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CONTENTS

Foreword xi
Preface xiii
Introduction 3

1. Basic Concepts of Brief Strategic Family Therapy 15
Family Systems 16
Structure: The Script for the Family Play 20
Strategy 24
Context 27
Process Versus Content: A Critical Distinction 30
Advice to Therapists 34
Key Takeaways 34

2. Joining: Preparing the Terrain 35
Creating the Therapeutic System 35
Joining Techniques 39
Advice to Therapists 47
Key Takeaways 48

3. Diagnosing Family Systems Patterns of Interactions 51
Organization 55
Resonance 60
Family Developmental Stage 66
Identified Patienthood 70
Conflict Resolution 73
Life Context 75
Key Takeaways 77

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4. Applied Issues in Diagnosis **79**
Encouraging Enactment 79
Defining Adaptive or Maladaptive Patterns 81
Planning Treatment on the Basis of Diagnosis 84
Interrelationship Between Dimensions 87
Key Takeaways 89

5. Orchestrating Change: Restructuring **91**
Building on Joining and Diagnosis 92
Working in the Present 93
Developing Mastery: Helping the Family Build Competence in Adaptive Interactions 96
The Process of Restructuring 103
Key Takeaways 118

6. Pitfalls to Avoid **121**
Content-Driven Therapy 122
About-ism 123
Centralization of the Therapist 123
Lecturing and Philosophizing 124
Losing the Leadership in the Therapeutic System 125
Doing for the Family or Playing a Family Role 128
Getting "Sucked" Into the Family's Frame 129
Failing to Close the Deal 130
Key Takeaways 131

7. Engaging Families Into Brief Strategic Family Therapy **133**
Challenges for Therapists 135
Diagnostic Dimensions of Engagement 140
How to Engage Reluctant Families 143
Working With Challenging Family Interactional Patterns 147
Key Takeaways 155

8. Applying Brief Strategic Family Therapy to Different Circumstances **157**
When the Family's Home Is the Practice Setting 157
Family Compositions 159
Special Circumstances 163
Key Takeaways 171

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9. Bringing It All Together: The Case of JJ **173**
JJ's Case *174*
Engaging the Family *174*
The First Therapy Session *178*
Session 2 *188*
Sessions 3 to 5 *194*
Sessions 6 and 7 *200*
Session 8 *204*
Sessions 9 to 12 *205*
Key Takeaways *211*

Concluding Thoughts 213
References 217
Index 229
About the Authors 000

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Introduction

Are you searching for an approach that will make you more effective in treating families of children and adolescents between the ages of 6 and 18 who present with behavioral and emotional problems? An approach that helps families regain their parental competence and leadership and that brings love, nurturance, and caring back to families who sorely need it? An approach that defines families functionally to respect the broad diversity of family cultures and compositions?

Forty-five years ago, we were looking for such an approach, and we spent the intervening 4 decades developing a model for clinicians working with such families. Our journey began in 1974 when parents came to our clinic not knowing how to help their teens who were out of control—teens who were delinquent, depressed, using drugs, constantly fighting with their parents, uninterested in school, and hanging out with other troubled teens. Their parents felt they had run out of options.

These families were in crisis and thus had a sense of urgency about getting a resolution to their troubles. Feeling they had no other options, they were looking for therapists who would take charge and give them relief. These parents had lost their ability to manage and guide their children. They were looking for a treatment that would eliminate the problems at home quickly and empower them to manage and guide their youth to become productive members of society. This is what the parents wanted. As for the teens, they simply wanted to "get their parents off their backs."

