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ABSTRACT

At the request of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Research and Education Foundation of the American Association of Marriage and Family Therapy organized a series of 12 panels that focused on family issues in adolescent treatment. In these workshops, panelists discussed the importance of involving the adolescents family members in the treatment and presented innovative approaches for doing so. This monograph follows up on these conference panels to further clarify issues and treatment models and to explain the steps necessary to implement a family-centered approach to adolescent treatment. The monograph is designed for alcohol and other drug abuse and mental health professionals, paraprofessionals, administrators, and policymakers who want to learn more about family-centered treatment. An introduction explores the origins of the interest in family-centered treatment and presents specific examples of family-centered programs. Part 1 presents a brief overview of family systems theory and practice. Part 2 focuses on some specific aspects of family-centered clinical practice. Part 3 examines the administrative, organizational, financing, and training issues related to implementing a family-centered approach to adolescent treatment and outlines strategies for addressing these issues. Part 4 presents a checklist to guide the efforts of those who wish to implement a family-centered approach in their programs. Part 5 provides a selection of annotated references to help whose who are interested in learning more about specific aspects of family-centered treatment. Appendixes include references for resource organizations related to family-centered adolescent treatment and brief biographies of the authors who contributed to the monograph. (GCP)

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Empowering Families, Helping Adolescents

Family-Centered Treatment of Adolescents With Alcohol, Drug Abuse, and Mental Health Problems

Technical Assistance Publication Series

6

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Table of Contents

Part V:
Annotated Bibliography

Appendixes

Diagrams

Project Background

The Substance Abuse and Mental Health Services Administration (SAMHSA), the Federal agency charged with overseeing policy and research in this field, has responded to a growing concern about adolescents with alcohol, drug abuse, and mental health (ADM) problems with increased attention to the issue of adolescent treatment. The agency's effort to provide technical assistance to the States led to a national conference on the topic of adolescent treatment in the fall of 1989. Researchers, policymakers, administrators, and clinicians from around the country came together to share their expertise and experience. They explored what is known and what needs to be known and identified necessary new directions in the treatment of adolescents.

Indicative of a growing trend, the conference gave considerable attention to the role of families in adolescent problems and in the treatment of these problems. The Research and Education Foundation of the American Association for Marriage and Family Therapy (AAMFT) organized 12 panels for the conference. These panels examined a wide range of clinical, administrative, financial, research, and policy issues related to families and treatment of adolescents with ADM problems.

This monograph represents a next step in the Federal effort to assist treatment professionals and concerned others to increase their understanding and expertise in dealing with families. It was produced by AAMFT's Research and Education Foundation under contract with SAMHSA's Center for Substance Abuse Treatment (CSAT).

Wendy Snyder and Theodora Ooms
May 1991

Introduction and Overview

Wendy Snyder and Theodora Ooms

Ms. Snyder is a consultant and family therapist in private practice and the principal editor of this monograph. Ms. Ooms is director of the Family Impact Seminar and co-editor.

Adolescence is a time of change and confusion, full of promise and challenge for youngsters and parents alike. The biological, psychological, and social/interpersonal changes of adolescence portend trouble for some youngsters. When they exhibit complex problems such as abuse of alcohol and other drugs, delinquent behavior, or the frightening symptoms of psychosis or serious depression, they need the powerful resource of appropriate family support and guidance more than ever. Sometimes, though, parents become too angry and frightened to be of help; they may feel overwhelmed in the face of the adolescent's problems. At other times, parents' own problems, such as abuse of alcohol or other drugs, serious marital conflict, depression, and so forth, may directly relate to, or exacerbate, their teenager's problems and diminish their effectiveness as parents. Regardless of the parents' relationship to the adolescent's problem, they always need to be involved in the solution. Treatment of adolescent problems that does not include the family is unlikely to be successful in the long run.

In exceptional situations, attempts to involve parents in the adolescent's treatment may reveal such intense or longstanding abuse, hostility, or indifference that the parents cannot realistically be seen as a resource to the youngster. Even then the treatment professional must recognize the impact of the family in the adolescent's life. He or she must help the youngster to deal with the limitations of the family as a resource and look to the extended family or the community for the support so vital to the youngster's healing.

The challenge for the treatment professional, then, is clear. Treatment services must avoid further overwhelming and undermining the family or the troubled adolescent. The goal is to help parents regain their competence and ability to help their teenager survive the passage to responsible adulthood. Treatment must empower the family in order to help the adolescent.

Purpose and Scope of the Monograph

There is a growing concern about the high rates of teen drug- and alcohol-related deaths and injury, suicide, school dropout, pregnancy, and sexually transmitted disease. These and other problem behaviors are often interconnected and have grave consequences for the teenagers themselves, their families, and society. The increasing interest in developing successful strategies for helping troubled adolescents led the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services (DHHS) to hold a national conference on treatment of adolescents with alcohol, drug abuse, and mental health problems in the fall of 1989. The conference addressed a wide range of themes and topics.

At the request of SAMHSA, the Research and Education Foundation of the American Association for Marriage and Family Therapy (AAMFT) organized a series of 12 panels that focused on family issues in adolescent treatment. In these workshops, panelists discussed the importance of involving the adolescent's family members in the treatment and presented innovative approaches for doing so.

This monograph follows up on these conference panels to further clarify issues and treatment models and to explain the steps

necessary to implement a family-centered approach to adolescent treatment. The monograph is designed for alcohol and other drug abuse (AODA) and mental health professionals, paraprofessionals, administrators, and policymakers who want to learn more about family-centered treatment. The monograph was prepared and produced by staff and consultants of the AAMFT Research and Education Foundation.

Readers are encouraged to consider the relevance of all parts of the monograph to their work, whether they are AODA professionals or mental health professionals. While the specific family dynamics involved in AODA and various mental health problems may differ, the importance of involving the family is a constant. Both AODA and mental health professionals need to understand basic family functioning. Both need to know how to assess a family's strengths, weaknesses, and resources and be prepared to intervene effectively with the family. Both must contend with the many barriers that make it difficult to focus on the family in treatment of adolescents.

A brief description of the monograph's contents is provided here:

- This introduction explores the origins of the interest in family-centered treatment and presents specific examples of family-centered programs.
- Part I presents a brief overview of family systems theory and practice.
- Part II focuses on some specific aspects of family-centered clinical practice. Four authors discuss current cross-cutting issues in family-centered treatment. Four others then present family-centered models for the treatment of selected adolescent problems.
- Part III examines the administrative, organizational, financing, and training issues related to implementing a family-centered approach to adolescent treatment and outlines strategies for addressing these issues.
- Part IV presents a checklist to guide the efforts of those who wish to implement a family-centered approach in their programs.
- Part V provides a selection of annotated references to help those who are interested in learning more about specific aspects of family-centered treatment.

What Is Meant By family-centered, family-focused, family-based, family preservation, home-based?

The use of these terms can be confusing; they mean different things to different people. Some use them interchangeably, and, indeed, they do convey related or overlapping concepts. The constancy of the family as the organizing concept in health and social services is conveyed by all these terms.

In some instances, "family preservation" is equated with short-term, intensive, crisis-oriented services that are offered in the family home with the express intention of preventing out-of-home placement. In other instances, the term may refer generally to any effort to help families stay together and function successfully. The expression is used in both ways in this monograph and the meaning is clarified by the context or is explicitly stated.

"Family-centered," "family-focused," and "family-based" are used here to mean that the services referred to are organized around the family as the unit of concern, while "home-based" means services that are actually rendered in the home.

- Appendixes include references for resource organizations related to family-centered adolescent treatment and brief biographies of the authors who contributed to the monograph.

What Is Meant by a Family-Centered Approach?

The term "family-centered" used in this monograph refers to a respectful orientation toward the family as a major force in adolescent development and the primary resource for most adolescents. The fundamental assumption of family-centered treatment is that the best way to help a troubled adolescent is to support, strengthen, and empower his or her family.

A family systems orientation toward drug abuse and mental health treatment shapes all levels of service delivery, from direct clinical treatment to the structure and organization of the program or agency itself. Thus:

- At the clinical level, "family-centered" refers to treatment services and procedures based on family systems theory, which views the family, rather than just the adolescent, as the unit of treatment.

- At the program or agency administration and policy level, "family-centered" refers to concern and support for the family's involvement in treatment as provided through the financing, policies and procedures, staffing, training, recordkeeping, and the structure and organization of the program or agency itself.

Why a Family-Centered Approach?

In the past two decades, numerous trends account for the growing interest in family-centered treatment for adolescents:

- The understanding of adolescent development began in the sixties and early seventies, to shift away from the prevailing Freudian and Eriksonian ideas, which held that the normal task of adolescence was to establish identity and autonomy through emancipation—a kind of *breaking away*—from the parents. Services and treatment were then typically geared toward helping the adolescent become more independent. More recently, a view has emerged from research in which the adolescent is seen as participating in a *renegotiation* of the parent-child relationship. He or she maintains ties with the parents and at the same time functions with increasing independence. The adolescent is seen as maturing in the context of his or her family. Contemporary adolescent treatment based on this new understanding would, then, focus on facilitating this renegotiation, which inherently means including the family.

- At the same time, alcohol and drug abuse, mental health, and social service professionals began to realize that providing services to adolescents alone was not sufficient to produce lasting change. Many adolescent problems were centered on family relationships or were played out in the family—and all of them had an impact on the family. These situations could not be adequately addressed by work with the adolescent alone or by occasional information interviews with the parents. The behavior changes effected by treatment that excluded the family—such as intensive treatment in a hospital or a residential AODA program—often disappeared when the teenager returned home. Professionals began to suspect that treatment needed to include the family members in order to address their own concerns and help them recognize how their own actions might be maintaining the adolescent's problem behaviors, even as they aspired to change them. The family could then be mobilized as a resource in support of stable behavior change.

- A parallel development was the emergence of the field of family therapy. Several of its best-known leaders, including Salvador Minuchin and Jay Haley, were doing pioneering work and research with adolescents who were emotionally disturbed. James Alexander's work with delinquent youth (many of whom were also alcohol and drug abusers), another influential force, resulted in the development of the treatment model described in Part II of this monograph. Working together and independently, many family therapists and researchers were discovering that an individual's problems were more easily understood and more effectively treated within the context of his or her interpersonal relationships, especially those powerful relationships within the family.

- In the nonclinical world, a growing respect for the integrity, rights, and needs of the family was developing, stemming from the public concern in the seventies and eighties about escalating rates of family breakdown. This concern led to a reassessment of how public policy and human services may themselves play a role in the instability of the contemporary family. At the same time, the parent consumer movement in the field of mentally disabled and handicapped youngsters has grown and recently spread to the field of children's mental health and alcohol and other drug abuse. (See Rusche in Part III, page 121, and Fine in Part III, page 129.) This has led to a growing public sensitivity to the rights, roles, resources, and responsibilities of parents and helped fuel the impetus to family-centered treatment.

- The child welfare reform movement was another major force in the push to "preserve" families and avoid institutional placement. A 1980 Federal law (P.L. 96-272) requires that prior to placing a child in foster care, an agency must make a "reasonable effort" to maintain the child in the home. Current legislative reform proposals also strongly emphasize the need to strengthen efforts to preserve and support families.

- In addition to the growing concern about the human costs of out-of-home placements reflected in the child welfare reform movement, there is increasing concern about the escalating monetary costs of such placements. (See Lynch in Part III, page 135.) A component of this problem is the alarming increase in the number and cost of adolescent psychiatric and alcohol and drug abuse hospitalizations. (See Combrinck-Graham in Part II, page 43.) While there have been few well-designed studies documenting the short– and long–run savings of family-centered treatment, many program administrators, managed care administrators, and policymakers are increasingly convinced of the promise of at least some direct cost savings of family-centered treatment. (See Zarski in Part II, page 53.) In addition, they value the other benefits to the adolescent and the family and believe that improved family functioning and lowered stress should result in indirect savings through diminished need for other services. These indirect savings are, of course, even more difficult to measure than are direct savings.

- Even as the costs of institutional treatment were being seen as an increasing burden, research findings were indicating that inpatient services were generally no more effective than nonresidential psychiatric services offered in the community (Friedman & Street, 1985; U.S. Congress, OTA, 1986). Similar findings regarding the lack of long-term differences in outcome for inpatient versus outpatient treatment of alcoholism have also been documented. (See Miller & Hester, 1986.)

In the 1980's, several developments in the AODA and mental health arenas at the Federal level both reflected and fueled the interest in family preservation and a family-centered, community-based approach to adolescent

treatment. Under the administrative umbrella of SAMHSA—

- A development of particular importance was the initiation of the Child and Adolescent Service System Program (CASSP) at the National Institute of Mental Health (NIMH). CASSP provides limited funding and technical support to more than 40 States working to improve the coordination of community-based, family-centered mental health service systems available to children and youth with serious emotional disturbances.

  The CASSP effort produced a model for a "system of care" presented in a monograph by Stroul & Friedman (1986). The philosophical framework for the system is based on "core values," which, the authors stress, reflect a *commitment to serving the child in the context of the family and to preserving the integrity of the family whenever possible.*

  The CASSP effort and the child welfare reform movement together created a powerful momentum in the direction of family-centered treatment. (For more information on these movements and related programs, see Bibliography, Ooms, Beck, & Herendeen, June 1990; Ooms & Herendeen, July 1989.)

- The National Institute on Drug Abuse (NIDA), NIMH, and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), sponsored several studies that evaluated family aspects of adolescent problems and treatment issues in the care of adolescents, many of which focused on the family. (See Dishion, Patterson, & Reid, 1988.) A recent NIDA study done by Dr. Howard Liddle is the basis for the adolescent AODA treatment model he presents in Part II (see page 91). This study is one of several funded by NIDA to investigate family-based treatment for this population.

- The Office for Substance Abuse Prevention (OSAP), established in 1986, was mandated by the U.S. Congress to fund demonstration projects targeting high-risk youth. In their criteria for determining "at-risk" status, the Congress identified parental alcohol and other drug abuse as an important factor. Some of the prevention programs funded by OSAP closely involve parents.

- The Center for Substance Abuse Treatment (CSAT) was mandated by the U.S. Congress to focus on adolescents as one of three groups identified as "critical populations." CSAT's 1990 and 1991 criteria for grant applicants specifically require that their programs include the families in adolescent treatment. It was CSAT that sponsored the 1989 conference on adolescent treatment which led to the publication of this monograph.

Acronyms

AODA—Alcohol and other drug abuse. This term has generally replaced "substance abuse" in Federal and State agencies because it is more specific and emphasizes that alcohol is a drug. Note that throughout the monograph, when the word "drug" is used, it is assumed to include alcohol.

ADM—Alcohol, drug abuse, and mental health. This acronym is used to refer to a class of problems and to the professionals who treat those problems. For example, "adolescents who have ADM problems..." or "the ADM professionals who treat these adolescents..."

Family-Centered Treatment: Does It Work?

As mentioned above, there is an intuitive notion on the part of treatment professionals, based on their experiences with adolescents, that family factors must be addressed in order for adolescents to initiate and maintain behavior change. In addition, more and better research is supporting this idea. The research supporting family-centered treatment for adolescents falls into two main categories:

- Social science research, which documents the central role of the family in the continuing development of the adolescent and in the health and well-being of family members (see, for example, Baumrind, 1987; Campbell, 1986; Combrinck-Graham, 1988; Doherty & Campbell, 1988; Gilligan, 1987; Hill, 1987; Lerman & Ooms, 1988; Smollar, Youniss, & Ooms, 1988; Steinberg, 1990).

- Outcome research, which documents the clinical effectiveness of family-based interventions (see, for example, Alexander & Parsons, 1973; Aponte &VanDeusen, 1981; Gurman, Kniskern & Pinsof, 1986; Gutstein, Rudd, Graham, & Rayha, 1988; Hogarty, et. al., 1986; Klein, Alexander, & Parsons, 1976; Rahdert & Grabowski, eds., 1988; Szapocznik, et. al., 1989).

Family Systems Theory: What Is It?

While many human service professionals are working with the families of adolescents with AODA and mental health problems in a variety of ways, some still operate within an individualistic model of development and behavior. The family-centered approach being presented here is based on a different theoretical model, family systems theory, which views adolescent behavior and development in the context of the entire family's development as it passes through the family life cycle.

Family systems theory integrates the biological, psychological, and social/ environmental aspects of development. It recognizes that an individual's behavior is the product of many varied forces and contexts. An individual's immediate family is usually the most important of these contexts. Family therapists focus on family interactions as the primary source of meaning and influence and therefore a source of power to produce and sustain change. At the same time, family therapists recognize that other treatment modalities, aimed at the individual or at the larger system, may also be necessary to deal with adolescent problems. Medications, for instance, can help the teenager who is chemically depressed or psychotic. Self-help groups such as AA and Alateen can help the teenager who is dealing with his or her own abuse of alcohol or other drugs or with abuse of these chemicals by others in the family.

Family therapy does not rule out work with the adolescent alone or work that involves agents outside the adolescent's family, such as school, friends, or the judicial system. Indeed, family therapy provides a framework for understanding the importance of each of these. (See Part I, Combrinck-Graham in Part II, page 43, and Boyd-Franklin in Part II, page 71.) The family therapist believes that whatever combination of approaches is to be used, it should be planned together with the family and the adolescent. However troubled and alienated from the family the youngster may be at the time, it is the family that is the one constant factor in his or her life; family members have an ongoing relationship with and commitment to the adolescent. The primacy of the family should be respected; the family should be empowered rather than supplanted by the treatment.

If concerted efforts to work with parents show them to be unable or unwilling to be a

constructive resource, the systemic view would lead the treatment professional to look for alternative familylike supports for the youngster.

