time constraints, clinicians working in the trenches are expected to see more of these difficult cases for much shorter durations of treatment.

To help combat these clinical challenges, those fortunate surviving agencies, clinics, and specialized treatment programs that have well-endowed training budgets are purchasing expensive empirically supported family therapy treatment packages. These include staff family therapy training, supervision, case consultation with stuck cases, and a program evaluation component. Unfortunately, the vast majority of these agencies, clinics, and treatment programs can't afford them. Even if they

could, they lack the staff to implement them and the capacity to provide 24/7 home-based treatment and crisis management.

These empirically supported family models have produced solid therapy outcome data that indicate they work well with high-risk treatment populations such as adolescents who are violent, delinquent, disruptive in school, substance-abusing, eating distressed, self-injuring, severely depressed, and suicidal (Alexander, Waldron, Robbins, & Neeb, 2013; Diamond et al., 2006; Diamond, Diamond, & Levy, 2014; Diamond & Stern, 2003; Henggeler & Schaeffer, 2010; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009; Henggeler & Sheidow, 2011; Le Grange, 2011; Liddle, 2010; Liddle & Diamond, 1991; MST Services, 2014; Robin & Le Grange, 2010; Robbins, Horigian, Szapocznik, & Ucha, 2010; Rowe, 2012; Schwartz, Muir, & Brown, 2012; Smith & Chamberlain, 2010; Szapocznik, Hervis, & Schwartz, 2003; Szapocznik, Waldron & Brody, 2010). Yet they are not panaceas, and the leading proponents of these models seldom write about or present in-depth data on why some families prematurely drop out or experience treatment failures. Most of these models are heavily problem focused, therapist or team expert driven. From my perspective, they are not client directed or collaborative enough, and do not incorporate enough important psychotherapy outcome research findings on the *common factors*. Studies in psychotherapy research suggest that 40% of what counts for treatment success is client extratherapeutic factors, a subset of the "common factors" described in the literature, such as utilizing client strengths to the maximum degree, resources, resiliency protective factors, past successes, theories of change, and stages of readiness for change to empower clients to resolve their difficulties (Duncan, Miller, Wampold, & Hubble, 2010; Norcross, 2011; Selekman & Beyebach, 2013; Sprenkle, Davis, & Lebow, 2009). In view of the client extratherapeutic common factor research findings, clinical evidence-based practitioners recognize the dangers in adopting the "one-size-fits-all" treatment philosophy. They view the clients as the experts on their lives and recognize the importance of establishing collaborative partnerships with them so clients have the lead voices with goal setting and all clinical decision making. In addition, clinical evidence-based practitioners recognize that it is best to view these challenging cases through multiple theoretical lenses. These practitioners know they need to include themselves as part of the observations they are making in the clinical encounter; to ask bold and well-thought-out questions from a position of not-knowing and curiosity; and never to lose sight of how the complex interactions among the families they treat involve larger systems professionals, key resource people from their social networks, and the community at large. These other people hold tremendous potential for the co-generation of multiple high-quality solutions.

All family therapy models need to be flexible, and more integrative to better meet the contemporary needs of today's high-risk adolescents and their families. The empirically supported family therapy models will have even better outcome results by adopting a stronger client strengths-based, outcome-informed emphasis, and by integrating some of the ideas from newer therapeutic approaches that are showing clinical promise. In this spirit, this highly practical book presents a *collaborative strengths-based family therapy* (CSBFT) model that combines the best elements of the major empirically supported family therapy approaches with clinical practice wisdom regarding *what works* with high-risk adolescents presenting with both externalizing and internalizing disorders. What is unique about the CSBFT approach is that it *individualizes* the treatment for high-risk adolescents and their families. Under this model, therapists carefully tailor what they do therapeutically with the clients' preferences, theories of change, expectations, goals, and input regarding therapeutic intervention design and selection, throughout the clinical decision-making process.

In this chapter, I first discuss four key dimensions of adolescent risky behaviors including how they are maintained individually, by peers, families, concerned professionals, and members from their social networks. Next, I provide a comparative critical analysis of the strengths and weaknesses of the major empirically supported family therapy approaches and recommendations for ways to further improve treatment outcome results. Two clinically promising family therapy approaches for self-injuring and suicidal adolescents are also discussed. I follow this with a discussion on the importance of evidence-based clinical wisdom and the benefits of combining therapeutic art with family therapy science. I then offer a brief overview of the CSBFT approach, followed by a discussion on *individualizing* what we do therapeutically to the unique needs and characteristics of high-risk adolescents and their families. Finally, I present 16 CSBFT practice guidelines for working with more challenging high-risk adolescents and their families.

Let's start with a perspective on four important dimensions of adolescent high-risk behaviors: (1) adolescent risky behaviors as resources for coping; (2) key findings from recent neuroscience research on the adolescent brain; (3) the need for positive risk taking and collaborative risk management with high-risk adolescents; and (4) how "high-risk" adolescent problem-determined systems are created and maintained.

Adolescent Risky Behaviors as Gifts and Resources for Coping

Having worked for decades with adolescents who were deemed "high risk" by mental health, healthcare, and school professionals, I have observed

that there is a logical dimension to their provocative, intimidating, troubling self-destructive and destructive behaviors. For many adolescents, their high-risk behaviors have served as gifts, resources, and attempted solutions to help them to cope with individual, family, and social stressors in their lives. It is no surprise that they gravitate toward particular behaviors that work for them. You probably see these kinds of things in your practices routinely:

- Using anger and aggression to gain power and control over others when one feels disempowered and devalued in one's family, among one's peers, and in life in general.
- Cutting oneself to get quick relief from emotional distress, to soothe oneself, or for numbing out bad thoughts and feelings.
- Engaging in extreme daredevil behaviors as a way to escape from feeling emotionally dead inside.
- Using cocaine, methamphetamine, and other stimulants to elevate one's moods.

That's not to say these behaviors are benign or to be encouraged. The longer adolescents engage in high-risk behaviors, the more uses they find for them and the more fearless they become (Selekman, 2009; Selekman & Beyebach, 2013). Often, these youth will associate with peers who engage in similar behaviors, share the same struggles in their lives, and with whom they feel a strong sense of connection (Hardy & Laszloffy, 2006; Taffel, & Blau, 2001). It is important to note that, developmentally, adolescents must figure out a way to fit in with their peers; failure to do so is equivalent to social death (Selekman, 2009)!