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Brief Strategic Family Therapy, by J. Szapocznik and O. E. Hervis
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When we started our clinical work in 1974, we recognized the powerful influences of environment, and the family, in particular, on child and adolescent behavior. Much research has documented the role that families play as risk and protective factors for child and adolescent outcomes (Bögels & Brechman-Toussaint, 2006; Donovan, 2004; Hawkins, Catalano, & Miller, 1992; McComb & Sabiston, 2010; Morris, Silk, Steinberg, Myers, & Robinson, 2007; Pinquart, 2017; Repetti, Taylor, & Seeman, 2002; O. S. Schwartz, Sheeber, Dudgeon, & Allen, 2012; Wight, Williamson, & Henderson, 2006). Since then, a body of research in the field of epigenetics has revealed how environment "gets under the skin" of adolescents through the continuous interplay between biology and environment (National Academies of Sciences, Engineering, and Medicine, 2019). Although many laypersons believe that the impact of heredity is unchangeable, research into gene–environment interactions and epigenetics shows that the way heredity is expressed in behavior depends dramatically on environmental influences (Halfon, Larson, Lew, Tullis, & Russ, 2014), of which the family is the most impactful (Fraga, Ballestar, Paz, Ropero, & Setien, 2005). It follows that positive experiences in the family will produce flourishing child and adolescent development, whereas adverse experiences in the family lead to at-risk or poor development. According to the National Academies of Sciences, Engineering, and Medicine (2019) recent consensus report on adolescence, intervention in the present can remedy past adverse experiences. We thus propose that changing families' patterns of interaction from conflictive to collaborative and from angry to loving in the present will have a positive impact on the development of its children in the future.

WHAT IS BRIEF STRATEGIC FAMILY THERAPY?

To address this challenge, we decided to develop a flexible approach that can be adapted to a broad range of family situations in a variety of service settings (as mentioned in the Preface). We started by combining two important schools of family therapy: the structural, led by Salvador Minuchin, and the strategic, learned from Jay Haley. The therapy we developed by combining these two approaches, Brief Strategic Family Therapy® (BSFT®), is brief, problem focused, and practical. We incorporated the structural model because our families were overwhelmed with multiple problems, and one of the extraordinary features of structural family therapy is that it provided us with a formula for focusing not on each separate problem but on the ways that the family organizes itself in managing the lives of its members. Although problems are many, the interactional patterns that give rise to and maintain these problems are few. Among these few, to create a brief intervention, we focused on changing only those interactional patterns that were directly related to the youth's presenting symptoms. That made our work as therapists manageable. When we focused on family interactional patterns, we were clear on what we needed to change to correct the families' ways of managing their multiple problems. By changing

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the family's interactional patterns, we created self-sustaining changes in the lasting family environment of the child or adolescent. The "treatment environment" is thus built into the child's daily life.

BSFT builds on universal principles across cultures, such as the importance of the family and the focus on relational health (Kaslow, 1996; Walsh, 2012; Wynne, 1984) as reflected in patterns of interactions. In all cultures, the family's job is to be supportive and encouraging of each family member's well-being as well as to raise children to be productive members of their particular culture or society. However, cultures differ in the manner in which they accomplish these tasks. For example, regardless of culture, patterns of interactions occur in all families, although specific family patterns are more likely in some cultures than others (Herz & Gullone, 1999; Poasa, Mallinckrodt, & Suzuki, 2000; Shearman & Dumlao, 2008). BSFT's focus is to identify those patterns of interactions that are creating problems for the family, fully understanding the cultural tradition in which these patterns of interactions occur. The therapy itself is also conducted in a way that takes into consideration each family's cultural style and tradition. In this book, we use clinical vignettes to demonstrate the cross-cultural applicability of BSFT.

An Evidence-Based Intervention

BSFT is an evidence-based intervention that has been extensively evaluated for more than 45 years and is efficacious in the treatment of children and adolescents with internalizing and externalizing problems. With adolescents, much of the work has focused on acting-out behaviors that include alcohol or drug misuse, delinquency, associations with antisocial peers, and impaired family functioning.

BSFT is a brief intervention that can be implemented in approximately 12 to 16 sessions. The number of sessions depends on the severity of the presenting problem and the number of family members with problems that intersect with the youth's presenting complaint.

A Strengths-Based Approach

BSFT is the ultimate strengths-based therapy. BSFT uses strengths to transform problematic family behaviors into constructive interactions. For example, when a family presents with pain, we help the family to uncover the concern, caring, and love that is behind the pain. When families fight, we talk about the strong connections among family members. When a mother is caring toward one child and not another, we help the mother to own her ability for caring and transfer it to her interactions with all her children. When a father is angry at his son, we redefine and relabel the anger as caring for the son's future and encourage the father to tell his son about his caring: "Your son knows you are angry, but tell him the other story about what is behind your anger because you care for him. Tell him the ways you care for him, the

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reasons you care for him, and the hopes you have for him." Thus, BSFT is an optimistic and strengths-based approach. In real time, we transform negative interactions into positive ones.