The key concepts of family systems theory are explained in Part I of this monograph.

Family Therapists: Who Are They?*

Professionals from several disciplines work with the families of adolescents in parent interviews, family interviews, family therapy, parent group meetings, and so forth. While some learn by doing, increasingly these professionals have had special training as part of their education or through inservice training provided by family therapists. Who are family therapists? What is their training? In what kinds of settings and in what capacities do they work?

Professional Training

Historically, those who have provided marriage and family therapy services come from a wide variety of educational backgrounds including psychiatry, psychology, social work, nursing, pastoral counseling, and education. In recent years, however, marriage and family therapy has been fully recognized as a distinct mental health discipline with graduate programs granting degrees in marriage and family therapy. The curriculum includes family systems theory and family development, comparison and contrast with traditional theories of development and behavior, family therapy practice in a variety of family systems models, professional ethics, and clinical internships under the close supervision of highly trained and experienced family therapists. In addition to those who are professional marriage and family therapists, clinicians from other mental health professions may choose to pursue marriage and family therapy training at the postgraduate level.

Roles

Marriage and family therapists practice in many settings and fill a variety of roles. They work in outpatient and inpatient settings in both public and private programs, private practice settings, and universities. They serve as therapists, clinical supervisors, program administrators, educators and trainers, and researchers. Family therapists also provide consultation to a variety of public and private agencies in how to implement a family-centered approach in their services.

Regulation

Marriage and family therapy is today recognized as a valuable and distinct mental health discipline requiring specialized training. The more than 17,000 members of the American Association for Marriage and Family Therapy (AAMFT) have documented that they have met the rigorous educational and clinical training requirements now recognized as the standard in the field. In addition, 22 States now regulate marriage and family therapists through licensure or certification.

Marriage and family therapy training is increasingly accredited by the AAMFT Commission on Accreditation for Marriage and Family Therapy Education. The commission is recognized by the U.S. Department of Education as the sole accrediting authority for marriage and family therapy education.

Marriage and family therapy practice is governed by both State licensing boards and AAMFT. Each State board establishes standards of practice and has disciplinary procedures to enforce these standards. AAMFT governs the practice of its members through its "Code of Ethical Principles for Marriage and Family Therapists" and operates its own active disciplinary committee. The AAMFT Code delineates standards of responsibility to clients, confidentiality, professional competence and

*While the proper, regulated title for the profession is marriage and family therapy, in this monograph we use family therapy as a broad generic term.

integrity, responsibility to employees and supervisees, responsibility to the profession, and responsibilities relating to financial arrangements and advertising.

Family-Centered Programs: Where Are They?

Family-centered programs varying in size and scope have been established at State and local levels across the country and in the private sector. New ones are being developed all the time. In this monograph, three principal examples are presented.

- Pennsylvania's mental health department and Delaware's Children's Services Department are implementing statewide changes to include a family focus in their child and adolescent services. (See Lindblad-Goldberg in Part III, page 163, and McCarthy in Part III, page 145.) Both States created mechanisms for interagency coordination and a multisystems approach to service delivery. Both States targeted reduced out-of-home placements as a major goal. Pennsylvania has implemented a home-based services program, and Delaware is about to do so.

- Montgomery County, Maryland, implemented a family-centered AODA program called Parents and Children Together (PACT). With this program at the core, the county combined all mental health (including AODA) and social work agencies under one case management system and all public dollars come through one agency that allocates the funds. (See Luongo in Part III, page 157.)

Many other States and localities have implemented home-based family intervention programs in child welfare services in an effort to decrease out-of-home placements. The best-known models are the Homebuilders program now in operation in more than a dozen States, the FAMILIES program in Iowa, and the Intensive Family Preservation (IFP) program in Oregon. (See Ooms, Beck, & Herendeen, June 1990).

Stimulated in part by the Federal CASSP program, several States and localities are developing innovative family-centered, community-based service systems to meet the needs of seriously emotionally disturbed children. Noteworthy examples are the Alaska Youth Initiative and the Children's Mental Health Demonstration Project in Ventura County, California.

Both outpatient and residential alcohol and drug abuse treatment programs are also increasingly including families in the treatment of adolescents. This is being done through a wide range of modalities, including family therapy, multifamily groups, and family education programs. Many of these programs work actively to refer family members to 12-step groups (Al-Anon, Alateen, and Families Anonymous), reflecting the significance of family dynamics in changing a pattern of alcohol and other drug abuse.

In recognition of all these trends, this monograph will explore current issues and present information and strategies relevant to the change to a family-centered approach. But first, Part I will place the adolescent in context by reviewing the basics of family systems theory and practice, including the major schools of family therapy. This sets the stage for the more detailed discussions of treatment issues and models.

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Part I:
Seeing the Troubled Adolescent in Context: Family Systems Theory and Practice

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Family systems therapy is an exciting approach to helping troubled youngsters and their families change. Its appeal is in part due to the reliability of systems theory as a guide to intervention. The family systems principles lead the therapist to attend to observable phenomena and to develop a clear plan for treatment based on those observations. The theoretical model allows the therapist to conceptualize how a variety of agents and forces figure into the picture presented by the adolescent and his or her family. Family systems therapy is flexible enough that it can often mesh with other approaches and techniques.

Purpose and Scope

This section explains the basic principles of family systems theory and briefly describes prevailing models of family systems therapy. It aims to give the reader an understanding of the "basics," so that he or she may better understand the discussions of family-centered treatment models and issues that follow.

Interdependence: The Family and Individual Development

The alcohol, drug abuse, and mental health (ADM) professional relies on theories of human development and human behavior to guide the assessment of an adolescent and to inform the therapeutic interventions employed with him or her. Traditional individualistic theories focus primarily on the intrapsychic (inner) processes of the individual. Family systems theory is considerably different from these. It focuses on the *interaction* among family members and can be seen as a theory of both family function and human development and behavior because these processes are so interrelated. Indeed, *systems theory sees all aspects of a person's environment as a "context" that creates meaning and influences the person even as it is redefined and influenced by him or her.*

Traditional developmental theories have explained the needs of a developing child and the historical importance of the family in meeting these needs. By its very presence, the family provides the child's earliest definition, the definition of himself or herself as distinct from "other." The family provides food, shelter, and a nurturing buffer between the less powerful child and the more powerful world. Family members react to events and persons and through their reactions create meaning for the child. The focus is always on outcomes for the child.

The individualistic focus of traditional developmental theories leads them to exclude an important phenomenon, however (Minuchin, 1985). That is, while the family fills a role of utmost importance in the life of the developing child, the family is at the same time transformed by the participation of the child. Members are defined in their family positions by virtue of the child's existence as mother, father, sister, brother, grandparent, and so on. The family responds to the child, and the child responds to the family. Each child within a family is responded to differently by different members. It is apparent that there is no real

beginning or end to these interactions; they are ongoing, circular, and continuous feedback processes.

Of course, every family is not an intact, smoothly functioning, warmly involved group. All families, in fact, fail to meet some needs of their members at some times. All families vary over time in their ability to work together and respond to the challenges of daily life. Detached, abusive, and even absent family members affect and influence one another, however. The content of issues may differ from family to family; the interdependence of behaviors and the importance of the family in the continuing development of individuals remain constant.

The recognition and understanding of this interrelatedness of behavior is the hallmark of family systems theory. In therapy, it leads to a focus on what goes on between people rather than what goes on within them. This focus is useful because interpersonal transactions are directly observable to the therapist while intrapersonal processes are not.

How did this new conceptualization arise? It grew out of the exciting changes in the focus of scientific inquiry that were taking place in the 1960's, which in turn influenced the social sciences.

Systems Theory: The Basis for Understanding Interdependence

During the first half of the 20th century, the family was seen primarily as a collection of individuals, and the focus of mental health research and treatment was on the characteristics of individuals. In the 1960's, developments in several scientific fields set the stage for change. In biology and physics, interest began to focus on the *relationships* among the parts of a whole rather than on the parts themselves in order to better understand how machines and living things worked. Cybernetics theory emphasized the importance of feedback between parts of a whole. The "whole" was seen as a "system" or a complex of interacting parts and the relationships that organize them within some kind of boundary.

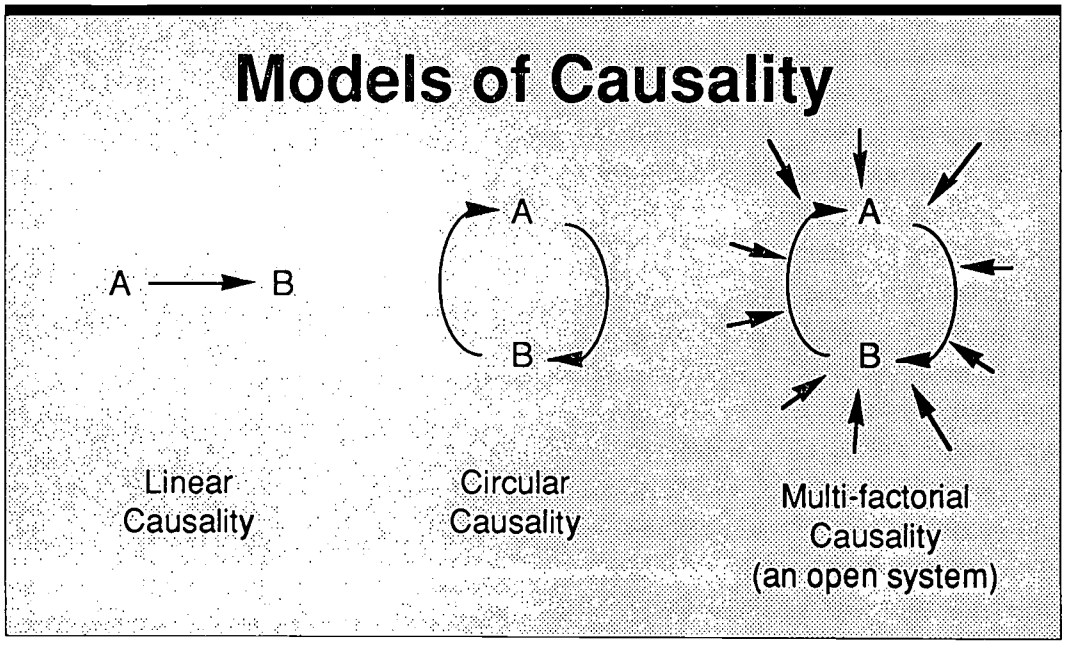

Diagram 1

Key Terms

Boundary—An abstract demarcation between or among individuals, systems, and subsystems that protects and enhances their integrity. Boundaries are defined by the rules that operate between the persons or systems, defining membership in each system and governing what is acceptable behavior toward one another.

Differentiation—The psychological separation of emotion and intellect and of self from others that is part of the developmental task of adolescence.

Disengagement—The condition of rigid boundaries and high levels of autonomy with little sense of loyalty and belonging among family members.

Enmeshment—The condition of diffuse boundaries and low levels of individual autonomy that leads family members to be highly emotionally reactive to, and dependent upon, one another.

Hierarchy—The distribution of control and authority in a family. In the hierarchy that family therapists consider to be most functional, the parents exert authority over the children.

Homeostasis—A balance or a state of equilibrium. The family as a system seeks homeostasis, and family members interact in ways that maintain this equilibrium.

Identified Patient—The person designated by the family as having "the problem." Family therapists tend to look at the implications of the situation for the whole family rather than focusing on one individual.

Joining—The process whereby the therapist connects with the family members in a shared understanding, building their confidence and trust in the therapist. Similar to establishing a "rapport."

Reframing—Relabeling a family's description or explanation of behavior and/or of its context to make the behavior more amenable to change. For example, the therapist may describe an anorectic youngster's behavior as "disobedient" rather than "sick," which not only redefines the behavior itself but puts it in the context of the family.

Subsystem—A system that is a subset of a larger system. In the family, subsystems might include "parents" or "siblings."

System—A group of functionally related elements that interact interdependently within a boundary that defines them as an entity. In the case of a family system, the members are the elements that interact interdependently. The family system is defined by an abstract boundary between it and the rest of society that designates it as an entity (for instance, "the Smith family").

It is through his or her interaction with others in this context that the adolescent derives meaning, develops an understanding of the world outside himself or herself, discovers the scope and limits of his or her ability to influence this world, and develops his or her capacities.

This led to a radically new and different way of looking at the concept of "cause." When mutual feedback among parts of a whole was recognized, an alternative to the existing linear view of causality— "A causes B"—arose (see diagram 1, page 14). In the old view, cause could be represented by a straight arrow between two events—the cause pointing to the effect. In the new view, though, the events could be seen as mutually determined. This phenomenon could be represented as "A causes B causes A." Both A and B were at the same time cause and effect. The arrow now curved around in a circular pattern pointing from A to B and back to A. The circular pattern defied the traditional notion of cause and effect altogether (Weiner, 1948, 1954).

The picture was still incomplete, though. What about the myriad other factors that might affect the events and the sequence in which they occurred? The new scientific systems model accounted for environmental factors by describing systems as "open" or "closed." Open systems exchange materials and energy with the environment, while closed systems do not. In an open system, then, there is opportunity for many forces to affect what happens within the system (von Bertalanffy, 1968).

Human Systems

Originally developed to explain the phenomena of the physical world, the systems model has advantages for conceptualizing human experience precisely because it accounts for the complexity of that experience. It is not simply a more complicated model, however; it is a different conceptual understanding. At the level of the individual, many physical parts and biological and psychological processes interact in a systematic way. There is no single specific cause of any specific human behavior because internal processes and social forces interact to produce it.

At the interpersonal level, individuals interact in systematic ways to produce recurrent patterns that can be observed. No one person's behavior causes the other's; they influence and constrain one another.

Thus, an individual can be conceived of as a system, and a family can be conceived of as a system, made up of several smaller systems. Likewise, a school or a church can each be seen as a large system made up of smaller ones. So can a neighborhood or a country. Individuals are members of many systems simultaneously. The systems nest within each other or overlap, yet each has a set of interacting parts that responds to feedback from one another within some kind of defining boundary. All human systems are open to some degree, that is, they must exercise some exchange with their environments.

Human Systems In Perspective: Family, Culture, and Society as Context

This set of nested systems constitutes an ecology that might be represented by a series of concentric circles (See diagram 2, page 17). At the center is the adolescent and his or her own biologic and intrapsychic processes. The next circle represents the immediate family and surrounding both of them, is the extended family. Making up the next ring is the family's daily contacts, including workplaces, schools, churches, and neighborhoods. Surrounding this is the larger community, which includes the health care system. The outer circle is the larger society. The set of beliefs and values known as ideology and culture constitute an overlay, as they affect all the systems within the ecology. Family, community, and society constitute levels in a hierarchy of systems making up the context of the adolescent; each is influenced and largely defined by cultural beliefs and values. All the systems represented by the rings interact with and influence one another to varying degrees. It is through his or her interaction with others in this context that the adolescent derives meaning, develops an understanding of the world outside himself or herself, discovers the scope and limits of his or

The Adolescent in Context: An Ecology of Nested Systems

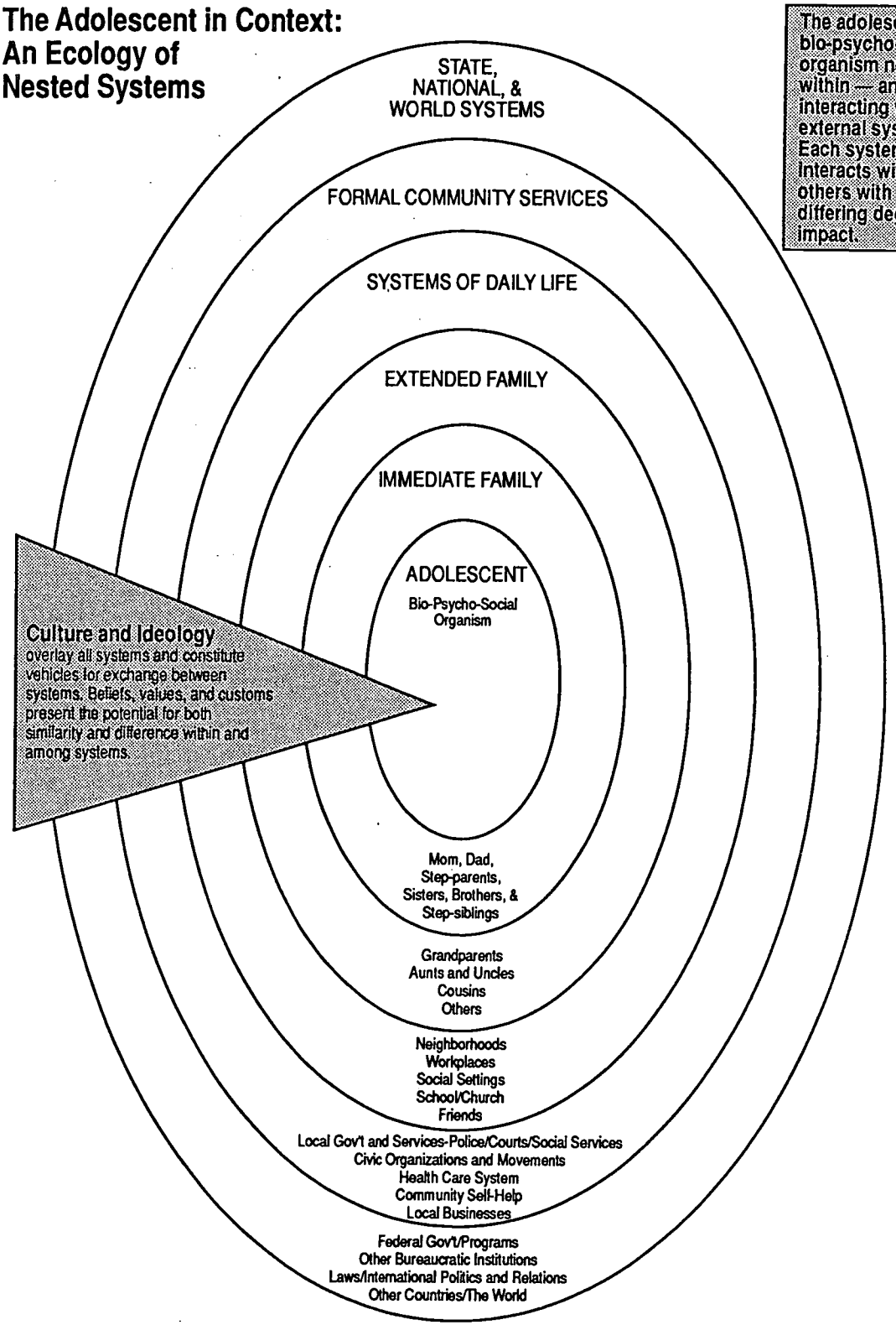

Diagram 2 — Snyder, Ooms, & Hutchins, 1991.