Bear in mind as well that adolescents who turn to high-risk behaviors may do so with distress they feel in the wake of a traumatic experience. According to van der Kolk and his colleagues (van der Kolk, 2014; van der Kolk, MacFarlane, & Weisaeth, 2007), we need to respect the clients' use of self-injury, eating-distressed behaviors, and substance abuse as coping strategies or defensive shields to ward off flashbacks, painful feelings and memories, and suicidal thoughts. Premature removal of these coping strategies can contribute to a youth's being so emotionally vulnerable that he or she becomes suicidal and needs to be hospitalized.

The Adolescent Brain and High-Risk Behaviors

The past decade's neuroscience research on adolescent brain development helps explain why adolescents are risk- and sensation-seeking beings (Siegel, 2014; Steinberg, 2014). The findings from this research help us to

understand why adolescents continue to engage in risky behaviors even when they repeatedly lead to quite severe consequences. This research also helps adolescents and their parents or legal guardians understand what is driving these behaviors. Knowing this important information can help prevent unproductive parental and professional social control responses like yelling, lecturing, dishing out severe and lengthy consequences, being medicated, psychiatrically hospitalized, or sent to residential treatment as a response to their risky behaviors. Research indicates that the frontal lobe areas of adolescents' prefrontal cortexes are not fully developed until ages 23–24. The prefrontal cortex area of the brain has to do with impulse control, planning, and judgment. So it makes sense that adolescents with their still-developing prefrontal cortexes would be impulsive, make poor choices, and repeatedly choose ultimately unhelpful means for managing stress and life difficulties they are faced with (Siegel, 2014; Steinberg, 2014).

The adolescent's hypothalamus and amygdale are also immature. These components of the brain have to do with mood regulation and management and serve as our brains' alarm systems (houses our fight-or-flight response) in response to emotional and external threats. This is why even small disappointments or frustrations can evoke intense and extreme emotional reactions in adolescents. In addition, some high-risk adolescents' amygdalae are so hypersensitive that when they are exposed to emotional distress they cope by lashing out at others or engaging in self-destructive behaviors for quick emotional escape. Adolescents' primitive survivalist brains drive them to pursue shortcuts to pleasure by engaging in risky behaviors for quick relief from emotional and physical distress. They are more likely to repeat high-risk behaviors that are attached to positive emotional memories and experiences that are stored in their brains' limbic system region. Finally, adolescents are more likely to engage in more extreme risky behaviors when observed and sanctioned by their peers (Schoen, 2013; Siegel, 2014; Steinberg, 2014).

The good news is that due to our brains' *plasticity* (our ability to create new neuronal pathways in our brains), we can develop a repertoire of positive behaviors and habits, such as mindfulness meditation, yoga, dancing, exercising, making art, or writing poetry (Selekman & Beyebach, 2013). These positive habits can become the go-to activities for coping with emotional and physical distress the more consistently they are practiced. Neuroscientists Schwartz and Gladding (2011) teach clients to counter their brains' self-defeating and/or self-destructive behaviors by telling themselves, "I AM NOT MY BRAIN!" Instead, clients are encouraged to pursue a wide range of healthy coping strategies and meaningful activities that they come up with and have been exposed to by their therapists, such as mindfulness meditation.

Positive Risk-Taking Opportunities and Collaborative Risk Management

Since we know that adolescents, by nature, are risk and thrill seekers, why not provide them with ample opportunities to be challenged by positive risk-taking activities and tasks? Positive school and community activities can take the form of psychological, physical, and social challenges, such as: rock climbing; fund-raising strategies for community or social causes that they are interested in; offering a wide range of service work opportunities; forming new clubs or groups to counter student difficulties like bullying and eating disorders; inviting a gang member to co-facilitate a violence prevention group; or serving on a student advisory council to help school administrative staff make the school experience more inviting, intellectually stimulating, and opportunity rich.

Adolescents who have been deemed "high risk" often possess many strengths and talents that can be accentuated and utilized to empower them and to help turn around their lives and the lives of others. When empowered, they can become positive leaders and peer counselors in their schools and communities. They enjoy and find meaning and purpose in life when helping the less fortunate and doing prevention and outreach work with both their peers and younger children (Selekman, 2009; Selekman & Beyebach, 2013).

Another way we can aid adolescents engaging in risky behaviors is to encourage them to take the lead in making good choices, through looking at their options and reflecting (Steiner, 2014; Welch, 2009). We can ask the following types of questions:

"With your crew (friends), how much and how often do you have to party (drink/do drugs) with them in order to be accepted by them?"

"Do you think it is possible to cut back a little if you chose to and still be accepted by your friends?"

If the answer is "Yes" ask, "How will you decide to cut back and how specifically will you pull that off successfully?"

If the answer is "No" ask, "What will you choose to do, especially if your heavy partying is continuing to cost you big time in most areas of your life?"

"High-Risk" Adolescent and Problem-Determinied Systems

There are two major ways adolescents can be labeled as "high risk" and they and their families can become ensnared in problem-determined

systems. The first pathway is by being red-flagged for engaging in risky or intimidating behaviors, like cutting, substance abuse, eating-distressed habits (bulimia, binge eating, obesity, self-starvation), aggressive behavior, and delinquent behaviors, such as bullying or gang involvement. The second pathway is by just coming out of or having a history of incarceration, psychiatric hospitalizations, and residential treatment. This latter group is often placed in specialized support groups at school or in therapeutic day school settings with the belief that they will have grave difficulty surviving emotionally, behaviorally, and academically in regular public or private school settings and need a lot of individual attention. There also may be a strong push from the juvenile court system, the school, or their psychiatrists for them to receive intensive multimodal outpatient treatment, which often includes being on psychiatric medications.

According to Anderson (1997) and Anderson, Goolishian, and Winderman (1986), once a "problem" is identified or defined, a system of helping professionals and, in some cases, concerned members from the adolescent's social network coalesce around trying to solve the problem or control identified "high-risk" behaviors. For example, if a female adolescent student is identified as a "self-injurer" at school, often there is a wide range of pressing questions, beliefs, and emotional reactions (fear and anxiety to take immediate action to protect the student from herself) that are triggered in the minds of the school professionals involved, such as: "Is she suicidal?"; "Has she been sexually or physically abused?"; "Does she have 'borderline personality disorder'?" Due to school liability issues, there may be a strong administrative push with her parents for her to be psychiatrically evaluated or worse, hospitalized. This may lead to her being placed on antidepressant medication and either referred to a specialized adolescent outpatient program for self-injurers or a short stint in a psychiatric hospital, with the thinking that she might be at high risk for a suicide attempt. Once she gets involved in the specialized intensive outpatient program or gets out of the hospital, she will be tightly monitored and seen quite regularly at school by her school social worker or counselor and may be placed in a special group for students just coming out of hospital and residential treatment programs. Within the context of the problem-determined system, a negative self-fulfilling prophecy and an oppressive dominant story can inadvertently get set in motion. This can lead to the adolescent's questioning her own abilities to cope and to her return to self-injuring and possibly concurrent self-destructive habits. Even if the adolescent refrains from cutting herself, appears happier, and is avoiding associating with former toxic peers, these positive *sparkling moments* often go unnoticed because they do not fit with the dominant story of her having "poor coping skills," or that "self-injurers are sneaky and I bet she is still doing this behind the scenes," and so on. If caught