We are able to do this because we know that behind the negative interactions, there are bonds of love. We remind the reader of Nobel laureate Elie Wiesel's (1986) words: "The opposite of love is not hate, but indifference" (p. 68). As long as family members are fighting with each other, they are powerfully connected and far from indifferent. In BSFT, we give family members the opportunity to change their interactions in ways that free them to move toward happiness. We believe that all families have the potential to be caring, and all people have an inherent desire to be happy but may not know how to achieve happiness. In BSFT, we help families remove impediments to happiness and mental health such as fear, anger, insecurity, distrust, lack of self-efficacy, and inexperience, among others. In the upcoming chapters, we unpack the theory and research that supports our experience and deeply held beliefs about love and anger.

The James family came to therapy because the teenage granddaughter was disregarding curfew, failing her classes, and fighting with her grandmother. She was arrested and referred for therapy by her probation officer. When the session opened, Grandma immediately told her granddaughter that she was a disgrace who brought her nothing but sorrow. When the therapist asked the granddaughter to respond to her grandmother, the granddaughter said, "You don't even care that I lost my mother." It was clear to the therapist that no one was listening to her pain. The task of the therapist was to help Grandma attend to her granddaughter's pain.

For Grandma to be able to do this, the therapist had to help her view her granddaughter as someone in pain. Grandma had a long list of complaints about her granddaughter. With anger and disdain, she said to her granddaughter, "I am sick of you. You only bring me sorrow. I am too old to be saddled with raising you." The therapist told Grandma, "I hear your pain and frustration. You are two women in profound pain. You are both in great pain because you lost your daughter, and she lost her mom [cognition and affect]. Grandma, tell your granddaughter about what you are going through, how you miss your daughter [behavior]." After Grandma did so, the therapist was able to ask the granddaughter to speak about how much she missed her mom. The therapist highlighted the granddaughter's suffering and said to Grandma, "Grandma, you are more experienced [cognition]; you, unfortunately, have lost loved ones before [affect]. What can you tell your granddaughter to help her with her loss [behavior]?"

In this example, it is apparent that the therapy not only builds on strengths but also works in the here and now to change the way grandma and granddaughter interact and behave with each other in the moment. The focus of the therapy is to change how family members behave toward each other. In this case, we used cognitive restructuring (Beck, 2011) to change the way family members perceive each other, which changes the affect between them, thus facilitating a new way for them to interact. Ultimately, the job of BSFT

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is to rebond family members with each other in a loving and mutually caring relationship.

Another aspect of BSFT that reveals its strength-based foundation is our diagnostic approach. Whereas most diagnostic approaches in the health and mental health fields, such as the *International Statistical Classification of Diseases and Related Health Problems* (10th rev.; World Health Organization, 1992) and the *Diagnostic and Statistical Manual of Mental Disorders* (fifth ed.; American Psychiatric Association, 2013), focus on disorders, BSFT diagnoses both adaptive and maladaptive interactions. BSFT uses adaptive interactions or strengths to support the therapist's efforts to transform maladaptive interactions.

WHAT ARE THE GOALS OF BRIEF STRATEGIC FAMILY THERAPY?

BSFT has three major goals:

- to eliminate the presenting problem or to reduce it to where the behavior is no longer problematic for the family;
- to increase mastery and competence, where *mastery* is defined as the skill level family members need to competently manage family life; and
- to improve family functioning by correcting interactional patterns in ways that allow the family to reduce chronic negativity resulting from unresolved conflicts, increase the family members' sense of belonging and cohesion, and improve the family members' ability to cooperate in parenting and other aspects of family life.

Ultimately, the goal of BSFT is to transform interactions from conflictive to collaborative, from anger to love, from negative to positive, and from habitual to proactive. Families change because the love that is trapped behind the anger is allowed to flourish.

WHAT ARE SOME KEY COMPONENTS OF BRIEF STRATEGIC FAMILY THERAPY?

Several aspects that are key to understanding BSFT we explain in forthcoming chapters. Here, we review some key aspects of BSFT to give the reader a sample of the tools available to a BSFT therapist, including a focus on family interaction patterns; identifying who the family comprises; the systemic diagnostic approach; the role of strategy; congruency in changing affect, cognition, and behavior; and BSFT Engagement.