The approach dictates that the primacy of the family should be respected and that the family and the adolescent together should be "in charge" of involving others in the treatment. The therapist's role is to empower the family and help everyone to behave responsibly and helpfully.

her ability to influence this world, and develops his or her capacities.

One important clinical implication of the systems view is that an individual may behave very differently in different contexts. Thus, a teenager may be rude and out of control in a classroom run by a permissive teacher, but a model of good behavior in his authoritarian, structured home setting. Or an adolescent may be self-centered and self-absorbed with her parents, but sensitive and empathic with her peers.

Focus on the Family System

Family systems theory recognizes and respects the importance of each system in the ecology of the adolescent, from his or her own internal processes to the social and cultural forces many "rings" removed. The theory focuses attention on the family because the interactions in the family are among the most powerful forces in a person's life and are most easily available for observation and intervention. The family context therefore provides a unique resource for leveraging change. In addition, family therapists are increasingly intervening in other important systems as well—schools, churches, courts, and social service agencies—as part of an effective therapeutic strategy with a family.

In a family-centered approach, the therapist may see the adolescent alone or with other members of the immediate or extended family. The approach dictates that the primacy of the family should be respected and that the family and the adolescent together should be "in charge" of involving others in the treatment. The therapist's role is to empower the family and help everyone to behave responsibly and helpfully.

Some families may be concerned, caring, and hard working in their efforts to help their troubled children; others may be unconcerned, uncaring, uninvolved, and even abusive. Even when family members are detached or abusive, they are important in the adolescent's experience and cannot be ignored or discounted. Direct contact with the adolescent's family members is important in all cases in order to assess their role in the teenager's problem and its potential to be involved constructively in working toward a solution. While the nature and degree of the family's involvement in the treatment may vary, its importance to the process will not.

A Closer Look: What Is a Family and How Does It Operate?

Definition of "Family"

What is meant by "family?" Who is included? Who is excluded? There is wide variation in what might reasonably be called "family." It might be limited to mother, father, sisters, and brothers in one instance, or include several generations—or even people not related by blood—in another. Generally, those people who live together in a household and who share blood relationships are considered immediate family. The definition can expand dramatically from there.

In some cases, members of the nuclear family are geographically split through separation and divorce. In other cases, the parents of a child were never married and may never have lived in the same household. Indeed, some families have no household; they have no home at all and may or may not live together wherever they are. As the number of divorces has increased, so has the number of single-parent families and the number of remarried or "blended" families. Each is a family just as surely as the mother-father-son-and-daughter stereotype is. The members have the same needs to be loved and cared for. The families face the same challenges in supporting the growth and development of the family members. In many cases, in fact, they face

additional challenges in a society that is organized around its stereotype of a family.

The modern conception of "family" must account for an increasing variety of human situations if today's adolescent is to be seen realistically so he or she can be helped effectively. The treatment professional must evaluate in each case who is of importance in a given system, that is, who is considered "family" by the adolescent.

Family Function

Rules: All families operate according to a recognizable set of principles. In all families, there are unspoken as well as spoken rules. For instance, it might be openly stated and known to everyone that no one may interrupt Mom when she is talking. It might be unspoken but equally known to everyone that anyone can interrupt Dad. The rules themselves will differ from family to family; the fact that rules exist does not.

Roles: Roles, too, are a universal aspect of family operation. Roles define each member's function in the family. For example, a 13-year-old girl might be a school student, the caretaker of the family pet, the family hero who gives everyone something to be proud of, and the family "switchboard" who carries messages from person to person.

Families may rigidly adhere to rules and roles, making it difficult to adapt to the changing needs of family members or changing circumstances in the environment. On the other hand, families may flexibly alter rules and roles when they encounter changing needs. In some families, rules and roles are so flexible and ever changing that chaos results. The family's pattern over time reflects its larger metarule, that is, a rule for making and changing rules.

Communications: Family members perpetuate these rules and communicate their intentions and needs through a variety of means, both verbal and nonverbal. Their communications may be generally clear and consistent, or vague, confusing, and inconsistent. The pattern of communication in a family is itself a powerful message to the family members. When parents communicate to their child what behavior is acceptable and what is not, they also communicate the more subtle but far-reaching message that they are in charge. Conversely, of course, when the child *tells* the parents what he or she will do (or fails to consult them at all), the communication establishes that the child is in charge. Confusion arises when the parents say they are in charge but the transactions make it clear to all that they are not. A kind of ambiguity is set up that limits the family members' abilities to know what is real and what is not.

Proximity (Closeness and Distance): Relationships are established and constrained by these communications. Some relationships are close and the family members are quite available to one another. Other relationships are distant and the members wouldn't think to call on one another for help and support.

Boundaries and Hierarchy: Some family members display appreciation of one another as distinct beings and display a respect for one another's right to this individuality. Others seem confused about their separateness and become anxious when family members think or act independently. These abstract demarcations between individuals are called boundaries. There are boundaries between the subgroups in a family as well. For example, the generational boundary between the parent and child subsystems may be clear, with the parents demonstrating their difference from the children by exercising authority in the family. The boundary is said to be unclear when the child/children hold more authority than the parents; that is, there is confusion about the distinction between parents and children in the family. This distribution of power demarcated by subsystem boundaries is referred to as the family hierarchy.

In a healthy family, verbal and nonverbal communications are congruent. Roles and rules are clear but tend to be somewhat flexible, allowing for adaptation to the changes inherent in living. Parents hold the power, and children are respected but subordinate.

The concepts described here present a picture of the family. They define the family's structure. The picture is brought to life by the dynamic interaction of family members. They are the interdependent parts of the family system. In a family, this means that changes in one member will be accompanied by changes in the others. These changes range from subtle escalations of old behavior to startling displays of new behavior. The rules, roles, relationships, and communications in a family create a pattern that becomes familiar and represents the status quo. The pattern provides a sense of balance and predictability; people know how to "be" in the family. They act and react to preserve the balance or "homeostasis." The total family experience is the product of those forces producing growth and change and those forces maintaining the status quo.

In a healthy family, verbal and nonverbal communications are congruent. Roles and rules are clear but tend to be somewhat flexible, allowing for adaptation to the changes inherent in living. Parents hold the power, and children are respected but subordinate. Individuals are able to diminish personal stress by calling on others for support, understanding, and assistance, and by using other resources, including friends, work, and school. The interrelatedness of the family members is a source of meaning and provides for both the togetherness and the separateness of the members. Change proceeds at a pace that allows for assimilation by all members.

The Long View of the Family: The Family Life Cycle

While families can be characterized in terms of the concepts described above, such a description is a "slice-in-time" look at a family. A family does not simply come into existence as it is, nor will it necessarily stay the way it is. Families come to be as they are over time. They pass through developmental stages much like the stages that define individual development. The family systems view of the life cycle, though, focuses on the reciprocal nature of role definition and personal development. A couple marries and the man becomes a "husband" and the woman, a "wife." They must renegotiate their relationships with their respective families of origin to allow for the presence of the spouse. A baby is born and the woman becomes a "mother," the man, a "father." They must adjust their marital relationship to make room for the child and again realign their relationships with their parents to allow for the new "parenting" and "grandparenting" roles. The repetition of these realignments over the generations puts the family in its historical context. When a family fails to negotiate a transition successfully or resolve a major issue, the family members will carry with them the messages inherent in that experience and may pass along these messages in their parenting of the next generation. Thus, a process develops whereby the family attempts to work out similar issues over the generations.

Each stage in the life cycle presents a challenge to all involved. Negotiating the transitions is a mutual undertaking. The success of any individual in meeting his or her

What Is Adolescence?

What defines adolescence? Is it a biological, social, or legal concept? When does it "start"? When does it "end"? Some define adolescence as the time between biological puberty and legal adulthood, that is, age 18. Some define it as the "teen years" between 13 and 20. In this monograph, some authors' comments clearly apply only to "teenagers," while others may apply to a wider age range. In general, then, adolescence is defined broadly here as the period between ages 12 and 24.

challenges in these transitions depends in part on the success of the other family members in meeting their own. In this respect, each transition represents a potential "snag" in the fabric of individual and family development.

Adolescence as a Stage in the Family Life Cycle

When a child reaches adolescence, the family is presented with a unique set of developmental challenges. The family's boundaries must be increasingly flexible in order to accommodate the youngster's increasing independence. The parents must permit the adolescent to move more freely in and out of the family system. The adolescent must exercise responsibility while the parents refocus on younger children, their own midlife marital and career issues, and the aging of their own parents. Younger siblings are also affected. Of course, this is a simplified view for the sake of clarity. Depending on the number and ages of children and other factors, the family is dealing with a complex set of concurrent developmental demands.

At one time, adolescence was seen as an inherently conflictual stage and the adolescent's task as emancipation or breaking away from the parents (Blos, 1979; Freud, 1965; Hall, 1904). Recent research has shown that, in more instances than not, adolescence proceeds without serious disturbances. Most parents gradually change to a mode of support and guidance rather than direction and dominance. Most teenagers balance parent and peer relationships and involvements successfully. The adolescent's maturation takes place within the framework of the evolving parent-child relationship. Parent-child contact is maintained, but the relationship is restructured. Thus, adolescence is currently conceptualized as a time of renegotiation between the child and the parents (Kandel & Lesser, 1972; Offer & Offer, 1975; Youniss & Smollar, 1985; Steinberg, 1990).

Most adults continue to be involved with their parents over the course of their lives. Their relationships evolve to accommodate the changing capabilities and needs of both parents and adult children. Thus, the parent-offspring relationship will undergo many transformations over the years, but the change during the child's adolescence is significant in that the basic nature of the relationship is altered from one of subordinance and authority to one of parallel adult responsibility and friendship.

Context, Behavior, and Development Come Together: The Adolescent at Risk

While all adolescents and their families are challenged by the demands of this stage of the life cycle, especially in the context of today's rapidly changing social and cultural environment, some young people are at more risk of developing problems than others. Many factors contribute to risk in this period.

Adolescents undergo significant changes in biology, cognitive capacity, and self-image. They encounter increasingly risk-filled opportunities just when—and sometimes well before—their ability to think abstractly and evaluate risk is developing. Of course, some risk-taking is to be expected and can promote maturity and build confidence. But an unrealistic sense of invulnerability is typical in early adolescence and can contribute to risk-taking that is truly dangerous and destructive, particularly if it continues into later adolescence. Early drug use, for instance, may alter judgment and thereby inhibit the adolescent's development of a more mature ability to assess risk.

Family members are a factor in adolescent risk as they are role models and sources of incentive or disincentive to adolescent behaviors. They vary in their ability to provide support, guidance, and assistance to the young person. Families may contribute to the development of adolescent problems or simply

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not respond adequately to interrupt them. Problems may arise from longstanding family issues, disturbed family function, or difficulty in negotiating the transition of a family member into young adulthood.

Parenting behaviors and experiences that disrupt normal family management may influence the onset and/or continuation of some adolescent problems (Patterson, 1982, 1983). For example, while peer attitudes and behaviors are known to be influential in adolescent choices about alcohol and other drug use, parent factors may mediate this influence. Through their own drug use, parents may model drug use for their children, and their diminished attentiveness to child-monitoring and other parenting behaviors may allow peer practices to have increased influence in the child's life (Baumrind, 1985). Similarly, parents' intercession may mediate the influence of pro-drug-use messages in music, movies, and other community and social forces. It is clear that contextual factors, parent factors, and adolescent factors overlap to produce stress, create problems, and present risk to the whole family. These phenomena are interrelated, and no doubt many adolescent problems reflect all of them.

The high-risk behaviors themselves are interrelated as well. It is difficult to assess these interrelationships, in part because of the categorical way in which services (and therefore data collection efforts) are currently organized. Most programs serve adolescents with one problem or the other, but few address the overlap of problems in the same population. For example, programs may treat either alcohol and other drug abuse, pregnancy, or depression, but not all three, although for many teenagers these problems are linked. Even prevention programs are largely based on this categorical approach.

A growing body of research, however, confirms the longstanding observations of practitioners that high-risk behaviors are interrelated (Dryfoos, 1987; Irwin & Millstein, 1986). These interrelationships take different forms. Some high-risk behaviors may make the adolescent susceptible to others, as in the case of the drug-abusing youngster who engages in unprotected sex. In other instances, a minor risk may lead to a more serious risk, as in the case of the young person who first experiments with alcohol, then graduates to marijuana and perhaps to other "harder" drugs. When this interrelationship of risky behaviors is considered together with the individual and family factors that contribute to risk, it is clear that some segment of the adolescent population is at high risk for multiple problems, even if the direction of the influences is unclear. Thus, when children reach adolescence, context, development, and behavior come together to challenge the whole family system.

Origins of Family Systems Therapy: The Pioneers

Family systems therapy is an approach to treatment that takes into consideration the reality of an adolescent's current context. The approach is based on a theory that accounts for the major forces in the adolescent's life and guides the interventions to be employed.

How did family systems therapy come into being? While family systems therapy evolved along several parallel lines, there are distinct and traceable roots in the research on family interactions. For example, in the early to mid-1950's, Jay Haley, a linguist, and Don Jackson, a psychiatrist, studied communication in the families of schizophrenic patients in Palo Alto, California. Their work spawned a number of family treatment approaches over the years.

Haley focused on power and control as the explanatory factor in family interactions,while Jackson generally focused on the rules governing the interactions. Ultimately, Jackson established the Mental Research Institute and invited Virginia Satir, a social worker, to join

him in continuing to develop methods for working with families. Satir's therapy focused attention on family communications and thus fit comfortably with Jackson's research and treatment interests. Haley also worked at the Mental Research Institute for some time. In the 1960's, he went to the Philadelphia Child Guidance Center (PCGC), where he joined Salvador Minuchin, a psychiatrist who was then the PCGC director, in transforming a traditional child guidance center into a family therapy center.

Minuchin valued theoretical simplicity and, with Haley and his other colleagues, developed a simple and direct approach to working with families that came to be known as structural family therapy. This approach was especially effective with low-income minority families, who made up the majority of the PCGC's clients.

Minuchin made several additional important contributions to the field. His original techniques were developed through work with juvenile delinquents. In Philadelphia, he worked with pediatricians in developing effective treatment for seriously ill diabetics and anorectics. Minuchin pioneered the innovative training methods that are today the hallmark of family therapy training. He and his staff believed in the need to work with the broader ecosystems in the community—schools, neighborhood organizations, and agencies. And Minuchin and his colleagues, Haley, Montalvo, Aponte, and others, also established a unique, intensive 2-year program for training members of the local black community to be paraprofessional family therapists.

Like Jackson and Haley, Murray Bowen studied and worked with the families of schizophrenics, first at the National Institute of Mental Health and then at Georgetown University. Early on, Bowen, a psychiatrist, believed that the mechanisms he saw operating in these families were unique to families of schizophrenics and, indeed, were the cause of the condition. He soon discovered through his observation of other families that the same phenomena were present in varying degrees in all families. Bowen focused on the degree of emotional "stuck-togetherness" of family members and the need for each one to differentiate himself or herself from the others. He paid a great deal of attention to the intergenerational patterns in families and eventually developed an approach to working with families that was predicated on these observations.

Other influential pioneers included Nathan Ackerman and Ivan Boszormenyi-Nagy, both psychiatrists. The work of each was informed by a psychoanalytic background. Ackerman focused on the family's effect on the intrapsychic development of the individual. He saw families as being emotionally divided into competing factions that he perceived as being similar to the conflicts within individuals. In the late thirties, Ackerman treated disturbed children in the Menninger Child Guidance Clinic in Kansas and at first followed the child guidance model of having a psychiatrist work with the child while a social worker saw the mother. Eventually, Ackerman experimented with having the same therapist work with both and began to view the family as the unit of treatment. In New York City in 1960, Ackerman founded the Family Institute, which was renamed for him following his death. The Ackerman Institute continues to serve families and train family therapists today. Similarly, in 1957 Boszormenyi-Nagy founded the Eastern Pennsylvania Psychiatric Institute as a center for research and training in families and schizophrenia. Nagy made a valuable contribution to family therapy through his emphasis on morality and on trust and loyalty as factors in family relationships.

Over the past three decades, many excited and dedicated professionals from a variety of mental health backgrounds have followed these pioneers and have themselves become leaders,

Rachel

"I've been gorging myself and then throwing up for several years now, and I'm really scared that I can't stop!" said 22-year-old Rachel, a college student. "I was such a good girl and my parents were always so proud of me, they would die if they knew!! I just can't tell them this, it would destroy them."

contributing to the refinement of family systems theory and the development of family therapy treatment models and techniques. Working independently and together, they set the stage for family therapy as it is practiced today.