at school cutting again, the parents will be notified their daughter may need to be placed in a therapeutic day school setting and they need to closely monitor her at home, which means loss of her privileges and freedom. These interactions can go on endlessly between the professionals, parents, concerned members of their social networks, and the identified "high-risk" adolescents. Often, the adolescent and the parents lose their decision-making voices in the problem-determined system. Interactions with the professionals in power positions can enforce response and action as long as they are concerned. Problem-determined systems and their concomitant oppressive dominant stories and problem life-support systems are not just limited to school systems. They can get set in motion by the complex interactions between multiple larger systems professionals, the family, concerned members from the family's social network, and the lightning-fast spread of concern and rumors among adolescents' peers' communications via social media.

When collaborating with members of the "high-risk" adolescent problem-determined system, the therapist needs to be sensitive to how his or her thinking and ways of responding to participants either opens up space for meaningful dialogue or inhibits conversational flow. We can never attain a God's-eye view from which to observe and study the problem-determined system members' interactions because we are part of the same system once we enter the conversation about an identified "problem" (Anderson, 1997; Hoffman, 1988). In addition, we need to adopt a curious stance and come to know the various participants' stories of involvement, attempted solutions, concerns, problem explanations, best hopes, and expectations. Finally, as therapists we need to be sensitive to the role context plays in determining what the participants will be able to see, hear, and understand (Anderson et al., 1986). For example, if we work in a mental health or psychiatric setting, the first order of business will be conducting a psychosocial assessment and coming up with a DSM-5 diagnosis based on an adolescent client's symptomatology and behavior (American Psychiatric Association, 2013). If the diagnosis is depression, more than likely a combination of cognitive-behavioral therapy and antidepressants will be strongly recommended and pursued. This treatment regimen will be pursued because there is a body of empirical research that supports this therapeutic course of action for depression, as the root of the patient's psychopathology is his problematic thinking patterns and unbalanced biochemistry. For the therapist who enforces this in-house clinic treatment protocol with every depressed adolescent who comes through the office door, he or she may experience grave difficulty opening the adolescent up to alternative problem formulations and courses of treatment by other members of the problem-determined system.

The Major Empirically Supported Family Therapy Models: A Comparative Analysis

The major empirically supported family therapy models being used both in this country and abroad with high-risk adolescents exhibiting externalizing and internalizing disorders are *multisystemic therapy* (MST; Henggeler & Schaeffer, 2010; Henggeler & Sheidow, 2011;MST Services, 2014; Weiss et al., 2013); *functional family therapy* (FFT; Alexander et al., 2013; Waldron & Brody, 2010); *multidimensional family therapy* (MDFT; Diamond et al., 2006; Liddle, 2010; Liddle & Diamond, 1991; Rowe, 2012); *brief strategic family therapy* (BSFT; Muir, Schwartz, & Szapocznik, 2004; Robbins et al., 2010; Szapocznik et al., 2012; Szapocznik et al., 2003; Szapocznik & Kurtines, 1989); *attachment-based family therapy* (ABFT; Diamond et al., 2014; Diamond & Stern, 2003); *Maudsley family-based treatment* (MFBT; Le Grange, 2011; Lock & LeGrange, 2005; Perkins, Murphy, Schmidt, & Williams, 2006; Robin & Le Grange, 2010); and *multidimensional treatment foster care* (MTFC; Smith & Chamberlain, 2010). I have critically reviewed the strengths and weaknesses of the models based on what the developers and research teams of these approaches have indicated after a decade or more of pilot projects and larger-scale outcome studies.

It is possible to offer guidelines regarding which of these models appear to work best for both adolescent *externalizing disorders* and *internalizing disorders*. By externalizing disorders, the researchers are referring to adolescents exhibiting the following behavioral difficulties: antisocial and delinquent behaviors, substance abuse, school disruptive behavior, sexually risky behaviors, and aggressive and violent behaviors. Adolescents with internalizing disorders exhibit problems with depression, eating disorders, self-injury, and suicidal behaviors. Many high-risk adolescents exhibit a combination of both externalizing and internalizing symptoms, but often exhibit more symptoms and behaviors from one of these categories of disorders. Below, by disorder category I discuss which empirically supported family therapy approaches are best suited for particular types of adolescent behavioral difficulties.

Externalizing Disorders

Out of all of the empirically supported family therapy models, MST has the best short- and long-term outcome results with antisocial, delinquent, aggressive, and violent adolescents. MTFC also has highly positive outcome results with delinquent adolescents, particularly with female adolescent juvenile offenders. Both MST and MTFC have successfully reduced adolescents' involvement with negative peer groups. In addition, MTFC has shown great outcome results at reducing sexually risky behaviors

among juvenile offending females. Both models provide a team approach, 24/7 in-home coverage for sessions and for managing crises, and target all of the systems levels in the adolescents' social ecologies for intervention. One can argue that this gives these family treatment models the advantage over FFT, MDFT, and BSFT. Adolescents in foster care are often deemed "high risk" due to having experienced multiple placements out of their homes and/or having experienced emotional neglect and/or past traumas. MTFC's strong emphasis on parental and adolescent skill development and tightly monitored behavioral management systems tailored to the unique needs of the adolescents and their biological parents or caretakers make it a most ideal model for foster care programs.

Although one can argue that a lot of high-risk adolescents abuse substances to self-medicate, regulate their moods, or escape from their problems, this behavior has been considered as an externalizing behavior by the leading proponents of the empirically supported family therapy models. This is because substance abuse often co-occurs with juvenile offending behaviors in their studies. FFT has had good outcome results with adolescent marijuana and alcohol abusers after integrating cognitive-behavioral tools and strategies into the treatment regimen. MDFT and BSFT have had the best outcome results with decreasing and stabilizing substance-abusing behavior, particularly with culturally diverse adolescents and their families. The researchers behind these models have found that they also decrease juvenile offending and improve school functioning behaviors. BSFT in particular has produced excellent outcome results with Latino adolescents and their families. Finally, the central research team behind BSFT developed an innovative one-person family therapy approach for adolescent substance abusers that has been proven to be just as effective as BSFT with whole-family groups. The implications of the one-person family therapy approach are far reaching in that it can potentially be used in clinical situations where conjoint family therapy may be contraindicated due to the parents' intense marital discord or post-divorce battles that overshadow the adolescent's needs; the parents refusal to participate in conjoint family therapy, in spite of the therapist's efforts to engage them; intense conflicts and verbal exchanges between the adolescent and the parents that are too disruptive and prove conjoint family work to be counter-productive; one or both parents suffering from severe mental health or substance abuse difficulties; and an older adolescent who is struggling to launch from the family and can benefit from independent living skills and support. The one-person family therapy approach also demonstrates that it is possible to both stabilize the identified adolescent clients' behaviors and produce significant family changes through one family member.