A Focus on Family Interactional Patterns

Perhaps the single most important lesson we would like our readers to take away from our work is to focus on how families interact and not on what they

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interact about. This is an important theoretical foundation of BSFT with many practical applications. A corollary of this lesson is that if the therapist focuses on the family's content and the many problems they enumerate, the therapist will be unable to help the family, just as the family is unable to help itself because it becomes overwhelmed by its many content issues. Whether the family talks about their kid's drug use or what they will have for lunch, the way family members interact with each other does not change.

For example, Dad says that he wants to have steak for lunch, and Mother says that she wants fish. The challenge is not in that they want different foods but in how they go about negotiating their differences (or fail) to come to an agreement. During the argument about what to eat, Mother may say to Father, "You never go along with me." What Mother has done with that statement is to change the topic of conversation from *what are we going to eat* to *what is our personal relationship*. When a family member changes the topic of conversation, the family is unable to come to an agreement on the original topic. Then, the family ends the discussion frustrated and angry and with no resolution to what to eat on which they can all agree.

This same pattern of how the parents interact repeats itself regardless of the topic of conversation, such as agreeing on a curfew for their drug-using youth. In BSFT, we let families resolve their own content problems, while we as therapists stay focused on helping them to improve how they go about solving their problems. The therapist's job in this example is to help the parents learn to resolve their differences of opinion by staying focused on the topic of discussion.

In BSFT, our job as therapists is to help family members interact (i.e., to behave with one another) in ways that are adaptive and result in symptom elimination. (We unpack these later in the book).

Identifying Who the Family Comprises

We consider the family to include all the individuals who are functioning in family roles that involve the identified patient (Pequegnat & Szapocznik, 2000). For this reason, we clarify that when we use terms such as *mom* and *dad* in BSFT, we are always referring to the persons who function in these roles. In 21st-century America, families come in many shapes and sizes. Many families are not made up of biological fathers, mothers, and children. Rather, families include a variety of persons who may function in specific roles, including stepparents, stepchildren, grandparents, aunts, cousins, and so forth. In some cultures, godparents can have an important relational role in the family as well. Among Latinxs, for example, the godmother is referred to as *comadre* or comother to the child's mother. In BSFT, we are always referring to the roles people play when we use terms such as *mom* and *dad*.

When we work with the families of children and adolescents, we define *family* as all the individuals who are significant contributors to the everyday life of the identified problem youth. These might include those persons who live under the same roof but excludes those who are transient—for example,

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an aunt or a friend who frequently "crashes" at the house. We include, however, other persons not living in the same household as the child who contribute to parenting and sibling functions—such as might occur with a remarried father and stepsiblings or a grandma who cares for the children until the single parent comes home from work. In our view, all these individuals who interact on an ongoing basis with the identified problem youth functionally compose the family and must be involved in therapy. All family members may not have to come to all the sessions, but we must bring them to the first session to enable us to diagnose how the family system functions with all the parts of the puzzle present. Thereafter, some may be excluded from some sessions, depending on the treatment plan.

Systemic Diagnosis

BSFT is a diagnostically driven therapy with a focus on interactional patterns. In BSFT, interactional patterns are what gets diagnosed and treated. This means that individuals are not diagnosed; rather, family interactional patterns are diagnosed. These are not static labels but dynamic descriptions of the repetitive patterns of interactions that occur among family members—that is, how family members behave with each other in interlinked sequences of behaviors that repeat over time. These patterns, unfortunately, are fairly rigid in families that make up our clinical population, and this is one of the reasons they are relatively easy to diagnose through any content that the family may bring up. In support of our therapeutic focus on interactional patterns, these diagnoses describe how the family interacts. The treatment, then, is simply to change the interactional patterns that have been identified and that are linked to the presenting problem. Our systemic diagnoses contribute to BSFT's brevity because treatment is fully guided by the diagnosis. The diagnosis provides a clear road map for the therapist to design specific treatment plans and allows the therapist to assess progress or the lack thereof. Moreover, because interactions are few (whereas contents are many), treatment has a small number of interactional targets.