Family therapy techniques, because they are behavioral in nature and aimed at changing observable phenomena, can be reliably demonstrated and taught.

The Unique Appeal of Family Therapy Training

Family therapy training is an important element in the attractiveness of the approach to human service professionals. Family therapy techniques, because they are behavioral in nature and aimed at changing observable phenomena, can be reliably demonstrated and taught. The training techniques developed in the field include the use of telephones and one-way mirrors for live observation and supervision of therapy sessions. In many cases, the mirror is used even by experienced therapists in order to bring a team approach to the therapy. From behind the mirror, the students may watch an experienced therapist work with a family. Alternatively, the supervisor/teacher can call in to the session being conducted by a therapist-in-training and guide the student's work as the session unfolds. This is similar to the process of the therapy itself, in which the therapist intervenes in the interactions of the family members.

Another important aspect of family therapy training and practice is the use of videotapes. Through the use of tapes, the student—or the experienced therapist—can review sessions. He or she can get additional information about the family and observe and evaluate his or her own interaction with it. This is particularly valuable because family systems therapy emphasizes the therapist's genuineness and use-of-self in the therapy. Videotaping also facilitates consultation when live supervision/consultation cannot be arranged. Videotaping is being used for supervisory purposes in home-based treatment programs as well as office settings. (See Lindblad-Goldberg in Part III, page 163.)

Family therapists also watch the recognized experts in the field in live and taped sessions, which are followed by lively discussions of the interventions employed. These training methods are an exciting change from standard methods, in which students could only process their interventions with supervisors after the fact and read about the work of their mentors.

Of course, the methods employed in family therapy training and practice require assurances of confidentiality and fully informed consent by the family. Access to the observation room "behind the mirror" is strictly limited, and the privacy of videotapes is carefully protected. Explaining the methods and obtaining consent is often one of the therapist's earliest interactions with families. It immediately communicates respect for them and establishes that the therapist has additional resources available to help them. Families themselves are usually quite accepting of these procedures and very rarely refuse them.

Major Schools of Family Therapy

From the historical roots described above, numerous models of family therapy have been developed, and they are categorized into several "schools." Family therapy is a dynamic, evolving discipline. Some models may not fit neatly into the schools as they have been defined here. The reader who is interested in

knowing more about the various models is referred to the reference list.

Intergenerational Family Therapy

Intergenerational Family Therapy is based on the work of Murray Bowen and others who focused on the processes among generations in families. Problems are seen as the product of intergenerational patterns of unresolved issues and inadequate differentiation among family members. The therapist assists family members to recognize the patterns, to understand the family legacy, and to see that they are not at fault and are free to change their own behaviors.

A widely used technique in this kind of family work is the construction of a family genogram, a kind of family tree that includes information about major events, losses, relationships, and other factors of importance to the family's issues. The genogram elucidates the family's intergenerational patterns. In the Bowenian model of intergenerational family therapy, the therapist keeps the affective level of the sessions low and acts as a "coach" to the family members working on behavior change. Even therapists who primarily apply other models of treatment in their work draw on the concepts and constructs from the intergenerational school and frequently use genograms in their work with families. (See Bowen, 1978, in the Annotated Bibliography.)

Structural/Strategic Family Therapy

The structural and strategic family therapy approaches are distinct but closely related and compatible. They are commonly referred to together, as they are here, and represent a major school of therapy within which a number of specific models can be categorized. The structural approach is the offspring of Salvador Minuchin and his colleagues at the Philadelphia Child Guidance Clinic, including Jay Haley, whose work with Cloé Madanes later spawned the strategic approach. Strategic work is very problem-focused and does not aim to achieve understanding or insight but to resolve the presenting problem. Like structural therapy, it focuses on the here-and-now family organization as defined by the established patterns of interaction.

Like family therapists in general, structural-strategic therapists see the interactive behaviors of family members as "communications." Strategic therapists see power as the primary message being communicated. Patterns in these communications govern the functioning of family members, defining for them a range of behavior and influencing their further interactions with one another. A functional family organization is one that supports the members' individuation while still providing a sense of belonging. It reflects a clear understanding of the distribution of authority. When there are problems in a family, the boundaries are often unclear and the distribution of authority confused and incongruous. Problems arise in part because the family's worldview constrains it from seeing the situation differently and conceiving of alternative responses.

Structural-strategic family therapy aims to reorganize the family into a more functional structure in order to solve the presenting problem. Interventions aim to challenge the family's view of the problem and expand its options for response. They also alter the family's interactions to clarify boundaries and authority. Classic structural interventions include reframing situations to change perceptions and beliefs. Identification and enactment of both spontaneous problem-related interactions and alternatives in the sessions are also commonly employed. Strategic interventions are very directive, with the therapist taking much responsibility for inducing change. They are also very creative in that creative "reframes"—new ways of looking at situations—are used and many interventions involve the use of play and pretense in order to disrupt ingrained patterns of behavior. Strategic work also employs paradoxical interventions in which a directive

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seems in some way contradictory to the desired change but actually puts the individual or family in a kind of therapeutic "bind," inducing change. Some people characterize the directiveness of the strategic therapist and the frequent use of paradoxical techniques as "manipulative," but this approach is extremely effective in solving specific presenting problems and, because that is the goal of the therapy, Haley points out that the therapist is serving the family (see Haley, 1976, in the Annotated Bibliography).

Experiential and Communications Family Therapy

Experiential family therapy approaches are difficult to classify and describe precisely because they are so experiential and spontaneous in nature. Experiential therapy is the least theoretical of all the approaches. The most widely known family therapist whose work is clearly experiential is Carl Whitaker, a psychiatrist who, with his colleagues in Atlanta in the 1950's, pioneered the experiential approach to psychotherapy. Whitaker has stressed what he sees as the danger of theory as the basis for psychotherapy and instead emphasizes the importance of intuition and creativity. By avoiding theory and technique, Whitaker believes that he forces families to develop their own theoretical basis for living. He stresses the importance of the therapist being genuine with the family as it struggles to solve its problems. Whitaker is known for insisting that many family members from all living generations be involved in the therapy.

Personal growth of the individual members within the supportive context of the family is emphasized in this approach to family therapy. While Whitaker works with large family systems in the room, he and other experiential therapists often focus attention on the family members one at a time, rather than working back and forth or facilitating interaction among the members of dyads or groups as the strategic-structural therapists do. This is reflective of the Gestalt influence in experiential therapy. Therapeutic change comes about through enhanced awareness, which expands each person's sense of choice in his or her own behavior.

Whitaker advocates the use of a cotherapist and quality supervision because he believes that it is personal support, not theory and technique, that allows the therapist to do his or her best work.

Virginia Satir is sometimes classified as an experiential therapist, although her work is just as often called "communications" therapy. In spite of her involvement with the highly theory-based communications people in Palo Alto, she focused more on dynamic work with families than on theory and so is difficult to place squarely within one school of thought or practice. She believed that low self-esteem, reinforced by family members, is the basis for dysfunction.

Satir used creative techniques that are very experiential in nature, including family sculpting, in which the family members were helped to assemble themselves into physical configurations that reflected their perceptions of their relationships and their roles in the family. This technique is illustrative of Satir's focus on helping family members become more aware of their experience of themselves and each other. (See Whitaker, 1988, and Satir, 1967, in the Annotated Bibliography.)

Social Learning, Cognitive, and Behavioral Family Therapy

There are a number of family therapy models that draw on learning theories and heavily utilize cognitive and behavioral techniques. These models are less systemic than other family therapy models. This category is less a "school" than an eclectic collection of individual treatment models that have been applied to couples and families. Cognitive and behavioral approaches are the basis of parent

training, which can be helpful in the treatment of some adolescent problems.

One particular model, Functional Family Therapy, is a thoughtfully integrated combination of systems concepts and techniques with behavioral and cognitive techniques based on psychological learning theories. (See Alexander in Part II, page 101.)

Feminist Family Therapy

Although the leaders of the movement point out that feminist family therapy is a perspective rather than a "school" of therapy or a new method, its impact on the practice of family therapy warrants mention here.

Within the context of the feminist consciousness that arose in the early to mid-1970's, four prominent family therapists, Marianne Walters, Betty Carter, Peggy Papp, and Olga Silverstein, came together to critique the family therapy leadership for its gender biases. Building on a ground-breaking work by Hare-Mustin (1978), they defined for themselves a feminist framework which recognized that gender serves as an organizing principle in society in general and in family life in particular. They sought in this framework to include the experience of women in all formulations of human experience and to eliminate the dominance of male assumptions. Their conception of feminism did not blame individual men for the patriarchal social system but attempted to understand the system as it existed.

These four family therapists formed the Women's Project in Family Therapy and explored ways in which family systems theory and family therapy had failed to acknowledge and deal with the impact of gender and examined family systems concepts for indications of patriarchal assumptions. For example, the notion of "overcloseness" in relationships as problematic may simply reflect an undervaluing of the more traditionally feminine way of relating to others and an assumption that the more distant, traditionally male way of relating is better. Another aspect of the same issue is the tendency to assume that the mother who is "overclose" to a child in the family is keeping the father distant rather than responding to a legitimate fear of the vacuum that might exist if she retreated or backed off.

The current and ongoing work of the feminists is the development of nonsexist and feminist systemic interventions and revision and adaptation of traditional interventions to take gender into account. These interventions are informed by a set of feminist guidelines that serve as reminders of the reality of female experience. That is, they remind the therapist to recognize the real limitations of female access to social and economic resources and the dilemmas and conflicts of childbearing and child rearing in our society. They also encourage affirmation of the values and behaviors characteristic of women and recognition of the basic principle that no intervention is gender-free. (See Walters, Carter, Papp, & Silverstein, 1988, in the Annotated Bibliography.)

Feminist thought cuts across the schools of family therapy and can be applied within different theoretical and practical frameworks and in different settings. It has changed how many therapists look at their clients and the options they conceive for them.

Goals and Techniques: What and How Family Therapists Help People Change

The schools of family therapy vary somewhat in their definitions of therapeutic goals, although they generally focus on the resolution of problems as opposed to the restructuring of personality. By virtue of its focus on problem resolution, much family therapy is relatively short-term work. Indeed, some models of family therapy are designed to be conducted in very few sessions. For

example, in a survey of selected American Association for Marriage and Family Therapy (AAMFT) clinical members conducted in 1987, it was learned that 70 percent of family therapy cases are terminated in less than 25 sessions, and 38 percent are concluded in less than 10. Families are often told that it is not unusual to hit a "snag," resolve the issues with a little help, and then move on, to return later if they again need help. This is especially relevant to adolescent problems, which often arise out of the family's difficulty in negotiating the developmental transition. Of course, the duration of treatment varies with the nature, severity, and chronicity of the presenting problem and the characteristics of the family.

Family therapy is an approach that can be applied to a wide variety of problems. When indicated, family therapists work in conjunction with other professionals, including psychiatrists, to set appropriate goals and manage cases of great complexity.

One of the ways family therapy differs most clearly from other approaches is its understanding of how people change and the therapeutic techniques derived from this understanding. Family systems theory leads to the assumption that people can change in response to changes in their here-and-now interactions with others.

Family therapy is less reliant on insight than psychodynamic models of therapy, although awareness of self is valued. Family therapy does not focus heavily on the past, but the importance of history is recognized. Family history is explored in order to establish patterns of experience or behavior and elucidate family rules or legacies. Otherwise, the therapy tends to focus on the here and now and is not concerned with what "caused" a problem, but with what seems to *maintain* it. Many family therapy interventions are designed to create the experience of different behavior for family members, who can then support each others' efforts to change.

Common family therapy techniques include reframing, which means relabeling or otherwise redefining behaviors or situations and/or changing the context presented. For example, if a mother describes her teenage son's behavior as "running out on me" and "running off to his father's house when I get angry," the therapist might reframe the behavior by saying, "So this is a boy who takes a break when the tension gets high." This allows the mother to conceive of the son's behavior as something other than a rejection of her and provides a starting place for figuring out how the son could take a break without "running off."

Reframes are generally used to expand the family members' views or to reorient them in relation to their own or one another's behaviors or motives. Usually, a more positive, benevolent view is introduced, although there are occasions when the severity of a situation has to be punctuated with a reframe to a more negative view. An example of this might be when a parent is inadequately concerned about the depressed affect of a suicidal adolescent and calls it "pouting." The therapist might relabel the youngster as being "in tremendous pain" and the situation as "urgent."

Other typical family therapy interventions involve teaching communication skills or changing the patterns of family communications in the sessions by blocking certain interactions and facilitating others. Often, the therapist will combine these approaches and then explore with the family what it was like for them to be different with each other in this way. For example, if Dad always interrupts when Mom speaks to their teenage daughter critically, the therapist might point this out and block the pattern by stopping Dad from interrupting, allowing Mom and Daughter to finish their dialog—coaching when necessary, and then discussing what it was like for all of them to have done this sequence differently.

In many family therapy approaches, the benefits as well as the costs of problem behaviors are explored, and the benefits of one person's behavior for others is especially emphasized. To continue with the previous example, the therapist might inquire about what the behavior sequence "gets for each of you." She or he might speculate whether Dad prevents Mom and Daughter from fighting and thus keeps the tension down but also keeps them from ever really resolving their issues. Does Mom get attention from Dad but feel unsatisfied because it is unpleasant attention? Does Daughter get some highly desired adolescent distance from her mom and dad but also feel insecure about their tension and the threat to their relationship? Daughter's behavior may serve to engage Mom and Dad with one another and provide them with someone else to focus on so they avoid tension over their own relationship issues. These ways of exploring behaviors and their benefits and costs allow the family to recognize that there are many possibilities for explanations and motivations. This is often more important than whether a particular explanation fits.

"Hovering" Parents

Frightened by their son's host of physical problems during childhood and the onset of schizophrenia in adolescence, Bill and Wanda first took Josh to a doctor and then to a parade of specialists over several years. Their message was always the same, "Maybe if you didn't hover over him so?" Never did anyone ask about their feelings as parents or draw on their wealth of knowledge about Josh. Even when he was hospitalized, they were told to restrict themselves to standard visiting hours and to "try not to upset him." Bill and Wanda felt embarrassed and intimidated, yet angry at their treatment. And worst of all, in their hearts they began to wonder, "Did we do something terrible to our own son?"

The use of metaphor is also a common technique in family therapy practice. Metaphors can help family members grasp the meaning of something, understand a problem, and/or envision alternative outcomes. In some cases, a metaphor or story may be complex and its relevance to the family's situation is not overtly explained; the metaphor is used to plant ideas. In other cases, a metaphor creates an analogy that is shared with the family and that may evolve into an ongoing theme in the therapy. For example, a teenage girl who is withdrawn and self-conscious might be likened to a butterfly in the caterpillar stage, hidden away in a cocoon, developing her inner and outer beauty and her strength. The story might continue to say (or ask) that one day she'll emerge and fly happily off to a lovely garden.

Family therapists also create change within the therapy sessions through very active, symbolic interventions, such as moving the family's chairs around or asking family members to change seats with one another in order to change images of relationships. For instance, when it emerges in a session that one parent perceives himself or herself to be "in the middle" between the other parent and a child, it is very common to notice that, indeed, that parent is sitting in the middle. The family members might then be asked to switch chairs so the parents are together to one side of the child. Sometimes the therapist will ask the family members to arrange *themselves* physically in ways that illustrate how they perceive themselves in relation to one another. This technique is called family sculpting and can create very powerful images that allow family members to gain new understanding of how other members experience them.

Family therapists may also direct activities, such as parents playing with children or spouses touching one another in expressions of support or affection. Sometimes they assist the family to perform a task such as working out a

rule or a consequence for an adolescent child, perhaps developing a whole "contract" or set of agreements about rules and consequences. Parents might be helped to develop a plan for enforcing their authority and for monitoring the adolescent's compliance with rules. Family therapists also give "homework assignments," which might ask the family to accomplish similar tasks or to try out new behaviors outside the session.

The variety of family therapy interventions is enormous, and even standard interventions are often used very creatively in particular situations. Many of the publications in the reference list describe family therapy interventions in more detail and variety. (See especially Falloon (ed.), 1988; Fisch, Weakland, & Segal, 1982; Fishman, 1988; Fishman, Stanton, & Roseman, 1982; Haley, 1976; Imber-Black, 1988; Madanes, 1990; Minuchin & Fishman, 1981; Nichols, 1984; all in the Annotated Bibliography.) The reader is urged to explore them.

To summarize, while they may differ in emphasis, the schools of family therapy share a theoretical basis and share many of the same techniques and interventions. All see the family as a system developing over an intergenerational life cycle. All recognize the existence of many systems in the context of the individual and the family and share the perception of the family as the most important system in the context of the developing child or adolescent.

Family Therapy Misunderstood: The Issues of Parent-Blame, Biologically Based Disorders, and the Disease Model of Addiction

Because the systems view is radically different from the usual assumptions about human behavior and causality, family systems theory is not widely understood by the general public or by some non-systems-oriented mental health professionals, giving rise to some common misconceptions about its purpose and ideas.

Parent-Blame

Advocates for troubled adolescents and their families have been suspicious or skeptical of mental health professionals in general, fearing that parents will be blamed for the problems of their adolescent offspring. This legitimate fear grows out of the history of parent-blaming in the field of mental health and the child guidance movement in the 1920's and 1930's. Also, parent-blaming was blatant in the early research on families and schizophrenia. That legacy of blame continues to make people skeptical of those who want to address the family in treatment. (See Fine in Part III, page 129.) As already noted, though, family systems theory eschews the very notion of linear cause and effect in human behavior and is thus inherently nonblaming.