Internalizing Disorders

A newer and highly effective empirically supported family treatment approach for depressed and suicidal adolescents is ABFT. Histories of self-injury are often seen in the backgrounds of severely depressed and suicidal adolescents. For these adolescents, self-injury is designed to help ward off or "numb" painful thoughts and feelings. Some of these adolescents also use self-injury as a form of self-punishment. Adolescents with long careers of self-injury have conquered their fears of death and may perceive death as a "beautiful thing," which puts these youth at high risk for suicide attempts (Joiner, 2005; Selekman, 2009; Selekman & Beyebach, 2013). The researchers and therapists behind the ABFT model have observed and demonstrated that what works best with depressed and suicidal adolescents is achieving the following outcomes: disrupting emotionally invalidating family interactions, repairing parent–adolescent relationship ruptures, strengthening the parent–adolescent relationship, and supporting the adolescent's needs for more autonomy.

MFBT has demonstrated good outcome results for adolescents with anorexia and their families who have shorter-term histories with this disorder (Le Grange, 2011; Robin & Le Grange, 2010). Further research is needed to help determine whether this model or a modified version of it is equally effective with adolescents presenting with bulimia and binge-eating difficulties. Furthermore, the central research teams behind MFBT need thorough model expansion to look for additional methods to better meet the needs of long-term anorexic adolescents and their families.

Clinically Promising New Family Therapy Approaches in Need of Further Research

Two clinically promising family therapy approaches that require a great deal more research on their efficacy are the *DBT multifamily group* (Miller, Rathus, & Linehan, 2007; Rathus & Miller, 2015) and *collaborative strengths-based family therapy* (Selekman, 2009; Selekman & Beyebach, 2013; Selekman & Schulem, 2007). Miller, Rathus, et al. (2007) are the first to apply dialectical behavior therapy (DBT) methods to families of self-injuring and suicidal adolescents. They have had success varying the treatment format by concurrently running parenting and adolescent skills groups or seeing individual families using DBT techniques and strategies. Randomized controlled studies in the United States and Norway have indicated that the DBT multifamily group and its variations can improve management of emotional distress and greatly reduce depressive symptoms and self-harming behaviors well into outcome follow-up (Goldstein et al.,

2012; Rathus & Miller, 2015). The major problems with the existing studies were the small sample sizes, which compromises generalizability.

In a qualitative study of CSBFT, 20 culturally diverse high school-age self-harming adolescents and their families were randomly interviewed by an independent researcher (parents and adolescents separately) across the course of their treatment experiences and up to 2 years of follow-up. The adolescents were self-injuring with concurrent eating-distressed, substance-abusing, and sexually risky behaviors. In the research interviews, the families shared important feedback regarding therapist relationship and structuring skills, specific techniques and change strategies they found useful, and things the therapists said and tried with them that were not helpful. One consistent and quite surprising research finding was the adolescents' strong desire to grow into their relationships with their parents, no matter how much conflict was in their relationships. They wanted to know that their parents loved and appreciated them and wanted them to provide emotional support when they needed it. With all families in the research project, the adolescents' self-harming behaviors had greatly decreased and remained stabilized for up to 2 years at follow-up. The parent–adolescent bonds were stronger, and family and school functioning had greatly improved. Across the course of therapy, the researcher spoke with the families and interviewed the therapists and related back to them what the families felt about what was working and what they needed to do differently. This greatly helped the therapists better meet the clients' needs of and increase their satisfaction with their treatment experiences. We found the client interviews to be quite rich, particularly what specific interventions they found most beneficial. We also learned what was off the mark and where therapists needed to shift gears to find better fit with certain family members. The major problems with our study were the small sample size and the absence of control groups.

Evidence-Based Clinical Wisdom: Therapeutic Art, Improvisation, and Intuition

Although the leading proponents behind their respective empirically supported family therapy models encourage therapists to use their relationship skills to build strong alliances with their clients and be active in sessions, they must stay true to the model in order to demonstrate treatment efficacy. They must not lose focus by introducing therapeutic techniques and strategies from other therapy approaches that could contaminate the research results. In fact, most of these empirically supported family therapy models provide specific sets of procedures and activities that therapists are supposed to employ in designated sessions with families.

This indicates fidelity to the model. Yet if therapists are too preoccupied with "doing the model right," this can stifle their ability to stay truly present with their clients. If therapists think a particular technique or strategy from another therapeutic approach might work better, they are discouraged from trying it out. Over several years in different countries, I have heard these complaints and frustrations from therapists and supervisors alike who are tasked to implement and maintain stringent fidelity to the major empirically supported family therapy models in their practice settings. They have reported feeling clinically stifled, like prisoners in the boxes of the models.

It is my contention that family therapists should be free to be daring, to inject an element of surprise into their sessions, be playful, view uncertainty and constraints as opportunities, use large doses of humor, and stretch their imagination and inventiveness as far as they can go without being limited by a particular family therapy approach, as long as what they choose to do has purpose. This is why empirically supported family therapy models need to be allowed to evolve, be flexible, integrate new and older effective therapeutic ideas from other individual and family therapy approaches outside of their base models. The therapist can be free to take more risks and tap into a wider range of therapeutic techniques and strategies. Once liberated from the box of a particular family therapy model, the therapist becomes an improvisational artist. He or she is free to bring in ideas from the arts, literature, science, and philosophy as rich sources of inspiration for offering clients new ways of viewing their presenting problem situations and for co-designing with them high-quality strategies.

For evidence-based practitioners, *intuition* plays an important role in clinical decision making in both in session and between sessions. Like chess players, they rely on *pattern recognition* and a vast reservoir of past *action maps* in their heads about what has the best shot at working based on their past therapeutic experiences with particular types of adolescent difficulties, family problem-maintaining patterns of interactions, and therapist–family member interactions in sessions, such as engaging reluctant members to talk, how best to respond to "yes . . . but" client responses, and so forth. Back in 1986, I remember hearing Salvador Minuchin saying in a weeklong family therapy training, "I have seen this before" while sitting with a couple in a live consultation session (Minuchin, 1986). In his illustrious and remarkable career as a family therapy pioneer, Minuchin has probably seen just about every couple and family presenting problem and their corresponding problem-maintaining patterns and has perfected sets of interventions that are quite effective at resolving these difficulties, including his incredible use of self as a powerful and highly creative change agent.