When we diagnose family interactions, we choose to use the terms *adaptive* and *maladaptive* to connote that in BSFT, we view interactional patterns as malleable. That is, interactional patterns change as a function of therapy. We choose not to use terms such as *functional* or *healthy* and *dysfunctional* or *unhealthy* because these terms are often viewed more statically. A static view of interactional patterns is inconsistent with our philosophy and experience that family interactions can be changed, and in fact, changing them is the bread and butter of our work.

Strategy as a Theoretical Foundation

There are three major aspects to strategy in BSFT: It is planned, problem focused, and practical. The treatment plan that is designed to treat the maladaptive interactions diagnosed for each specific family is *planned*, which

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means that from session to session, therapy is planned to achieve the overall changes required to overcome each specific family's maladaptive interactions. Second, strategy also demands that plans are specifically designed to be *problem focused*, which means that we do not attempt to treat all maladaptive aspects of the family but only those that are directly related to the presenting symptom. In focusing on the problem or symptoms that bring the family into treatment, we typically have to treat a range of interactions that are linked to the presenting problem. For example, parents' ability to collaborate is required for them to parent effectively. This is intimately related to the couple's interactions, which have to be corrected to improve their collaborative parenting activities. The third aspect of strategy is that BSFT is *practical*, which means that for each specific family, treatment is planned to be most effective given that family's culture and idiosyncrasies. Practicality requires us to customize the therapy for each family. For example, if two families are both diagnosed as having an imbalance in the parental subsystem, and in one family, Dad has more power than Mom, we thus need to empower Mom, whereas in another family, Mom may have more power than Dad, and thus we need to empower Dad. In doing this, we have to carefully consider clinical, cultural, and other contextual realities of the family.

Congruency in Changing Affect, Cognition, and Behavior

In the years that we spent developing and refining BSFT, in addition to addressing behavior, we learned that achieving long-lasting change depends on a dance that includes cognition, affect, and behavior (Beck, 2011; Greenberg & Safran, 1987; Strümpfel & Goldman, 2002). For family members to behave differently, changes in cognitions and affect must always accompany behavior in a manner that makes the new behavior syntonic with the way family members are thinking and feeling at the time they behave in new and more adaptive ways.

Brief Strategic Family Therapy Engagement

All of this is well and fine when families come to therapy, but what if they do not? Early on, we learned that bringing families of troubled—and, in particular, acting-out—adolescents into treatment was hugely challenging. We also learned that many community agencies around the country had the same challenge. Thus, in the 1980s, we set out to understand what makes it so difficult to bring families into therapy, particularly when families members are in conflict with each other.

To address this challenge, we developed BSFT Engagement. Using what we had learned in building BSFT, we recognized that the kinds of family interactions that resulted in the presenting problem were identical to the interactions that resulted in the symptom of "resistance" to treatment. Families, in fact, are very consistent. Families have overlearned patterns of interactions

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that repeat themselves in all the content issues the family has to navigate in life. If family members have a set way in which they sit at the dinner table, which is inviolable, then other habits are similarly ingrained, and it is that consistency in the way family members behave with each other that becomes central to how we both diagnose and treat the family system. Hence, in BSFT Engagement, our first interaction with a family member who calls for help is directed at diagnosing whether the family's patterns of interactions will interfere with the family's ability to become involved in therapy as a whole family. We discuss BSFT Engagement in detail in Chapter 7.

Ms. Roura was referred by her son's probation officer to BSFT. When she called for an appointment, the therapist validated Ms. Roura's eagerness to help her son (this is part of what we describe later as *joining*), expressed the importance of the whole family coming to the first session, and explored and verified which members of the family are or should be involved in the son's life and whether she could foresee any impediments to any family member attending the first therapy session. The therapist emphasized the importance of each family member's participation and explained that the treatment can only be effective with everyone involved, and though it was possible that not everyone would have to come to every session, everyone did have to come to the first session: "Is it going to be OK with everyone to come to the first session?" Only with Ms. Roura's reassurance would the therapist go on to make the appointment, ending with an encouraging and motivational comment such as, "I am looking forward to working with you and your family. You will see that by working together, we will help your son."

If Ms. Roura indicated she expected that some family member(s) would be unlikely to want to or be unable to attend or that she did not want a specific family member to be involved or expressed hesitation in involving any family member, this is when the therapist would implement the BSFT Engagement model.