Biologically Based Disorders

Another controversy arises out of the limited understanding of systems theory combined with the history of early family research on schizophrenia, which ignored possible biological factors. Some parents and health professionals believe that family systems theory is not compatible with the concept of biologically based mental disorders.

In fact, however, family systems theory is not inherently in conflict with the concept of biologically based disorders that "reside" within an individual patient. Systems theory acknowledges the importance of biological and psychological processes as well as family interaction and other social experience in all human behavior.

The Disease Model of Addiction

In a similar controversy, some professionals think that family systems theory is incompatible with the disease or medical model of addiction. Actually, this is not true, although for years many family therapists have questioned the broad application of the term

"addiction"to adolescent abuse of alcohol and other drugs. While many family therapists employ the disease model of addiction with adults, classic family therapy literature recommends labeling teenage AODA as misbehavior rather than illness in order to bring the behavior into the domain of the parents and to create the distance needed to help parents take a firm stand against further drug use (Stanton & Todd, 1982; Madanes, 1981).

Unlike the medical model, the family systems model does not purport to explain the "cause" of AODA or addiction, but only to explain an important part of what sustains the pattern and could help to change it. There can be little doubt that biochemical and family relationship factors—and many others—influence continuing drug use. Thus, treatment professionals must recognize the biological factors in drug use—including the effects of the drugs themselves—and recognize that parents are an important resource for teenagers in the effort to stop use of alcohol and other drugs and to avoid relapse.

Parents offer the possibility of much-needed support for the adolescent's ongoing program of recovery, though they may be struggling with their own issues. These issues sometimes include their own abuse of alcohol and other drugs. Parental AODA is a reality in many adolescents' lives and must be addressed. Its impact on the youngster is most effectively addressed with the parents themselves involved in the treatment.

It is clear that the key to reliable treatment of adolescent alcohol and other drug abuse is not yet known. But successful treatment for these young people must surely be informed by all relevant research and treatment experience. The disease model and the family systems model are not mutually exclusive. Instead they represent different "pieces" of the same reality and together inform professional work with a richness neither framework alone can offer.

(See Todd in Part II, page 79, and Liddle in Part II, page 91.)

That richness is evident in the concept of codependency, which arose in the addictions treatment literature and is at the same time inherently systemic in nature. That is, codependency focuses on how a person behaves *in relation to others*. Codependency is related to boundary definition and the regulation of closeness and distance in relationships. These concepts are fundamental to family systems theory.

Therapy with these "codependent"clients often focuses on the futility and "costs" of overinvolvement with the abuser and simultaneously on the appropriateness and value of loving support for him or her. Al-Anon, Alateen, and Families Anonymous can be an important source of personal support for these ideas. Thus, the addictions treatment community and the family systems community share an understanding that can be a springboard for collaboration.

Differences in Terminology

The differences in terminology employed by family therapists and other disciplines may have contributed to the misunderstandings discussed here. The terms "disease" and "mental illness" have been controversial in the field of family therapy. The reluctance to use these terms, which are widely applied in the medical community and accepted among parent advocacy groups, has sometimes led to alienation between family treatment professionals and others. In many instances, the use of alternative terms by family therapists is a therapeutic technique and does not imply denial of a biological basis for disordered behavior or affect. For instance, family systems therapists have historically used the term "problem" rather than "disease" to refer to the situations and behaviors presented by clients as the focus of treatment. Family systems literature refers to

the "identified patient," leading some to believe that the patient isn't really seen as the patient at all. Critics think the implication is that there is no disease or illness, only a "problem," perhaps caused by the "unidentified patients" in the family.

Indeed, it is true that family therapists do not limit their attention to the troubled adolescent, the identified patient. The very nature of family systems work dictates that the focus be on the whole family system. In addition, many family therapists resist the term "illness" because the "sick role" often includes helplessness, leading individuals or families to see themselves as helpless to change even those behaviors that are under their own control. Referring to a "problem" is often a way of classifying the behavior as manageable in order to help families exercise their competence.

Throughout this monograph, reference is made to "problems" and "solutions." It is understood that, in some cases, adolescents may indeed suffer from biologically based disorders that cannot currently be "cured" but can be coped with or handled. These include not only those conditions that are the subject of controversy, but those that are clearly biological, such as juvenile diabetes. In these instances, the "problem" referred to might be the stress perceived by the family and those aspects of behavior—both the adolescent patient's and his or her family's—that can be changed to some extent to bring relief to all family members. Such changes might require the use of medication, education, family therapy, self-help groups, or all of these. The changes effected and the family's relief would constitute the "solution." (See Anderson in Part II, page 105, and Liddle in Part II, page 85.) In other cases, the meaning of the terms "problem" and "solution" are obvious.

Finally, the term "dysfunctional family" has been used in both the addictions and family therapy fields. While many adolescents and adults have found relief and help by recognizing that problems in their families profoundly affected them, labeling families as "dysfunctional" can be a harmful and offensive practice. In fact, behaviors, not persons, are dysfunctional. That is, certain behaviors do not accomplish their intended goals (their "functions") and/or result in unintended detrimental effects. The label "dysfunctional" reduces the family to a simple, negative force. In reality, families are complex systems and have strengths as well as weaknesses.

Family-Centered Treatment in a Variety of Settings

Whatever terminology they employ, the aim of family therapists is to help adolescents and their families as they struggle to meet the variety of challenges that confront them. Currently, family therapy is practiced in a variety of inpatient and outpatient, public and private AODA and mental health treatment settings. In some cases, family-centered programs are not clearly reflective of family systems theory, but simply reflect a concern for the central role of the family in the adolescent's life, and the social and legal commitment to preserving families.

Family-centered treatment is offered in many outpatient settings in both the mental health and drug abuse treatment fields. Settings include private practices and privately run programs, community mental health centers, and public AODA programs. Many outpatient settings represent public-private partnerships, with private programs delivering services under grants or contracts with Federal, State, or local governments. In these outpatient settings, families are often included in educational programs and individual and multifamily group therapy.

Under some circumstances, outpatient services are delivered in the adolescent's home. Although home-based and crisis-intensive services have a long history, the family

preservation movement spawned a new interest in these programs, which typically offer crisis services to adolescents in danger of hospitalization or other out-of-home placement. They represent a community effort toward family preservation in most cases, though private insurers and managed mental health care companies are also becoming interested in these models because of their potential for cost-saving reductions in hospitalizations. Some of these programs are based on a family systems model and emphasize ongoing work with the families. Others are based on crisis intervention theory and assist the family through the crisis but do not provide long-term assistance. Those programs may refer families to outpatient family-centered treatment when the crisis has been resolved. (See Zarski in Part II, page 53, and Lindblad-Goldberg in Part III, page 163.)

In inpatient settings, both public and private, adolescents have historically been isolated from their families, often only being allowed to see them during brief visiting hours. Increasingly, though, families are involved in the inpatient care of their adolescent offspring in both hospitals and residential AODA treatment programs. As Combrinck-Graham points out in her paper in Part II, it is most helpful to the child and the parents in the long run if the family is included in the decision to hospitalize. This means not only giving consent, but being involved in the evaluation of hospitalization as a treatment option for the adolescent. In this way, the parents are respected and empowered from the beginning, and it is made clear that the family is still in a position of importance with respect to the child.

Once the adolescent is admitted to an inpatient facility, the family is involved in many treatment activities similar to those that take place in outpatient settings, including educational presentations and individual and multifamily group therapy. Some inpatient/ residential programs are exploring more innovative ways to involve families, including having them advise the treatment team about disciplinary guidelines for the youngster. In some of these programs, parents are consulted when their adolescent acts out, and they are asked to recommend disciplinary tactics that the treatment staff will then employ. A family focus in the treatment helps maintain an ongoing sense of involvement and prepares both the young person and the family for living together again.

Increasingly, inpatient facilities refer adolescents to "aftercare" programs, some of which include families in their activities, following discharge. These programs are designed to facilitate the transition of the adolescent back into daily life. Their very existence acknowledges the systemic notion that the adolescent's environment is a powerful influence in his or her behavior and, similarly, the returning adolescent is a powerful influence in the family's behavior.

Another setting in which family-centered treatment is taking place represents a relatively new concept in the treatment of troubled adolescents—day treatment or partial hospitalization programs. An even stronger family link can be maintained in these programs than in residential (overnight) programs because the adolescent sleeps at home and thus continues to "live with" his or her family. In addition, these programs can offer virtually the same treatment modalities as full hospitalization, but at greatly reduced costs.

The community itself is also a setting in which a family-centered approach to adolescent problems has emerged. There are an increasing variety of community-based self-help groups that target the families of troubled adolescents as well as those that target the young people themselves. Those serving adolescents include groups based on the12-step model such as young people's Alcoholics Anonymous (for the recovering alcoholic teenager) and Alateen (for the teenager who is dealing with alcoholism in a family member or other important person).

Alateen and Al-Anon, the self-help groups for families of alcoholics, reflect a systemic view of the interplay between the alcoholic and the family. Families Anonymous, a more recent addition to the list of 12-step programs, targets the families of adolescents specifically, and thus represents an especially relevant community-based, family-centered resource. In addition to the groups dealing with alcohol and other drug abuse, there are 12-step groups for eating disorders and for a variety of other problem behaviors. Families Anonymous, for example, assists parents of teenagers who are abusing drugs as well as those whose children are acting out in other ways.

There are also numerous other self-help groups not based on the 12-step model. They target a variety of specific problem situations. Through the Toughlove program, for instance, parents of adolescents who are acting out or severely misbehaving give each other both emotional support and practical help in dealing with their youngsters.

Some groups focus on interpersonal support, while others focus on advocacy, and many do both. For example, the Parents Involved Network (PIN), described by Glenda Fine in Part III, provides personal support and information to parents of children and adolescents who have emotional problems. PIN also advocates at the local and State levels for policy changes and funding that will benefit these children.

William and His Dad

William's dad is paralyzed with fear. He is afraid to go to work, even afraid to go to sleep at night for fear he'll awake to find William dead. At 14, William had seemed unhappy and withdrawn. Now, at 17, he is depressed all the time and talks about dying as if it were the answer to all his problems. Dad cajoled him, bribed him, and pleaded with him, but William was unable to promise that he wouldn't take his own life.

The very notion of self-help reflects the systemic, ecological understanding of human experience—that is, through interaction with others, meaning is created, needs are met, and behavior is influenced. The increasing development of self-help groups for the families of adolescents reflects a recognition of the interdependence and mutual influence among family members.

Another family-based approach that has arisen in the community is the use of an alternative living site for the adolescent as a respite for a beleaguered family. In the past, a family had to rely on neighbors or friends to take in an adolescent. Increasingly, there are organized approaches to seeking such respite, including turning to the parents of other children who have had problems. This approach is advocated by the Toughlove program (York, York, & Wachtel, 1982) and is employed by some alcohol and other drug abuse treatment programs, most notably Straight, Incorporated, as a routine part of the treatment course. There are also runaway shelters in many communities that will sometimes agree to accept an adolescent who has not yet run away but is in danger of ending up on the street. In each case, in order to be considered a family-based approach and a resource to families, respite must be provided with the family's knowledge and involvement. While the tension is often very high at the time when the adolescent leaves the home, the family's ongoing responsibility to the adolescent must guide the efforts to help it through such a difficult time.

Thus, families are increasingly afforded a central role in the treatment of adolescents in many settings. Efforts are under way in both public and private settings to involve families in ways that hold promise for keeping them together. Even in the presence of enthusiasm and hard work, however, a number of factors constitute barriers to the full

realization of the goal of community-based, family-centered care.

Barriers to Family-Centered Treatment

The organization of AODA and mental health services for adolescents has long been based on the individualistic view of human experience. When it was believed that adolescents needed to break away from their parents to complete their development, treatment itself attempted to facilitate the adolescent's emancipation, and service organizations that furthered the rift between parents and adolescents were not seen as dysfunctional or counterproductive. Because of this history, a philosophy of individualism underpins the established services available to adolescents. The need to reorient the philosophies of a large number of people involved in the treatment of adolescents presents a barrier to the implementation of a family-centered approach to treatment.

The categorical organization of adolescent treatment services also presents an impediment to a family focus. Services that treat only one aspect of an adolescent's behavior miss the interrelationship of the biological, cognitive, social, emotional, and contextual factors that create behavior. It is precisely these interrelationships that can be addressed through family-centered treatment based on a systems model of adolescent development. Within the current categorical organization of services, however, an adolescent may not qualify for an essential program—say, AODA treatment—or may qualify for many different and unrelated services. It may be unrealistic to expect that the adolescent and his or her family can fully participate in a patchwork of uncoordinated services and programs.

Financial and practical issues also constitute a barrier. The financing rules, program policies and procedures, recordkeeping practices, staffing patterns, and many aspects of service delivery are organized to serve individual patients or clients with specific diagnoses rather than families in trouble. Treatment services for other family members and social services that might be helpful in coordinated combinations are offered in isolation from one another and sometimes even work at cross-purposes.

Financing presents both ethical and practical problems in that reimbursement for treatment services is most often dependent on an individual being diagnosed with a mental "disorder." This focuses attention on individuals and presents problems regarding whose health insurance benefits are to be used when a whole family is seen in treatment. There are a host of other issues related to the traditional structure of insurance benefits and the limitations of other sources of funding for family involvement in adolescent treatment as well. These issues are explored in more depth in Part III.

Administrative concerns include the need for coordination both within programs and across service divisions. For example, the juvenile justice system is intimately involved with many of the same young people who are involved in AODA and mental health treatment services, but the only collaboration or coordination is often left to conscientious individual professionals who must negotiate through obstacles present in the existing systems.

Alcohol and other drug abuse and mental health treatment services themselves are often not coordinated, even though they are closely related and serve many of the same clientele. The administration of these services is separate in most States and localities. Even when they reside within the same department or agency, the coordination effort is challenging. The effort to cooperate can be facilitated by a shared commitment to family-centeredness as the organizing principle among intake, referral, and treatment services. (See McCarthy in Part

III, page 145, and Luongo in Part III, page 157.)

Some ADM professionals are concerned that family-centered treatment violates client confidentiality, and this belief constitutes yet another barrier to family-centered treatment. Family therapists are keenly aware of the potential problems related to confidentiality among family members but have developed approaches that prevent its standing in the way of effective treatment of the family. The complex legal issues involved in providing confidential health care to adolescents is not addressed in this monograph, however. (See Ooms, September 1990.)

Despite these obstacles on the road toward family-centered adolescent treatment services, a growing number of States and localities have begun to work toward this goal. The CASSP effort and the other influences discussed previously have fueled the interest in and commitment to families at high levels of policy-making. Many of the pioneers in these efforts have been successful in developing programs and even restructuring whole departments. In Part III, two of these experiences are described by Peter Luongo of Montgomery County, Maryland, and Patrick McCarthy of Delaware. They outline innovative changes in service organization, funding, case management, and other aspects of service delivery to provide family-centered treatment for troubled adolescents. These experiences can serve as an incentive and a guide to others. As they demonstrate, the challenges are many, but they can be met—and the promise is great.

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Part II: The Family-Centered Clinical Approach

Given a basic understanding of family systems theory and practice, one might ask, How do family therapists actually treat adolescents and their families? How does a family-centered assessment differ from an individual-centered assessment of an adolescent? These questions, along with others, are addressed in Part II, which focuses on family systems clinical work. Several current cross-cutting issues are explored, and four family-centered models of treatment for specific adolescent problems are presented.

Current Issues in the Family-Centered Treatment of Adolescents

The issues and topics included here are fundamental to the treatment of adolescents today and illustrative of the unique perspective and appeal of family systems work. They do not represent an exhaustive review of the field, nor are they necessarily the most controversial issues. But they offer the opportunity for administrators, clinical professionals, and support personnel to see how family-centered clinical work differs from individual-centered work and to see what the two approaches may have in common by examining issues encountered daily in working with these youngsters.

Lee Combrinck-Graham explains how family-centered assessments are conducted and explores the continuum of services the therapist must consider in planning the treatment of the adolescent. In so doing, she explains how family therapists view the role of hospitalization and other treatment modalities.

John Zarski describes home-based services as an approach to avoiding hospitalization and other out-of-home placements of adolescents. He explains why and how programs of this type are being started all across the country.

Betty MacKune Karrer provides a systems-based framework for understanding culture and seeing the practical implications of cultural issues. She sets forth guidelines for working with families of differing cultural backgrounds. While an effort to address cultural issues of a wide variety of groups is outside the scope of this monograph, Ms. Karrer does present a case study of family therapy with a Mexican-American family as an example of culturally sensitive work.

Nancy Boyd-Franklin describes cultural concerns in the treatment of the inner-city, African-American adolescent and presents her multisystems approach to the treatment of youngsters from this critical population.

Family Assessment and Treatment Planning for Adolescents With Alcohol, Drug Abuse, and Mental Health Problems

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Introduction

The mental health profession is slowly coming to the conclusion that families are the most important interpersonal resource for most adolescents. This conclusion has been reached in public policy, for example with the Federal endorsement of family preservation as a first step before removing a youngster from the family. Although family preservation has been largely implemented in child protective settings, these interventions are increasingly used in other settings as well. Mental health practice is coming around more slowly because of a long tradition of viewing adolescents as primarily involved with issues of separation and individuation. The consequent practice has been to help adolescents separate from their families by substituting adults other than the parents as advisers in settings outside the home while getting treatment.