Klein (1998, 2002, 2013) studied experienced professionals in crisis management occupations like firefighters, hospital emergency room staff, and air-traffic controllers who have to decide and act quickly. He found that across the board they all relied on their intuition and past action maps to guide their present action plans and problem resolution strategies. They also were quite skilled at future visioning (projecting themselves into the future to see the results of a selected and implemented solution strategy). They used this to look for any loopholes in the selected plan of action and would quickly identify backup plans B, C, or D that might have a better shot with successfully managing a crisis situation.

Nobel Prize winner Daniel Kahneman (2011) has done pioneering research in the areas of intuition and how our cognitive biases can greatly influence on our decision making. He has identified two systems of thinking: *system 1* and *system 2*. According to Kahneman, system 1 thinking should be used with problem situations that are clear, acute, and where logical, straightforward solutions are most likely to work. With system 1, he recommends that you go with your gut (intuition) and clinical solutions that have worked in the past with a particular client problem situation. With more complex and chronic client problem situations, system 2 thinking should be used. For this, he recommends that you step back from the problem situation, reflect, think about your options, and incubate any ideas you come up with before trying out one or more change strategies. Many therapists get into trouble with complex and challenging clinical situations because they do not step back and reflect on potential therapeutic options (system 2 thinking). Instead, cognitive biases drive their actions. They dive into the situation with optimism, overconfidence, and bank it all on a particular therapeutic technique, strategy, or therapy model. Rather than remedying the situation, the client's situation gets worse or the clients lose their faith in their therapist's ability to help them and may drop out of treatment. Kahneman's practical and well-researched framework can serve as a helpful guide for family therapists in the midst of therapeutic action, but we should not allow it to constrict us from taking risks as we see fit when our guts tell us something has a great shot of working based on our past success using it with similar family situations.

Schon (1983) has identified two sets of reflective activities used by experienced practitioners representing a wide range of professional disciplines. These can greatly benefit family therapists both in and out of sessions with their clients. The first is *reflection-in-action*. It involves the therapist stepping outside of his- or herself and carefully observing how family members respond both nonverbally and verbally to whatever he or she tries therapeutically in order to determine what appears to be working. The second therapeutic activity is *reflection-on-action,* which involves taking the time immediately after the session to reflect on the following

question: "If I could conduct this session all over again, what would I have done differently?" In response, therapists can compile a list of reflections and questions to ponder and guide them in interacting with particular family members to help build better working alliances and spark the change process. Both of these therapeutic activities can help us keep an open mind, be more curious about our clients' presenting dilemmas, be therapeutically flexible, and stay on target with how we use ourselves in the therapeutic process.

By making room for evidence-based clinical wisdom, therapists using the major empirically supported family therapy models can have even better outcomes. They will also find their work much more meaningful and enjoyable. Both the major empirically supported family therapy approaches and evidenced-based clinical wisdom can complement one another and help us to be much more therapeutically knowledgeable, versatile, and competent family therapists producing better treatment outcomes with our client families (Diamond, 2014; Williams, Patterson, & Edwards, 2014).

A Brief Overview of CSBFT

CSBFT is an approach that helps clinicians integrate empirically supported approaches and clinical wisdom. The model has been evolving since 1985 (Beyebach, 2009; Selekman, 1995, 2005, 2006, 2009, 2010; Selekman & Beyebach, 2013). It is a flexible, collaborative, and integrative family therapy approach that incorporates the best elements of *solution-focused brief therapy* (Berg & Miller, 1992; Miller, 1997; de Shazer, 1985, 1988, 1991; de Shazer et al., 2007; Franklin, Trepper, Gingerich, & McCollum, 2012; McKeel, 2012; Ratner, George, & Iveson, 2012), *solution-oriented and Ericksonian* influences (Erickson & Rossi, 1979; Gilligan, 2002; Gordon & Meyers-Anderson, 1981; Haley, 1973, 1983; Havens, 2003; O'Hanlon, 1987; O'Hanlon & Weiner-Davis, 1989; Rosen, 1991; Short, Erickson, & Erickson-Klein, 2005; Zeig, 1980), *positive psychology* (Csikszentmihalyi, 1990, 1997; Fredrickson, 1999; Lopez, 2013; Lopez & Snyder, 2009; Lyubomirsky, 2007; Peterson, 2006; Peterson & Seligman, 2004; Seligman, 2002, 2011; Tugade, Shiota, & Kirby, 2014), the *stages-of-change model* (Norcross, Krebs, & Prochaska, 2011; Prochaska, DiClemente, & Norcross, 2006), *motivational interviewing* (Miller & Rollnick, 2013; Rollnick, Mason, & Butler, 1999), *MRI brief problem-focused therapy* (Fisch & Schlanger, 1999; Fisch, Weakland, & Segal, 1982; Ray & de Shazer, 1999; Watzlawick, Weakland, & Fisch, 1974), *narrative therapy* (Duval & Beres, 2011; Freeman, Epston, & Lobovits, 1997; Maisel, Epston, & Borden, 2004; White, 2007, 2011; White & Epston, 1990), *client-directed,*

outcome-informed therapy (Duncan, 2010; Duncan, Hubble, & Miller, 1997; Duncan & Miller, 2000; Duncan et al., 2010; Hubble, Duncan, & Miller, 1999), *collaborative language systems therapy* (Anderson, 1997; Anderson & Gehart, 2007; Anderson et al., 1986; Goolishian & Anderson, 1988), *Milan systemic therapy* (Boscolo & Bertrando, 1993; Boscolo, Cecchin, Hoffman & Penn, 1987), *Ackerman systemic family therapy* (Sheinberg, 1985; Sheinberg & Fraenkel, 2001), other *postmodern systemic therapy* influences (Andersen, 1991; Friedman, 1995; Hoffman, 1988, 2002; Tomm, 1987; Tomm, St. George, Wulff, & Strong, 2014), and *harm-reduction therapy* (Marlatt, 1998; Tatarsky, 2007).