HOW DO FAMILIES TYPICALLY PRESENT FOR BRIEF STRATEGIC FAMILY THERAPY?

In our experience, a family typically brings a child or adolescent to treatment asking the agency "to fix him (or her)." If we look beyond the youngster, we readily see that the family is in turmoil. Emotions such as anger, guilt, pity, hopelessness, and despair are running rampant. Communication lines have collapsed. The family approaches the agency out of desperation and perhaps because it was ordered to do so by, for instance, the juvenile justice, welfare, or school system.

A family comes into the agency asking that changes be made because they are in pain. They typically demand that the youngster—the one the family views as responsible for inflicting all this pain—be cured. Having decided that this young person is the one with the problem, they ask the agency staff to

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"fix him, make him stop, or just send him somewhere for a long time and send him back when he is fixed."

Adolescents often present with more than one problem. Research has shown that many adolescent behavior problems co-occur (Donovan & Jessor, 1985; Donovan, Jessor, & Costa, 1988, 1991; Kazdin, 1992). Research has also suggested that families, in particular, play an important role in preventing, giving rise to, and maintaining the adolescent's problem behaviors (Coatsworth et al., 2002; Donovan, 2004; Hawkins et al., 1992; McComb & Sabiston, 2010; Pinquart, 2017; Stone, Becker, Huber, & Catalano, 2012; Szapocznik & Coatsworth, 1999; Wight et al., 2006). Some of the family interactional problems that have been identified as linked to adolescent acting out include

- parental under- or overinvolvement,
- parental over- or undercontrol,
- poor quality of parent–child communication,
- lack of clear rules and consequences,
- lack of consistency in the application of rules and consequences,
- inadequate supervision or monitoring of peer activities,
- poor parent–child bonding,
- poor family cohesiveness,
- lack of nurturance and guidance, and
- high negativity.

Many of these interactional patterns are also found in internalizing youth (Bögels & Brechman-Toussaint, 2006; Morris et al., 2007; Repetti et al., 2002; O. S. Schwartz et al., 2012). Because these family interactional problems are an integral part of the profile of internalizing and externalizing youth and because many of these family problems have been linked to the initiation and maintenance of youth symptoms, it is necessary to correct the family interactions to achieve a family context that discourages self-defeating symptoms and promotes the youth's positive development. BSFT targets all the family problems listed earlier.

THIS BOOK

This book introduces therapists to concepts needed to understand the family as an organism or system that may show symptoms in one of its members. The book describes strategies for gaining entry into families, assessing and diagnosing maladaptive patterns of family interactions, and changing patterns of family interactions from maladaptive into adaptive. The book also presents our strategies for engaging families whose members are reluctant to become involved in family therapy.

In Chapter 1, we discuss the basic theoretical concepts of BSFT. Chapter 2 explains how to join the family in such a way as to create an effective collaborative therapeutic system. Chapter 3 presents the BSFT systemic (relational) diagnostic approach, whereas Chapter 4 explains how to apply it clinically.

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Chapters 1 and 2 each conclude with a section called Advice for Therapists, which gives practical pointers or indicates a key skill for prospective BSFT therapists to learn. From Chapter 3 to the end, all material is geared toward practical application; thus, our specific advice is incorporated within the body of the chapters.

Chapter 5 describes how to change the maladaptive patterns of family interactions that are associated with the youth's presenting problems. Through this process, maladaptive interactions are restructured into adaptive interactions. Chapter 6 discusses the kinds of pitfalls that prevent therapists from being successful in correcting maladaptive interactions. Chapter 7 provides a detailed discussion of how to engage families when some members are reluctant to become involved in family therapy. Chapter 8 discusses the application of BSFT to different practice settings, family compositions, and aggravating family circumstances. Finally, Chapter 9 presents an extended case vignette to provide an additional opportunity for readers to consolidate the lessons from the book and mentally rehearse how they might apply BSFT principles in their practice. In all case material we present in this book, we have taken steps to conceal individuals' identities and the details of their family situation to protect their privacy.

BSFT is manualized in this book with well-specified theory and intervention techniques. However, it requires the ability to use clinical judgment in its implementation. Clinical creativity and flexibility are needed to implement BSFT in an effective manner, so for readers who are trainees or early-career practitioners, we recommend undergoing a training program before offering BSFT in your practice.