It is now becoming clear, however, that the consequences of separating teenagers from their families may be as serious as the disturbing circumstances that originally signaled the need for assistance. Specifically, with emotionally or behaviorally disturbed adolescents (including those abusing alcohol and other drugs), the removal and substitution of another adult system for the family communicates to both the youth and his or her family that the family is unable to manage and is an unfit resource to this adolescent. Such an act is too readily accepted—in fact, too often sought—by young people and their families. Many families have been encouraged to expect professionals to take over for them when they experience difficulties, and experts have grown accustomed to taking control. At this point, confidence of family members in their own resourcefulness seems to be at an all-time low.

To reestablish the family as a significant resource system, the therapist must involve family members in the assessment and in the planning of solutions to the youngster's distress. To accomplish that, it is necessary to do the following:

- Consider the family a part of the solution.
- Keep in mind that while problems occur in the context of certain family patterns, families do not "cause" these problems.
- Understand that problems occur in a developmental context that involves all family members.
- Recognize that there are underlying issues in family relationships that may be stirred up by developmental or other stresses.

If a major problem in adolescent distress is related to the unavailability of the family as a resource, then the major goal of family treatment is to mobilize this resource. This requires a careful balance on the part of the mental health professionals between exercising their own expertise and respecting the family's expertise. Of course, this balance will be negotiated differently with each family, but the goal is to empower families to take responsibility for their own members.

When an outside expert, a relative stranger, enters the picture to discuss personal issues with the adolescent, he or she also places the young person in a loyalty conflict. This is the most important danger of separating youth

Clearly, it is important for the therapist to make a strong connection with the parents, both to underscore their competent concern for their teenager and to ensure that they involve their youngster in the treatment.

from families in mental health care. Other dangers are the communication of incompetence and lack of accountability, both the youngster's and his or her family's. This communication becomes a basis for chronicity in the sense that once the youngster and family have learned to turn to others to take over when things are difficult, they will tend to do so in future instances, unless their competence as a system has been successfully addressed. To address this requires that the family be included in the assessment of the youngster's difficulties from the outset and that this assessment become the basis of a family-centered plan that is developed with the family's participation with the aim of strengthening the family. This task should begin even as the therapist conducts the assessment. In the first questioning and commenting, the family-centered therapist indicates that the family is responsible for its members.

How Family-Centered Assessments Are Done

It is usually not difficult to get a family to come in when it is concerned about a child. If, however, the child has been involved in a therapeutic or counseling relationship with a professional without the family being involved, it may be difficult to involve the family fully in a helpful fashion later, even in a crisis.

Family assessment typically takes place in an office setting, but there may be good reasons, especially in a crisis, to conduct an assessment in a setting more convenient for the family. The family home or a familiar community location may facilitate the involvement of more family members and members of the family's social network.

Family therapists differ about whether to start with the whole family or to begin with the parents alone. Clearly, it is important for the therapist to make a strong connection with the parents, both to underscore their competent concern for their teenager and to ensure that they involve their youngster in the treatment. For this reason, many therapists will first speak to the parents alone to get their story and to form a relationship with them. I prefer to begin with the whole family, because I am concerned about the problem of the adolescent feeling that an alliance has been formed between the parents and the therapist in the adolescent's absence. As a rule, the adolescent should not be seen alone first, because that begins to alienate the youth from his or her family in therapy, a process very difficult to reverse later.

Two exceptions to this rule are when the youngster comes alone, in some sort of crisis, or when the family explicitly indicates that it does not want to be involved in the treatment. In the first instance, the therapist should tell the youngster's family as quickly as possible that he or she is not rescuing their child from them. In the second instance, the therapist should focus on the youngster's relationship with a family that has decided to turn him or her over to the therapist. The focus should be on the youth's place in the family and the parents' reasons for deciding not to be involved at this point. The therapist presses the youth to bring in the family members, thus communicating that their coming is not violating the therapeutic relationship. The family is invited in not because it has caused the problem but because it can help solve it.

What the Therapist Hopes To Accomplish

Initial efforts to involve the family are part of the process of joining. Joining consists of listening to the family's story, encouraging family members to describe their efforts to solve problems, and confirming that they are caring and competent. Their failure to solve the problem is not blamed on them, but on the difficulty of the problem. Their efforts are supported as well intended. Through these actions, the family is encouraged not to give up.

Besides joining with the family, the therapist has two major objectives in the initial session. The first is for the therapist and family to develop a framework for understanding the current difficulties. The second is for the family to explore its own ways of solving the problems before it. Though these are stated separately, they are done simultaneously by the way the therapist addresses the family. Generally, one expects that by the end of a first session the therapist and family will have arrived at a shared metaphor for the family in its current situation. This might be summarized by a sentence such as, "I see, this is a family that...." For example, a family with many children and much chaos was described, "I see, this is a family that has trouble getting people's socks in the right drawer." Another family, pugnacious and angry, was described as, "I see, this is a family that, like the Tareyton ad, would rather fight than switch." Clearly, the language and the imagery is derived from the material of the session, the family's own language combined with the therapist's image of the family, crafted and checked out during the session.

How the Therapist Pursues the Objectives

The therapist asks questions of the family with respect and with an objective of inviting the family to ask about itself. In a situation in which there is a problem with an adolescent, it is best to start out with a question, "Who can tell me why we are here today?" Who responds and how they respond are of interest. Therapists may have different goals at this point. If looking for a definition of a problem, the therapist will focus on consensus. If one is also trying to get the family to explore itself, one will focus on differences as well.

After hearing different family members' versions of a problem with an adolescent who stays out all night and skips school, one therapist said, "You agree that you are worried about Beth. But Dad seems more upset about her behavior, and Mom seems more upset about the unhappiness in the family." This reflection back to the family about differences gets them to think. Dad begins to wonder about unhappiness, and Mom about the relationship of unhappiness to behavior. Questions that focus on differences can be developed, and they can go back in history or focus thinking on the future. For example, one could ask, "If Beth's behavior improved, would the unhappiness be more likely to affect Mom, Dad, or younger brother?" In addition to focusing on differences, this approach also identifies the problems as the family's even though they are being expressed by the adolescent. Through this process, the family members begin to identify with the problem—to see it as a problem for them all.

If the content of the family's answers and comments provides the therapist with the means to characterize the problem as shared, the process of the family's interactions in response to this type of questioning gives some important information about its functioning. Several dimensions of family functioning are assessed simultaneously. They are, in fact, so closely related that their behavioral indicators are not very discrete. For this reason, it is the total picture, the entire process of interaction, to which the therapist attends.

One aspect of family functioning the therapist evaluates is flexibility. If a family does not enter into the exchange invited by this process, is very literal, and insists on not discussing anything but the troubled adolescent, the therapist notes this as being a rigid family style. This does not mean that the family is rigid all the time (though it may be), but it does mean that in the current situation—the youngster's problem in the context of the family interview—the family has responded by limiting its field, rather than expanding it.

Other aspects of family functioning the therapist assesses include proximity and boundary maintenance. The therapist observes

the family members' interactive behaviors as indications of these dimensions of family functioning. How close do family members sit to one another? Do they touch one another? Do they interrupt one another? Do they listen when another is talking? For example, if a mother sits very close to her adolescent—straightening out his collar and brushing crumbs off his pants—while the father, who sits at some distance from them, is talking, the therapist might conclude that there is too much proximity between mother and son with father being left out. The closeness behaviors between mother and son may distance the father, and the father's distance may push the mother and son closer together. More information would be needed to confirm these observations, of course.

One might even pose the question to the family, "Which is more important to work on first—Beth's behavior and sadness, or Mom and Dad's constant fighting?"

Another important aspect of family functioning to be observed by the therapist is the hierarchy, or the order of authority in the family. Generally, one expects the parents to be in charge and the children respected but subordinate. Consider a 17-year-old girl who speaks with authority and interrupts everyone else to explain and interpret their statements. When she speaks, everyone stops to listen. Here, the natural hierarchy of the family is upside-down.

By observing these aspects of family behavior, the therapist comes to understand how the problems may be maintained despite the family's efforts to change them. This helps the therapist determine what family interaction patterns will have to change in order for the adolescent to achieve stable behavior change. The assessment of these parameters, together with information about the resources available to the family, also helps the therapist evaluate the family's ability to manage safely any dangerous or otherwise critical situation.

The adolescent's difficulties are at the center of most such family assessments, because that is why they have come. Thus, as a rule, for the therapist to make the observation that the adolescent is having trouble because of marital conflict or some other problem in the family is premature at this stage. One might agree with the family members, if they bring it up, that the adolescent is having trouble and the parents are having marital conflict, without noting a relationship. One might even pose the question to the family, "Which is more important to work on first—Beth's behavior and sadness, or Mom and Dad's constant fighting?" If the family members choose Mom and Dad's fighting, one might assume that Beth feels that her problems are related, and she will be relieved when Mom and Dad stop fighting. It is not appropriate for the therapist to make this assumption without the family's confirmation, however.

Focused Attention on Specific Adolescent Difficulties

There are many adolescent difficulties that require focused attention. Suicidal intentions and/or acts, antisocial acts, abuse of alcohol and other drugs, eating disorders, withdrawal, and failures in school are some of the important ones. In each case, the therapist should focus a significant part of the assessment on the family members' ideas about the problems and potential solutions. Psychological explanations for the problems need not be central to the inquiry. Family members will offer explanations as they see fit, yet rarely does an explanation alone provide a map for intervention. As a rule, the therapist should not offer an explanation, because it tends to limit the family's inquiry and places the therapist in a one-up, expert position. Rather, the therapist should evoke and support the family's own views and ideas about the problem by asking appropriate questions focused on the current situation.

For example, in the case of a suicidal youngster, the therapist must first inquire about safety: Who stays with the adolescent? Who checks to see that means of suicide are out of

the way? How can they decide what degrees of freedom to allow? Do they think they can adequately protect the youth? If not, how do they propose that the youth be protected? While it is tempting to offer hospitalization as a solution, it is best offered as an option, rather than as a solution recommended by the therapist.

One line of questions to the family of an adolescent who is involved with alcohol or other drug abuse may be similar to those concerning suicide, since supervision, how the youth passes time, and who he or she associates with are significant in providing opportunity and motivation to drug abuse. Drug abuse has often been going on for some time and has insidiously undermined the youth's competence and responsibility, so activating the family may be more difficult. The family members' unsuccessful efforts to help their youngster may have left them feeling they are helpless in the face of the adolescent's addiction, compulsion, or influence from peers. Anger and blaming are also common, so it is helpful to come to understand everyone's perceptions in order to help them recognize one another's good intentions and personal pain.

In addition, it is necessary to explore the pattern of drug use by the adolescent, that is, what drugs has the youngster tried, and what does he or she prefer and use most often? How frequent and of what duration are the drug-using episodes? With whom does the youngster use drugs, and are all current friendships centered around drug use? Is he or she maintaining other age-appropriate activities, or has drug use become a major life focus? This will help the therapist assess how significant a life change is required and how compromised the youngster's thinking and judgment may be. While many therapists have traditionally asked these questions of the youngster alone, it is advisable to explore these issues in the presence of the whole family. All family members have relevant information and observations, and the process assists them to overcome their own denial and to understand the youngster's experience better.

The full extent of the exploration that must take place when a family presents with an adolescent who is abusing alcohol and other drugs is outside the scope of this paper. There is currently no definitive standard of what must be known and what treatment approach is most helpful in what circumstance, but in general, the therapist must follow up on the responses to questions until he or she has an understanding of the extent to which drugs are controlling the adolescent's life and affecting the family and an understanding of the family's willingness and capacity to invest in whatever effort it takes to help the child stop. Initially, this may involve intensive monitoring for some period in order to help a youngster attain a drug-free state. It may mean intensive involvement, or, on the other hand, it may mean backing off considerably after this initial period. The therapist must determine what the existing pattern of response to the adolescent's drug use has been so he or she can help the family recognize what has not worked in order to help it do something different. The therapist must assess the family's flexibility in order to determine what interventions will help it respond differently.

While an increasing number of the well-advertised inpatient alcohol and other drug abuse (AODA) programs for young people can be seductive to beleaguered parents, and there is a paucity of structured outpatient programs for this age group, the problems inherent in separating the child from the family are the same as described here in relation to psychiatric hospitalization. As discussed above, the initial establishment of a drug-free state can be a challenge to both the youngster and the family, but this can be—and often has been—done without hospitalization. The youngster must ultimately live a non-drug-dependent life in his or her normal surroundings, so artificially controlling those surroundings to prevent drug use simply postpones the inevitable. It may be

On considering referral to an expert among the treatment options, information and recommendations should be provided to the family members in such a way that they can understand and incorporate it into their view of what might be done. The therapist avoids fostering the notion that the family is turning the youth over to the expert.

necessary for the therapist and the family to devise an individually tailored program involving the family in 12-step self-help groups and using the framework of the 12 steps in therapy.

For an antisocial youngster, the explorations should focus on accountability and the law. Families need to be encouraged to see the legal system as assisting them in communicating accountability to their child, rather than as an enemy from which to protect the youngster. Professionals must hold both the adolescent and other family members accountable for their behaviors and assist them in holding each other accountable. In some cases, this requires insisting that parents involve the police with adolescents who have committed antisocial acts, or assisting parents to face their child's serious alcohol or other drug abuse by enrolling him or her in an AODA treatment program, as described above.

In instances of withdrawal, the family may need to focus on the youngster's peer group, sense of self-esteem, and its own involvement with him or her. Have family members really invited him or her into a discussion or family activity recently?

Finally, with school failure, the efforts to involve school personnel in both the assessment and the solutions should be initiated by the family, if at all possible.

In each of these instances, it is possible that there are individual intrapsychic or even biological issues (that is, not family system related) underlying the adolescent's difficulties. The therapist should have access to an expert in these areas if he or she does not have such expertise. On considering referral to an expert among the treatment options, information and recommendations should be provided to the family members in such a way that they can understand and incorporate it into their view of what might be done. The therapist avoids fostering the notion that the family is turning the youth over to the expert. Thus, if the youngster is psychotic, for example, clear explanations can be helpful to assist the family members to select the best treatment for them and to evaluate the effectiveness of the modalities selected.

Treatment Planning: Utilizing the Continuum of Care

The family systems therapist is always mindful that the system of care for an adolescent includes many more options than simply either outpatient psychotherapy or hospitalization. In some communities, an expanding array of services, from home-based crisis services to out-of-home respite care, supplements traditional options.

Before any of these options is considered, though, the resources in the adolescent's own social network should be evaluated and enlisted. At the very top of the list is the family itself. If the family is not able to manage its child, is there some assistance available to help it to do so at home? Extended family members, close friends and neighbors, and others organic to the family's system should be considered first. Next, the therapist should suggest institutional systems in which the family is closely involved, particularly church and community organizations. Often families in trouble seem to be isolated from these immediate systems. In fact, this isolation can be a problem in itself and may be addressed by encouraging the family to make these important connections to care for its youngster.

The role of the mental health system should be to supplement, rather than substitute for, care available in natural settings. Thus, even if hospitalization or long-term residential treatment is determined to be the treatment of choice, the family's role in the child's life is still seen as central and the treatment setting as supplemental. Even residential treatment must have a specified function and goal, such as to

assist the family in raising the child by providing a stable living situation and educational setting at a time when the family is unable to provide this.

Hospitalization and Residential Treatment

Family-centered treatment is often erroneously considered as an alternative to hospitalization. While certain family-centered programs have been designed to circumvent unnecessary hospitalizations, familycentered treatment in general is an *approach* to treatment, and hospitalization is one among many *treatment options* the family therapist considers. Hospitalization may have a significant role in treatment, but it must be planned, it must include the family as co-therapists, and it must be well integrated into the continuum of care. There are several not very complicated steps that must be taken in order to achieve this sensible use of hospital treatment.

The first is to think of the hospitalization as an episode in an evolving treatment plan. All too often the hospitalization initiates treatment and is seen as *the* treatment. Even during a crisis, it is always better to initiate treatment first, then consider how hospitalization might be useful. A crisis is not the best time to hospitalize, because this response teaches family and child to give up on their relationship system in crisis rather than to mobilize it. A therapist should assist the family in managing the adolescent rather than take over for them. Whether in a holding area in the emergency room or with a respite team in the home, the family members can develop a plan to supervise and assist their child themselves.

When hospitalization is considered, there should be specific objectives to be

The role of the mental health system should be to supplement, rather than substitute for, care available in natural settings.

The Spectrum of Help for Adolescents: A Family-Centered View

Any or all of these services may be needed by an adolescent with mental health or alcohol or other drug abuse problems and his or her family over time. Whatever the nature or the setting of the service, the family's involvement should *always* be supported and facilitated.