With many high-risk adolescents, it is simply not enough to utilize their strengths, resources, and past successes at coping to resolve challenging life situations, alter outmoded rigid parental beliefs, and disrupt problem-maintaining family patterns of interaction. These can fail to stabilize their presenting emotional distress and behavioral difficulties. These young people may be experiencing grave difficulty regulating and coping with their powerful emotions; identifying and verbalizing their painful thoughts, feelings, and conflicts; challenging their oppressive thinking patterns; and maintaining self-control. To help remedy adolescents' difficulties in these areas, CSBFT therapists employ the following therapeutic tools and strategies: *mindfulness meditation and self-compassion practices* (Bowen, Chawla, & Marlatt, 2011; Chodron, 2010; Dodson-Lavelle, Ozawa-de Silva, Negi, & Raison, 2015; Germer, Siegel, & Fulton, 2013; Hanh, 1998, 2001; Neff, 2010; Peltz, 2013; Pollak, Pedulla, & Siegel, 2014; Rathus & Miller, 2015; Siegel, 2009; Simpkins & Simpkins, 2009; Willard & Saltzman, 2015), *cognitive skills training* (Andreas, 2012, 2014; Pahl & Barrett, 2010; Stark, Streusand, Krumholz, & Patel, 2010; Weersing & Brent, 2010), *self-control management skills* (Brier, 2010, 2014; Donohue & Azrin, 2012), *art therapy* (Malchiodi, 2003, 2008; Selekman & Beyebach, 2013), and *expressive writing* and *drama therapy* tools and strategies (Malchiodi, 2006; Pennebaker, 2004).

Another important dimension to the CSBFT model is the creative use of self both within and outside the boundaries of any single-therapy approach. Three of the most inspiring and brilliant pioneers of the creative use of self are Salvador Minuchin (Fishman & Minuchin, 1981; Minuchin, 1986; Minuchin, Reiter, & Borda, 2014); Carl Whitaker (Connell, Mitten, & Bumberry, 1999; Whitaker, 1989; Whitaker & Keith, 1981), and Virginia Satir (Satir, 1983, 1988). In my early family therapy training, these three pioneers, through their workshops, training videos, and publications, strongly conveyed the importance of being fearless risk takers, being transparent with our thoughts and emotional reactions, using a lot of humor and playfulness, and tapping into the wild and crazy sides of our personalities. Some of their major therapeutic techniques and strategies

may be useful once a therapist has exhausted all of the possibilities within the CSBFT model. Since most of the major empirically supported family therapy models are strongly influenced by structural and strategic family therapy ideas (Fisch et al., 1982; Haley, 1973; Minuchin & Fishman, 1981; Minuchin, Rosman, & Baker, 1978; Stanton & Todd, 1982), it may be worthwhile to integrate some of their techniques and strategies to enhance the effectiveness of the CSBFT approach with more challenging adolescents and their families.

From the initial intake call until family therapy is completed, CSBFT therapists actively collaborate with the referring person and all key resource people from a family's social network and involved larger systems professionals. These important individuals are viewed as part of the *solution developing, solution-determined system* (Selekman, 2009, 1995; Selekman & Beyebach, 2013). The goal is to counteract problem-determined systems, discussed earlier, that usually ensnare high-risk adolescents and their families.

Because the CSBFT model integrates a wide range of individual and family therapy approaches, it offers therapists multiple pathways for intervening on multiple systems levels in high-risk adolescents' social ecologies. This allows therapists to zoom in on the adolescents' and family members' unique needs and struggles, and zoom out to observe their complex interactions with concerned members from their social networks, involved larger systems professionals, and with their communities. CSBFT therapists are mindful of the fact that they can never find an outside place from which to look at their clients. CSBFT therapists realize that their thinking can greatly influence what they see and do in their interactions with everyone involved with the presenting problem situation. After decades of work with high-risk adolescents and their families, I have found it to be most advantageous to view concerned members from the family's social networks and larger systems as potential allies that possess a plethora of strengths and resources that can be tapped for co-constructing multiple high-quality solutions in our collaborative meetings with families.

Individualizing the Family Therapy Approach to the Unique Needs and Characteristics of the Family

The idea of tailoring what we do therapeutically to our clients is not a new idea (Beutler et al., 2011; Pinsof, 1995). The developers of MRI brief problem-focused therapy (Fisch & Schlanger, 1999; Fisch et al., 1982) and solution-focused brief therapy (de Shazer, 1988, 1991; de Shazer et al., 2007) have long encouraged therapists to determine how best to cooperate with each family member. Therapists can do this by carefully

observing what family members do and listening to what they say in their in-session responses and between-session management of suggested therapeutic experiments. Such interventions should be in line with the family members' goals, which will then dictate the best way to cooperate with them (de Shazer et al., 2007; Fisch & Schlanger, 1999). One important way to tailor treatment is based on decades of scientific research by Prochaska and his colleagues (2006). They have demonstrated with tens of thousands of individuals worldwide the importance of matching what we do therapeutically with the client's readiness for change. Therapists can gradually move clients through the six stages of change. With families, Friedlander and her colleagues (Friedlander, Escudero, Heatherington, & Diamond, 2011) found that family therapists must strive to accomplish the following in order to optimize positive treatment outcomes: build strong relationship bonds with each family member, maintain emotional safety in sessions, and elicit a shared sense of purpose from the family.

More recently, Lebow (2014, pp. 227–237) has provided 23 practical guidelines for individualizing one's integrative family therapy practice model. Nine of his most important guidelines for family therapists are in line with the key assumptions and mechanics of the CSBFT model:

1. One's family therapy approach should build on and work to enhance the common factors of positive outcomes.
2. Family therapists should shape their own unique combinations of concepts, strategies, and techniques from a wide range of approaches.
3. Client problems are manifested simultaneously on a number of systems levels. No one level should be privileged as more important.
4. In choosing intervention strategies, family therapists make vital choices about who is seen as well as what is done.
5. The integrative family therapist should be attuned to the personal values involved and the unique ethical issues in family therapy.
6. An essential therapeutic operation lies in co-constructing collaborative treatment plans and goals with families.
7. With each family, the therapist in close collaboration with them selects a set of strategies that will optimize achieving their identified treatment goals.
8. In choosing a specific intervention strategy, the therapist also must consider such pragmatic factors as acceptability to the clients and the resources available to best meet their unique needs and goals.
9. An integrative approach is not a static entity but an evolving method, a system open to new ideas to logically add to one's core model.

I wish to underscore those above guidelines that place a strong emphasis on building collaborative partnerships with families. This is where families have the lead voices in deciding what their goals are, are the lead authors of their treatment plans, and have major input in selecting therapeutic tools and strategies that they think can benefit them the most. Taking the individualizing process to the next level, clients can be invited to co-design therapeutic experiments sparked by their own creativity and resourcefulness. The case example below with an Armenian family illustrates how the therapist's and the adolescent's ideas can be combined to co-design a creative therapeutic experiment.