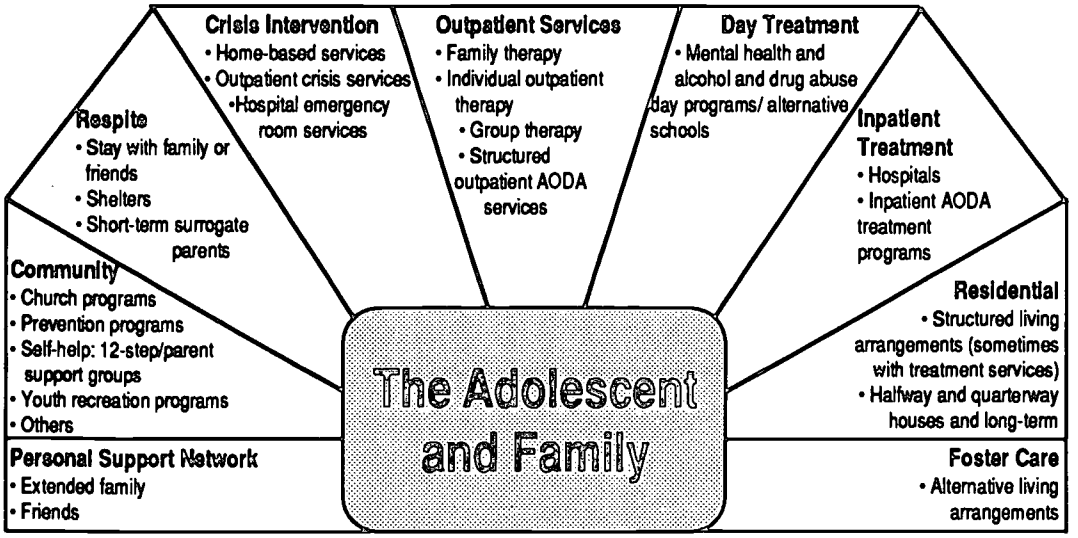

Diagram 3 — Snyder, Ooms, & Hutchins, 1991.

accomplished and specific strategies for accomplishing them. While it is relatively easy to involve the family in thinking about these options, it can only be accomplished if the therapists accept that the family is crucial to the overall management of the adolescent. Too often, professionals regard the family as only destructive, intrusive, exploitative, and harmful. Acting on this basis, professionals may hospitalize a youngster, not for treatment, but to rescue him or her from a bad environment. This is not an adequate justification for hospitalization or an appropriate use of such an expensive facility. Professionals must learn that even when families are destructive, intrusive, exploitative, and harmful, most remain highly significant to their children, and the therapist's task is to intervene in the family system in such a way that caring and nurturance are restored.

In keeping with holding family members accountable, an adolescent should be assisted to confront exploitative and abusive behavior from a parent in such a way that the youngster's loyalty to the parent is not undermined and the safety of the youngster and his or her parents is ensured. Only with this kind of approach can the family be preserved as a healing resource. In this instance, it may be that the hospital/residential setting is a good place from which to address these issues; the youth is temporarily protected from abuse, and there can be an approach to rebalancing the family. The adolescent, the family, and the therapist must recognize that the protection of the hospital or any treatment center is temporary. The only long-term solution is in correction of family dysfunction. Such correction is not a simple process. A priority in hospitalization situations is to find ways that safety, protection, and supervision can be ensured in the family so as to allow it to address the more complicated issues of living together.

Hospitalization should not mean that the family dumps (gives up on) its teenager and retreats to noninvolvement. Family members need to be involved intensively in inpatient treatment in a variety of ways. Thus, when contemplating hospitalization, the therapist must consider how much it disrupts family routines. Disruption is inevitable and is often a reason not to hospitalize. In many instances, however, causing such a disruption is exactly the point. Hospitalization can create a crisis that jogs everyone out of old patterns and focuses on the issue of the adolescent. The crisis of hospitalization provides an opportunity to mobilize people differently. Family members have to change routines, work during visits, spend more time together, face each other and issues that they have not faced, and take charge of aspects of their relationships that have gone neglected. This can work only if the professionals don't merely take the young person off the family's hands but, instead, actively involve the whole family in the process.

In order to keep families connected with a hospitalized adolescent, the parents should be involved in decisions regarding responses to his or her behaviors. For example, if a youth becomes involved in a fight, the parents may be called to advise the staff on how the youth should be dealt with, or they may be invited to come in to deal with the youngster themselves. Parents may be asked to provide special supervision for a suicidal teenager: to come in to put a psychotic youth to bed, providing the familiar in a strange place, or to feed an anorectic youngster. The family establishes new, more functional patterns of caretaking and builds on old established loyalties and attachments. Once these patterns have been effectively established in a controlled setting, it is possible to move quickly to try them at home.

Even after intensive, family-centered hospital treatment, there are some adolescents who can't go home. While it is not possible to estimate what proportion of the hospitalized population this would be, some need longer treatment out

of home, and some need to spend the rest of their growing-up years in a stable environment that is not their own home. In any case, family members should be involved, if at all possible. The object is not to arrange things so that the youth goes back to a family unwilling or unable to care for him or her, but to involve the family in decisions for the youth's welfare and to maintain family ties. For these young people, the hospital may be a step toward a more permanent living and treatment plan.

Summary

Involving the family in assessing and making decisions about the care and treatment of the troubled adolescent is essential to diminish the estrangement and incursions on sense of competence and confidence that inevitably accompany problems with alcohol and other drug abuse and emotional disturbance. Highly involved and competent families that have the resources to devote to the care of their youngsters may be able to be the major context of treatment, providing supervision for the suicidal, attention to the withdrawn, and limits for the antisocial. On the other hand, families that are seriously impaired by other stresses, such as poverty, mental illness, relocations, job loss, or abuse of alcohol and other drugs, may not be able to care for their youngsters, but they can be involved in thoughtful decisions about how the youth should be cared for and can maintain meaningful connections with him or her throughout the treatment. This can only be done, however, if the family is the center of the assessment and treatment plan.

Families that are seriously impaired by other stresses, such as poverty, mental illness, relocations, job loss, or abuse of alcohol and other drugs, may not be able to care for their youngsters, but they can be involved in thoughtful decisions about how the youth should be cared for and can maintain meaningful connections with him or her throughout the treatment.

Approaches to Family Preservation: Home-Based Services

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Overview

Historically, when the needs of adolescents experiencing severe behavioral or emotional disturbances could not be met by community-based social services, the mental health system responded by placing these individuals in group or foster homes and general or psychiatric hospitals. Treatment typically focused on individual therapy, group therapy, recreational therapy, social skills training, and education. Family involvement in treatment was minimal and usually consisted of weekend visits. Although this practice continues, Street and Friedman (1984), in critically assessing service standards, appropriateness of placements, and outcome research, conclude that the necessary services are either ineffective or lacking in the existing placement institutions. These authors were among a number of leading mental health professionals who encouraged the development of innovative and more cost-effective community-based programs that could benefit adolescents representing a broad range of problem severity and help families avoid placing these youth.

One such alternative to residential treatment and/or psychiatric inpatient services is intensive home-based intervention. The underlying philosophy of these programs is that the child or adolescent must be viewed as an integral part of the family system and that treatment of dysfunctional behavior or symptoms will only be effective if the family, together with the adolescent, is regarded as the unit of service. Likewise, the family is considered part of the community, which is an important resource in treatment. Intensive services are provided in the home to the adolescent and family with the primary goal of avoiding placement out of the home.

This article draws upon the author's experience in Akron, Ohio, in providing training and consultation to a home-based services program based in the mental health system. However, this approach to helping seriously troubled children and their families is spreading rapidly in the child welfare and juvenile systems as well. Sometimes the approach is known by other names—such as family preservation or family-based crisis intervention—however, although the models vary, the central principles and assumptions are shared (see Ooms, Beck, & Herendeen, June 1990). The approach is used with children of all ages, but is especially common in situations where an adolescent's severely acting-out behavior or other difficulties makes placement an imminent possibility.

What Defines Home-Based Services?

Core Values

Home-based programs evolved from a recognition that treatment which removed an emotionally disturbed adolescent from the family was ineffective and costly. While the model programs for home-based services that do exist vary somewhat in structure, they tend to share certain "core values," as identified by the Child and Adolescent Service System Program (CASSP) of the National Institute of Mental Health (Stroul & Friedman, 1986). First, the system of care must be directed by the needs of the adolescent and the family. Second, the system must be community-based, that is, services, management, and

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decisionmaking responsibilities rest at the community level. Third, there is an emphasis on a multidisciplinary team approach. Some programs utilize teams of two or three professionals, while others may rely on a single therapist who can consult with agency-based personnel.

Program Characteristics

Purpose: The purpose of these home-based family intervention programs is to prevent family breakup and out-of-home placement of the adolescent while strengthening and maintaining the family members to behave in a more self-sufficient manner (Bryce & Lloyd, 1980; Tavantzis, Tavantzis, Brown, & Rohrbaugh, 1985).

Hours and Availability: Therapists are available on a 24-hour-a-day schedule; they work flexible hours, and appointments are scheduled on the basis of family and therapist need.

Admission Criteria and Duration of Services: Admission criteria vary among program models but typically include the stipulation that only families on the verge of having a child placed in a residential or psychiatric facility are accepted. Once a family is accepted, it is usually seen within a 24-hour period, and from that point on, at least one staff member is available, at least by telephone, on a 24-hour basis. The length of intervention with a family is typically brief, ranging from 1 to 4 months. The intervention time is usually established in advance and remains the same for all families, although therapists have the option and obligation of obtaining additional services, if needed.

Services Provided: The actual services provided by home-based programs include crisis stabilization; informational and educational programs; skills training, such as communications, behavior management, and problem-solving; emotional support; and family therapy. Other services might include homemaker services, financial planning, agency-coordinated recreational activities, and team members serving as liaisons to community resources (for example, health care, schools, vocational development centers, and medical services).

Benefits of Home-Based Family Intervention

- Through the visits in the home, the therapists increase their ability to become involved in the family system, thereby allowing more accurate assessments of individual and family needs, developmental stage, dynamics, and resources.
- The therapist's credibility is often enhanced when the family knows the therapist has *seen* incidents and observed behavior rather than relying on reports.
- Home visits increase the opportunity to impact all family members (who often are reluctant to come to an office interview) in the family's environment, which enhances the probability of success.
- Case management is facilitated when different aspects of a family's needs for services become known.

Rationale for Home-Based Services

Numerous studies have supported the efficacy and cost effectiveness of home-based family services. A report compiled by the CASSP Technical Center at Georgetown University indicates that home-based programs have reported success rates ranging from 70 percent to 90 percent, where success is measured in terms of preventing out-of-home placement. In addition to the 19 studies incorporated in the CASSP report, other well-known programs indicate high success rates in terms of preventing placement (Whitaker, et al., 1990). For example, the Homebuilders Program in Washington State, in data covering a 13-year period from 1974 to 1986 and more than 2,900 cases, showed 94 percent of the children still at home 3 months after termination of services and 88 percent after 1 year. In Ventura County,

California, the Children's Mental Health Services Demonstration Project showed 91 percent of the individuals served stayed at home for 6 months or longer. Over and above the success in terms of preventing placement, studies completed in Virginia, Nebraska, Wisconsin, Ohio, and Washington have demonstrated improvement in overall family functioning, behavior, communication, and school performance, among other variables, where home-based family intervention was implemented.

Additional data (Stroul, 1988) suggest that home-based programs cost far less than a variety of residential placements, including foster care, group home care, residential treatment, and hospitalization. Studies estimated home-based services costs at $3,000-$5,000 per episode, while the annual per patient cost for group homes was $10,000, the annual cost for residential treatment was $30,000, and the annual cost for psychiatric hospitalization was $40,000. In 1988, the Ohio Department of Mental Health concluded that the cost of home-based programs is justified, since the typical cost of services is low compared to out-of-home placements and makes home-based intervention extremely cost effective (Ohio Department of Mental Health, 1988).

Recent reports critically examining these evaluation studies in family preservation emphasize that these early efficacy studies had significant design limitations and may have overstated and oversimplified the benefits of home-based services. However, there seems little doubt that many children are able to be kept at home through this treatment approach who would otherwise be receiving expensive institutional care (see Ooms, Beck, & Herendeen, 1990, in the Annotated Bibliography). Many States are implementing home-based services, including crisis-intervention family preservation services, convinced of the promise of this approach.

Implementation Issues

Several issues are of primary importance for public administrators considering implementing a home-based program in their county or State. One issue is whether services should be purchased, provided directly by the agency, or a combination of the two. A second issue is how the program will be designed so as to avoid two problem areas: the tendency to view the home-based program as a panacea for all difficult-to-serve families in the area, and the possible skepticism and resistance among other professional staff. The latter issue may arise when financing, office space, and other resources for the program come at the expense of current staff and services. Financing structures and strategies comprise a third issue of importance. While most funding comes from State departments of social services and mental health, some funding has been obtained through the juvenile justice system, educational system, and foundations.

A fourth issue involves clinical concerns, such as the definition of target populations and the establishment of criteria for acceptance into or exclusion from these programs. A wide variety of populations has been served by home-based programs, including families with children who are emotionally disturbed or developmentally disabled, families at risk of child abuse or neglect, and families with adolescents in conflict with family and community (status offenses, alcohol and other drug [AODA] abuse, or acting out). It is important to note that many are low income, and these families are typically unable to access office-based services because of a lack of transportation, chronic illness in a family member, or an inability to get everyone to agree to treatment. Additionally, these families may be unwilling to seek traditional treatment because they believe they were not helped by previous involvement, and have come to distrust social service agencies.

Many States are implementing home-based services, including crisis-intervention family preservation services, convinced of the promise of this approach.

Jenny

"Jenny has been making us crazy for too long and we're sick of it!" Jenny's mother screamed at the policeman. "I can't stop her from going off with boys and drinking and coming and going at all hours. She doesn't listen to me anyway, and her dad will just get drunk and beat her again when he finds out what she's done now. Just get her out of here, I don't care where you take her."

Some home-based programs do maintain some exclusion criteria. These may include adolescents who are actively suicidal, extremely violent, acutely psychotic, or severely retarded, as well as families where the parents are psychotic, severely retarded, or actively abusing drugs (and are unwilling to seek rehabilitation as an adjunct to the home-based program).

Another clinical issue concerns the staffing of the home-based program. Most home-based programs use bachelor's or master's level professionals with training in counseling, psychology, or social work. Many of these professionals, however, have minimal experience in crisis intervention, individual therapy, marital or family therapy, or parent training. Thus, training typically occurs on the job, and all home-based programs invest considerable resources in initial ongoing training and supervision. Results from a 1989 needs assessment survey, conducted by the University of Akron (Akron, Ohio) and mailed to professionals across the country who were involved in home-based programs, showed that directors and therapists were not always in agreement as to the importance of training areas. For example, directors viewed counseling ethics, conflict management, and report writing as important skill areas for home-based therapists, while therapists ranked training in family therapy, abnormal psychology, and alcohol and other drug abuse as more valuable. Because of the seriousness and intensity of the cases, the need to make critical decisions regarding family members, and other demanding job requirements, the establishment of criteria regarding selection and training and the provision of quality supervision are absolutely essential for the continued success of these programs. Presently, the University of Akron, which has attempted to build on the results of this survey, has instituted an interdisciplinary training program in home-based family intervention, and a project at the University of Washington School of Social Work has developed a competency-based training curriculum on supervision for family-centered practice.

Summary

Home-based family intervention programs operate on the belief that home-based intervention facilitates accurate assessment and enables therapists to best serve the needs of seriously troubled adolescents. Characteristically, these programs provide:

- Family-focused and community-based services.
- Flexibility to respond at times of crisis.
- Time-limited but intensive services.
- A variety of interventions, including parent training.
- Family therapy, where indicated.
- A variety of other services, including home-maker services and advocacy.

There is clearly a growing emphasis within the mental health profession toward improving community-based systems of services for adolescents that focus on client needs rather than on traditional, institution-based services. Intensive home-based family programs are an invaluable, innovative addition to a balanced continuum of care and a unique approach to meeting the needs of troubled adolescents and their families.

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The Multiple Dimensions of Culture in the Treatment of Adolescents and Their Families

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Introduction: The Importance of the Cultural Dimension

The United States has always been a Nation of immigrants. Cultural pluralism was a reality before it was a theory. While the flow of immigrants has been constant for many years, an increase in immigration has been predicted for the next decades. The 1980 census projections for the year 2000 indicate that ethnic *diversity* will be the salient characteristic of the U.S. population.

These census figures also reflect that the present proportion of minority groups has dramatically increased (currently, 1 in 5 Americans is a minority). The increase in minority populations is the result of a rapid influx of immigrants from Latin America and Asian and Pacific Islands. By the year 2000, 46 percent of California's population will consist of individuals of Latin American descent. By the year 2010, this figure is estimated to grow to 55 percent.

It is important that the field of mental health acknowledge and value cultural diversity and the importance of the cultural dimension in effective treatment. Heterogeneous societies such as the United States are continuously in flux, redefining their values and adapting to changing circumstances. The cultural dimension refers to behavior, attitudes, and beliefs of a group of people that are easily recognizable and serve to provide a sense of continuity and identity to that group. These behaviors and values are usually expressed through descriptions of what is "typically" French, black, Latin American, Asian, and so forth. Descriptions of a national, racial, or ethnic group, however, unfortunately lend themselves to stereotypical connotations, particularly if they become reified into the notion that these are all the possible characteristics of this culture, and thus deny the variety of subcultures that exist within a national or ethnic identity.

Preconceptions about national or ethnic character are based on brief encounters with a given culture. Although these experiences ring true, they represent partial views of people and their culture. Some examples of these stereotypic notions are commonly found in the media, humor, sayings, and subtle ways of describing people. For example, Jewish people are verbal, French people are sophisticated, Mexicans are passionate, etc. It does not matter whether the notion is positive or negative, the end result is that it constrains the way we think about a given culture.

This paper will first discuss the meaning of cultural values across various levels of social organization. The second part will present a multidimensional approach to culture that describes contexts which influence value formation and account for shared worldviews as well as differences in worldview. Specific attention will be given to how cultural transition, cultural fit, and culture evolution influence and are influenced by these dimensions. The third part will focus on treatment issues, including the neglected dimension of the cultural background of the therapist, and will provide therapeutic guidelines. The fourth part illustrates the multidimensional cultural approach as applied to the case of a rebellious, out-of-control Mexican-American teenager.

People who share status on one or more of these dimensions may find that they have much in common, even as they are very different by virtue of their status on other dimensions. The goal is to conceptualize culture from a multi-dimensional perspective and not limit it to issues of race or ethnicity, as is so often done.