Fifteen-year-old Sabina and her parents came for a live family therapy case consultation in the context of a workshop I was giving. In the past, Sabina and her mother would get into intense power struggles that at times would get quite physical. Sabina also used to have problems with self-injury and self-starvation, which she contended were a result of her mother's controlling and micromanagement behaviors. Sabina alluded to the parents being unhappy that their marriage had become too humdrum. Because Sabina was a talented dancer, I offered her the therapeutic experiment of *adolescent as mentor to her parents* for 1 week (Selekman, 2009). When asked what type of dance she would teach her parents over the week, she shouted, "Hip-hop!" The parents, consulting therapist, and I laughed and thought this was a great idea. Sabina shared with me at the end of the session that she would film the dance lessons and send me a copy of the video. The added bonuses with this therapeutic experiment were that it injected playfulness and new life into the parents' dull marital relationship situation and it was a great opportunity for Sabina to shine as a loving and competent daughter.

In addition to co-designing therapeutic experiments with families, as collaborative partners we need to ensure the following: honoring clients' requests for having more subsystem session time such as with the parental couple or the adolescent wanting to learn more about specific coping tools; deciding who participates in sessions, including key resource people from the family's social networks and involved larger systems professionals that comprise the solution-determined system; the frequency of sessions; and deciding when families are confidently ready to complete treatment.

Collaborative Strengths-Based Family Therapy Practice Guidelines

For CSBFT therapists, therapy begins with the initial telephone contact with the parent. We need to make this initial conversation a very positive and memorable experience. It should instill hope and raise the parents' expectation that something special is going to happen in our work together and it is only a matter of *when*. In addition to using relationship

skills like listening generously, validating, and conveying warmth and empathy, there is no better way to begin co-creating a therapeutic context ripe for change than offering the concerned parent a pretreatment therapeutic experiment prior to the first family therapy session (McKeel, 2012; Selekman, 2009; Weiner-Davis, de Shazer, & Gingerich, 1987). The pretreatment experiment is as follows:

> "Over the years, my colleagues and I have been so impressed with how creative, resourceful, and resilient clients are, that well before we have seen them for the first time they have already taken important steps to better cope with or resolve their difficulties, even with the most chronic and severe problems. In order for me to learn more about your and your son's/daughter's strengths and resourcefulness, I would like you on a daily basis to pull out your imaginary magnifying glass and carefully observe any encouraging or responsible steps that you see your son/daughter take that you would like to see continue. In addition, I would like you to pay close attention to what you may be doing during those times that may contribute to preventing your son's/daughter's situation from getting much worse and improving his/her behavior even a little bit. Please write down everything you have observed and discovered and bring your list to our session next week. I look forward to hearing what further progress you made!"

Some of the major benefits of beginning family therapy in this strengths-based fashion are that it accomplishes the following: it increases clients' awareness about their strengths, resourcefulness, and resilience; it can raise their expectancy, hope, and optimism about their ability to resolve their difficulties; it triggers positive emotion, which can neutralize negative emotions and thoughts; therapists learn about key family members' solution-building thoughts, feelings, and actions and can encourage them; and the initial family therapy session becomes like the second session, which can greatly shorten clients' lengths of stay in treatment. In the first session after coming to know family members by their personal and occupational strengths, the therapist can explore with the parents and the adolescent what has gotten better with their problem situation as a result of the pretreatment therapeutic experiment. The therapist can amplify and consolidate all of their pretreatment changes, determine with them what they need to increase doing, and find out from them what next steps will propel them closer to successfully completing treatment.

In the spirit of solution-focused brief therapy (de Shazer et al., 2007), CSBFT therapists place a strong emphasis on underscoring and maximizing clients' strengths, resources, talents, life passions, past successes, and future visions of success. This starts in pretreatment and runs throughout

the whole course of family therapy. When families report a wealth of pretreatment changes, their initial complaints at intake are absent from the conversation. Minus problems, they are feeling optimistic about their futures. Their lengths of stay in treatment can be greatly reduced to four to six sessions with longer intervals between the sessions as a vote of confidence to them. Over the years, I have worked with a number of adolescents deemed high risk and their families, some of whom had had extensive treatment histories. They had responded quite well to a fairly pure solution-focused approach, which also involved separate subsystem work with parents and adolescents and active collaboration with the concerned helping professionals from larger systems. Often, once adolescents are labeled "high risk," they will remain on the "watch list" for some time, particularly in school settings even after they make quite dramatic changes. This is why CSBFT therapists offer to serve as advocates for their clients and collaborate with the concerned school personnel until they are less concerned, so the adolescent no longer needs to be tightly monitored. It can help quell school staff members' anxieties and concerns to have monthly or bimonthly collaborative meetings at adolescents' schools to hear about their important changes. Family members are present at the meetings throughout the course of family therapy and for a short period after treatment is completed. Failure to cover this important base can lead to adolescents' having slips in progress areas and family derailments.

At this point, readers are probably asking themselves, "Well, what do CSBFT therapists do when working with more difficult and complex adolescent family cases that do not respond well to the pretreatment experiment or a pure solution-focused brief therapy way of working?" Below, I provide 16 guidelines for what to do when family members cannot identify any pretreatment changes, past successes, or visualize hypothetical future successes, and the treatment becomes more problem-focused. In addition, CSBFT therapists will expand their base model and incorporate the most effective therapeutic strategies and techniques from the major empirically supported family therapy approaches. It is important to note that within the solution-focused brief therapy model there are many therapeutic options to pursue even with the most demoralized and pessimistic clients (de Shazer et al., 2007). Therefore, the guidelines begin with what CSBFT therapists do once they exhaust all of the possibilities within the base solution-focused model component of their therapeutic approach.

1. With families that have had long treatment histories, it is important to provide them with plenty of floor time to share their long problem-saturated stories by using open-ended *conversational* questions, curiosity, and generous listening, being careful not to be a narrative editor by prematurely moving the conversation to finding out about pretreatment

changes, past successes, or beginning the goal-setting process (collaborative language systems therapy; Anderson, 1997; Goolishian & Anderson, 1988, 1991).

2. A critical area of inquiry is to find out from the family all of their attempted solutions, including what former therapists and treatment program staff had tried with them that did not work and was upsetting to them. In addition, revisit with the parents or legal guardians and the adolescent whether they can identify some past successful coping or problem solving strategies (MRI brief problem-focused therapy; Fisch & Schlanger, 1999; Fisch et al., 1982).

3. Next, we need to clarify with family members what they view as the *right* problem to begin working on first and break that down into bite-size pieces. It is okay to work simultaneously on separate pieces of the problem that the parents or legal guardians and adolescent identified to begin with. Solution-focused questions are great for establishing realistic behavioral goals with families (de Shazer et al., 2007).

4. Presenting problems can be reframed to offer family members alternative ways of viewing them and pattern intervention strategies can be used to disrupt the problem-maintaining family patterns using MRI brief problem-focused therapy (Fisch & Schlanger, 1999; Fisch et al., 1982); solution-oriented brief, Ericksonian, and strategic family therapies (Haley, 1973, 1983; O'Hanlon, 1987; O'Hanlon & Weiner-Davis, 1989).

5. If the family describes the problem as chronic, oppressive in nature, and warranting extensive treatment, they are ripe for more of a narrative therapy approach (Duval & Beres, 2011; White 2007, 2011; White & Epston, 1990). Here, the main oppressive problem, DSM-5 disorder, habit, lifestyle, or pattern can be externalized and rituals can be employed to empower the family to pioneer a preferred future reality.

6. With high-conflict and chaotic families with adolescents engaging in serious delinquent and aggressive behaviors, using family approaches with core structural–strategic and social learning strategies and techniques like MST, MDFT, FFT, BSFT with Latino families, or MTFC with foster care youth are the best courses of therapeutic action (Alexander et al., 2013; Henggeler & Schaeffer, 2010; Liddle, 2010; Robbins et al., 2010; Smith & Chamberlain, 2010; Stanton & Todd, 1982).

7. Families presenting with adolescents experiencing eating-distressed difficulties like anorexia are most likely to respond well to the therapeutic strategies and techniques from the MFBT family approach (Le Grange, 2011; Robin & Le Grange, 2010). Important components of this model that have produced good clinical results are the *family lunch*

strategy (Minuchin, Rosman, & Baker, 1978) and narrative therapy strategies (Maisel et al., 2004).

8. With families presenting with self-injuring, suicidal, and depressed adolescents, using a combination of the major therapeutic tools and strategies from the ABFT, DBT multifamily group, and the base CSBFT models are the best courses of therapeutic action (Diamond et al., 2014; Rathus & Miller, 2015; Selekman, 2009; Selekman & Beyebach, 2013).

9. Families presenting with adolescents who have serious substance abuse problems and/or delinquent behaviors will respond well to the major therapeutic tools and strategies of MDFT, FFT, and BSFT (Alexander et al., 2013; Liddle, 2010; Robins et al., 2010).

10. With adolescents who are struggling with serious self-destructive habits like disordered eating, self-injury, and substance abuse, family therapy alone is often not enough to stabilize these difficulties. Therefore, individual session time in the context of family therapy needs to be devoted to offering adolescents a wide range of coping tools and strategies to constructively manage emotional distress and other powerful triggers. These tools include mindfulness meditation, self-compassion techniques, visualization, and self-control and cognitive skills and strategies (Bowen et al., 2011; Brier, 2014; Neff, 2010; Pelz, 2013; Selekman & Beyebach, 2013; Stark et al., 2010; Willard & Saltzman, 2015).

11. With families grappling with unresolved traumas, losses, and secrets, using postmodern systemic therapy approaches can be effective, such as collaborative language systems therapy (Anderson, 1997), reflecting team (Andersen, 1991; Friedman, 1995), Milan systemic and Ackerman systemic therapy approaches (Boscolo & Bertrando, 1993; Boscolo et al., 1987; Sheinberg & Frankael, 2001).

12. When the treatment process gets stuck and/or the family is not responding well to any of the above action steps, certain constraints may be keeping things at a standstill. Therapeutic options that can be pursued are using curiosity and wondering aloud with the family about the *negative consequences of change* (Fisch et al., 1982); the Milan systemic approach (Boscolo & Bertrando, 1993; Boscolo et al., 1987); the Ackerman systemic approach of using colleagues as a consultation team joining the family and the therapist debating about the dilemmas of change (Sheinberg & Frankael, 2001; Sheinberg, 1985); using a reflecting team (Andersen, 1991; Friedman, 1995) or the collaborative language systems therapy approach (Anderson, 1997; Anderson & Gehart, 2007) to open up space for possibilities and the revelation of the unexpressed, which may be family secrets that are contributing to the maintenance of the adolescent's behavioral difficulties, keeping treatment at a standstill.

13. Throughout the course of family therapy, CSBFT therapists are free to use themselves as the catalysts for change, which includes carefully observing and listening for opportunities to seize in sessions and improvise when necessary. Also, therapists must actively collaborate at the beginning of family therapy with all involved larger systems providers and concerned key members from families' social networks to gain their allegiance and to tap their expertise in the change effort.

14. In situations where multiple family members are struggling with severe marital discord, intense postdivorce conflicts, or serious mental health and/or substance abuse difficulties, it makes the most sense to work with individuals or subsystems of the family establishing separate goals and work projects. Using a modified one-person CSBFT approach or the one-person family therapy model developed by the BSFT research team can be the best treatment choice with these complex and challenging clinical situations (Selekman, 2006, 2009; Selekman & Beyebach, 2013; Szapocznik et al., 2003; Szapocznik & Kurtines, 1989).

15. Goal maintenance and relapse prevention are a family–social network affair, and this process should begin early in treatment and continue until the family therapy is completed. Solution-focused and other Ericksonian-oriented questions are ideal for consolidating family gains and empowering families to envision a compelling reality of future success (de Shazer et al., 2007; O'Hanlon & Weiner-Davis, 1989; Selekman & Beyebach, 2013).

16. Session by session, therapists must solicit feedback from their clients about the quality of their therapeutic relationship and their perceptions about the change process. This helps to prevent alliance ruptures, premature dropout, and negative treatment outcomes (Duncan, 2010; Lambert, 2010). In response to this invaluable client feedback, therapists need to shift gears, abandon unproductive therapeutic strategies and interactions, and pursue client-informed ways to better connect with dissatisfied family members and strengthen their alliances with them.

These 16 guidelines are not carved in stone, and they by no means capture all the possible therapeutic pathways for intervening with high-risk adolescents and their families. Furthermore, therapists should feel free to try therapeutic experiments and coping tools and strategies from a wide range of individual and family therapy approaches that they think can benefit their clients in any given session.

The most important considerations to keep in mind are that the therapeutic tools and strategies selected need to be theoretically compatible; they should have a good fit with or have been modified to better fit the needs of clients from different cultural backgrounds; and they are

in line with the clients' theories of change, stages of change, and treatment goals. Clients have the ultimate say regarding whether they choose to experiment with a strategy in and out of family sessions; their feedback determines whether to continue using selected therapeutic tools and strategies. Finally, with families entering treatment where the threat of suicide is great or some form of violence has occurred, the top priority is to immediately ensure that family members are safe. Stabilize the volatile situation first before pursuing any of the above treatment guidelines.

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