Cultural Values

What is meant by "cultural values"? A single definition is, at best, an oversimplification and, at worst, insufficient. It is best to consider several definitions that can have application at different times and in different contexts. Geertz (1973), quoting from Clyde Kluckhohn's *Mirror for Man*, lists the following definitions: "the total way of life of a people"; "a way of thinking, feeling, believing"; "a theory on the part of an anthropologist about the way in which a group of people in fact behaves" (4-5). The latter definition reflects the fact that observers define groups as much as groups define themselves.

At one level, cultural values are social norms about relationships between individuals and families, families and communities, communities and institutions, and the larger sociocultural context. Values cut across all levels of social systems and are recursive; that is, they influence all social and economic levels, but at the same time they themselves are being influenced by all social and economic levels.

Society, that is, the dominant culture, provides a general blueprint—a set of rules and expectations—for institutions, communities, families, and individuals. In turn, the family provides guidelines to its members for interpreting these social rules and expectations. Individuals and families interpret society's values in a variety of ways; each family and/or individual's perspective represents one interpretation within a range of possible interpretations within any given culture. Its perspective overlaps with other perspectives within the same culture, and with perspectives from other cultures as well.

Another definition of culture is provided by Falicov (1988): "... those sets of shared world-views and adaptive behaviors derived from simultaneous membership in a variety of contexts" (336). This author (Karrer, 1990) expanded Falicov's definition by suggesting some of the dimensions that illustrate the potential not only for diversity but for similarity, that is, for shared worldviews. In other words, people who share status on one or more of these dimensions may find that they have much in common, even as they are very different by virtue of their status on other dimensions. These dimensions are: generational (historical) patterns, economics, education, ethnicity, religion, gender, race, minority status, and regional background. The goal is to emphasize the need to conceptualize culture from a multidimensional perspective and not limit it to issues of race or ethnicity, as is so often done.

Dimensions of Culture That Contribute to Diversity and Present Possibilities for Shared Views as Well

Generational Historical Patterns

Shared historical events influence the evolution of beliefs. The impact of these historical events is now more visible and more readily shared than ever because of the fast dissemination of world news through the media. In today's technological world, information passes from one culture to the other at an unprecedented pace.

Throughout history, there have been patterns of beliefs that became salient for each generation. The pendulum swings back and forth between political dimensions (such as liberal and conservative), economic dimensions (such as fiscal responsibility and fiscal exploration), world-involvement views (global interdependence and cultural isolationism), and so forth. Families and individuals are influenced by these beliefs, and in turn contribute to their evolution by questioning those beliefs that constrain the growth of a society. Through consensus these generational historical patterns create the context that determines the beliefs considered appropriate by that generation. These generational

differences are often especially salient as background to understanding difficulties between adolescents and parents.

Economics

Economic status is a dramatic organizing context, and poverty, in particular, transcends other cultural dimensions in many ways. There are more similarities between the poor in Chicago and the poor in Sicily than the poor and the rich within Chicago.

Education

Education is also a dimension of culture that may transcend others. It has been the traditional route by which immigrants have become assimilated into the dominant culture and transcends class and economic boundaries. Often, individuals who manage to get a good education overcome some of the devastating effects of poverty and share something in common with the majority group in an educated society.

Religion

There are shared beliefs within religious groups across societies; for example, Catholics in the United States share a worldview with Catholics around the world, but their world-view differs, in some significant ways, from Protestant groups within the United States. There are also significant variations *within* religious groups depending on education, ethnicity, and socioeconomic and regional background. For example, religious views are observed in a more traditional manner in New England than in California. As with any other cultural phenomenon, the salience of religion in a society rises and falls over time.

Gender

Today's generation is experiencing an increased awareness about gender imbalances. It is possible that a move toward attaining gender balance will be one of the generational historical patterns of the 1990's. Families can vary in at least three possible ways regarding gender awareness. Some are traditional, believing in complementarity of roles, with men being the "breadwinners" and women the "caretakers." Some are in the process of transition, questioning gender roles and expectations; some are contemporary, viewing the predominant social gender roles as oppressive, constraining both men and women; they are striving for new, more egalitarian or androgynous roles.

Nationality, Race, Ethnicity, and Minority Status

Ethnicity has been used synonymously with race and/or minority status. In this paper, I make clear distinctions between nationality, ethnicity, minority status, and race. Nationality refers to the country where you were born and/or raised. Ethnic background refers to the nationality (country of origin) of your parents. Race is a demographic factor that reflects whether a person is black, white, oriental, or Native American, as well as the blending of these racial combinations. It is important to recognize that the majority of people in the world are multiracial. Attempting to define people as either one racial group or another is oppressive and limits the richness of background that multiracial families have. Minority status is imposed by the dominant culture upon specific racial, ethnic, and gender groups within that society. In addition, characteristics that are associated with particular economic groups have also been attributed to ethnicity. It is common, for example, to attribute some behaviors that are the result of generations of poverty to some ethnic groups and minority groups. [1]

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[1] Use of the term "Hispanic": The question of whether we can use the term "Hispanic" as an ethnic and/or racial referent to Latin Americans is controversial. Its definition excludes more groups than it includes. The term "Hispanic" refers to groups of Spanish descent (from Spain). However, groups of Spanish descent throughout Latin America are only one of the many ethnic groups that form part of these heterogenous societies. It is a particularly inappropriate term, since it leaves out Africans, other Europeans, Middle Eastemers, and Asians, all groups that emigrated to Latin

Race: Race must be considered in relation to the majority-constructed definition of who belongs to a racial group and who does not. There are over simplified ideas about who is white and who is black. This majority-constructed view tends to see people as either black or white. In reality, there are many racial variations in all societies: some are both black and white; some are either black or white; but many more are a mixture of all racial variations (black, white, oriental, and/or Native American).

Ethnicity: Ethnic beliefs and their impact on cultural evolution will be discussed below under "Additional Dimensions for Immigrants." It is however, important to emphasize that each family will vary on the acculturation continuum. Some members, usually the oldest generation, will likely identify more with the country of origin's beliefs, while some, usually a younger generation, will likely identify with American beliefs.

Minority Status: The term "minority"carries the weight of prejudice and discrimination (Meyers, 1984) . Discrimination is defined by Rodriguez as "those acts or institutional procedures that help create or perpetuate sets of advantages or privileges for the majority group, and exclusion or deprivation for the minority group" (p. 130).

Minority status is not only related to racial characteristics but to socioeconomic background, gender, and handicap. Women, although not a numerical minority, clearly have minority status in American society.

Regional Background: There is wide variation within cultures according to geographical regions (mountains and valleys) living environments (rural and urban), and climate. Each variation offers different possibilities and different constraints. These variations relate to time orientation and to accepted "space" (proximity and/or distance) in relationships. Rural environments, for example, spawn a different consideration of both time and space than do urban settings. Rural environments tend to be slow-paced, while urban environments are fast-paced. Rural environments tend to sanction more proximity in relationships; urban environments sanction less.

In summary, all of these dimensions—historical patterns of a generation, economics, education, religion, gender, ethnicity, race, minority status, and regional background—present opportunities for considering intracultural diversity. At the same time, membership in any of these dimensions provides opportunities for shared values across cultures.

Additional Dimensions for Immigrants

Immigrants contribute to the evolution of their host society by maintaining some of the beliefs and practices of their native land and incorporating them into their everyday lives. At the same time, they accommodate to the beliefs and practices of their host society. Through this reciprocal interaction and tension, immigrant groups contribute to the cultural evolution of a nation.

Cultural Transition

The decision to move from one country to another (immigration) begins the process of cultural transition that lasts several generations (acculturation).

Immigration is a transition that requires relocation across cultures. Acculturation is an accommodation process that occurs when groups from two distinct cultures are in contact

America, as well as Native Americans, who were the first inhabitants of these regions. The term "Hispanic" is also not appropriate as a referent for race, since Latin Americans come in all races and all combinations of races. The most accurate descriptor is nationality (that is, Mexicans, Puerto Ricans, Argentines, Chileans, and so forth).

over a sustained period of time. Karrer (1987) described acculturation as a transactional process in which the immigrant's contact with the host culture is either increased or decreased depending on the degree of synchronicity and/or discord experienced in the initial interaction. Synchronicity depends on motivation toward adaptation on the immigrant's part and on an accepting and validating response from the host society.

Cultural Fit

An accepting response from the host society depends on the perception of "goodness of fit" between the immigrant and the dominant majority that serves as reference for the host society. Immigrants who share membership with the host society on such critical dimensions as race, socioeconomic class, and education will experience a "goodness of fit" and will be more likely to experience synchronicity when interacting with members of the host society. However, the 1980 census figures report that the majority of recent immigrants to the United States are minorities. The census figures about the ratio of minority to nonminority population show that 1 in 5 people in the United States is either African-American, Latin American, or Asian. There is also a prediction that minorities will to grow in number by the year 2000. Therefore, because there is less synchronicity with the dominant majority population, these groups are likely to experience more conflict in interacting with members of the dominant society, and will consequently experience more acculturative stress.

Cultural Evolution

Culture evolves over time both within and across societies. A major influence in cultural evolution is the tendency of each generation to challenge the beliefs of its ancestors. In addition, cultural evolution is fostered within a society by interaction with immigrants from other cultures. For the immigrants themselves, the "match" between the rates of cultural evolution in their native culture and their host culture is an issue. Moving between radically different rates of cultural evolution can be very disconcerting and stressful, producing feelings of being "frozen in time" or of "accelerating into the future." While the instant access to events across the world provided through television may, on the one hand, encourage a more global perspective, it may also (as recent events in Eastern Europe, the Soviet Union, South Africa, and the Middle East demonstrate) fan the flames of ethnic, religious, and tribal fervor and separatism.

In summary, each of the contextual dimensions described above serves to delineate our beliefs by constraining the meanings we attribute to things. At the same time, each contextual dimension opens up opportunities for exploration of new meanings that have the potential to expand beliefs and actions. This process of constraining (providing stability to our beliefs) and expanding (introducing complexity into our beliefs) is ongoing and evolves over the lifespans of individuals, families, and societies. There are, however, some specific times when we are all more receptive to expanding our beliefs. Therapy is one such time. It is a time when the family itself is questioning its beliefs and when change is more likely to occur.

Each of these contextual dimensions is as important as the other but will be more or less salient in a given family. For example, for some families religious values are predominant, while for others ethnic background will be more salient. Economics, race, and minority status are always predominant when they are oppressive. These dimensions organize our lives in very basic ways and have a powerful impact on everyday events.

It is important to reiterate that we can easily fall into providing stereotypic descriptions when we narrowly define these contextual dimensions. There is not only variation across each of these dimensions but within each dimension. Therapists need to assess the

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importance of each dimension, as well as how they combine to show us a "cultural image" of the family; they must then contrast that image with our own "cultural image" in order to find commonalities and differences in cultural belief.

There is always overlap between the family and the therapist regarding these contextual dimensions. When we share some of these contextual dimensions with the family, the likelihood is that there will be commonality of beliefs between the therapist and the family along shared dimensions. However, there will always be some of these dimensions that we do not share in common with a family. In such a case, there will be differences in beliefs. Both commonalities and differences are important when working with families. Commonalities allow us to have more proximity with the family and understand its experiences better; differences allow us to expand our views and to enrich the way we conceptualize cultures.

The Cultural Background of the Therapist: A Neglected Factor

The tendency in the therapeutic field has been to focus on the family's culture and to ignore the therapist's culture. It is important for therapists to be aware of their own cultural background and how this fits with the background of their clients. Therapists, like clients, vary along the cultural dimensions described earlier. In addition, although therapists are more likely to be representatives of the dominant society by virtue of their training, they may also share a variety of cultural dimensions with the family. For example, therapists who are not immigrants themselves may, however, share some religious values or regional, ethnic, or socioeconomic background with an immigrant family. While the therapist and the family may have different ethnic backgrounds, they may share a similar educational or regional background.

Therapists will share both similarities and differences with families regarding gender and generational values. A female therapist will need to understand the experiences of being a man in a particular family, just as a male therapist will need to understand the experiences of being a woman in the family. A young therapist will have to depend on the parents' expertise when discussing parenthood, just as an older therapist needs to be able to connect with children of all ages.

Consequently, therapists and families are always accommodating each other's differences and similarities in values. Noting subtle distinctions along the contextual dimensions previously discussed will allow the therapist to understand diversity better and to recognize not only differences but similarities that constitute areas of connectedness with the families in treatment. This awareness will enable therapists to help with the cultural tensions or conflicts within families, as well as those between families and other institutions. When only differences are experienced, therapists tend to distance from families and may lack the necessary empathy to understand their experiences. When only similarities are experienced, therapists may be too "close" to be helpful to families.

Adolescence and Culture

All societies value their children's development and sanction appropriate ways to develop into adulthood. This developmental transition between childhood and adulthood is called adolescence and is one of the most critical stages of development. The transition provides time for refining ideology, in particular for developing a sense of autonomy and self-identity. In addition, it is a time to explore where the adolescent fits within the family and within the community, particularly the peer community. What varies across societies is the timing of when this transition begins and how soon it is completed. In some

societies, adolescence and adulthood start later than in the United States, where it seems adolescence begins earlier and lasts longer with each new generation.

For the family, the developmental stage of adolescence requires an accommodation between two generations. In the process of achieving such an accommodation, conflicts and tensions occur that may often be a result of cultural factors, especially in minority and immigrant families. If this accommodation takes place in a way in which both autonomy and loyalty to the family are balanced according to each family's values, the transition will be successful. In addition, the meaning of autonomy and loyalty differ across societies. Some cultures value loyalty to the family as much as—or more than—they value autonomy within the individual. These two tasks are not viewed in opposition but in a complementary way. Balancing the task of becoming an adult, and particularly a mainstream adult, in a host society that has a different definition of autonomy and/or loyalty places the adolescent and the family at risk.

This dilemma is further aggravated when adolescents and their families are part of a minority group. Issues of self-esteem, racial identity, and the polarization experienced between the dominant majority and the minority group will heighten the risk. Racism, sexism, and/or classism are oppressive practices that place the minority family in a specially vulnerable situation.

The immigrant family that is in the midst of this life-cycle transition experiences the dual task of making sense of two generations and two cultures. Because one of the adolescent's tasks is to move from the family to the community, the adolescent will tend to be more in touch with the values of the host society. The peer pressure to be "American" is very strong. While the adolescent is moving toward autonomy and entering the peer community and society, the parents of the adolescent may experience a sense of losing their child to an alien culture; they may react by becoming "more ethnic," thus increasing not only the generational gap but also the cultural gap.

Treatment Implications

In my training and clinical experience, I have frequently come across families that have all three levels of acculturation. The members of the Martinez family, for example, described their acculturative dilemma in terms of how each member of their large family experienced the differences between them. The parents (Mexicans in America) were adhering to the traditional beliefs of a generation ago (they were in their late fifties). The older children (Mexican-American) were attempting to make sense of their parents' views, contrasting them with their own, and helping with the younger siblings by functioning as intermediaries between their parents' values and their younger siblings' values (a common characteristic also present in large families). The younger children (Americans of Mexican descent) were typically pushing the family toward accepting more contemporary American values. For example, they questioned whether they had the right to decide how often to visit their relatives. In addition, the family was struggling with leaving-home issues. The younger siblings were hoping to go away to college. In the older sibling group, there were two college graduates, but both had gone to Chicago City Colleges and had remained at home until they married, reflecting more their parents' expectations. Nevertheless, they were supporting their younger brother and sister's attempts to go away to college.

The parents and older siblings shared traditional gender roles and expectations, i.e., women were viewed as only caretakers, and men as only providers. However, the younger generation was challenging its parents and older siblings' views by presenting a gender-sensitive view, in which both men and women

Balancing the task of becoming an adult, and particularly a mainstream adult, in a host society that has a different definition of autonomy and/or loyalty places the adolescent and the family at risk.

How can therapists incorporate an awareness of, and sensitivity to, these complex cultural dimensions in their work?

could have more options. These struggles are not unlike those that happen between generations in all families across cultures as a result of cultural evolution. What is specific to immigrant families is that the arguments the parents and/or children use are coded in cultural terms. For example, the Martinez parents would express these values by saying: "In Mexico, we knew how to respect our parents; you kids are learning the American ways of being disrespectful." To which the younger children would respond; "You are too old fashioned and rigid, your Mexican values are no good here." Obviously, American values do not encourage disrespect to parents, nor do Mexican values encourage rigidity. These issues are discussed further in the case study presented below.

Therapeutic Guidelines

How can therapists incorporate an awareness of, and sensitivity to, these complex cultural dimensions in their work? I develop here a set of guidelines that are not to be construed as sequential steps in the therapeutic process. Rather, my goal is to expand therapists' views about cultural thinking by providing a set of issues to keep in mind that emphasize the diverse, rich, complex, and numerous avenues for change that all cultures provide.

Because I conceptualize therapy as a process that expands perceptions, I consider the most important guideline for the therapist to be that he or she enter any interaction with an open, fluid view about cultures. If the therapist has preconceived views about the constraints of any given culture, he or she will lose therapeutic maneuverability. The therapeutic challenge is to explore with the family the many possible ways that culture creates barriers, sanctions adaptation, and promotes change.

Ultimately, as the therapist and family interact, they will develop a common history, as well as their own shared cultural context.

- *Diversity:* The therapist should assume that the family is a unique representation of its culture, that each family gives us a perception of its culture. It is like a flower in a group of flowers, in a garden with a multitude of flowers.

- *Scanning:* Because therapists and families share a commonality of contexts, the therapist should scan all the dimensions discussed in this article and check for commonalities and differences with the family. Finding both similarities and differences is necessary, in order to connect with families and to appreciate the complexity of their experiences.

- *Partnership:* The therapist and family should be equal participants in the therapeutic process. The therapist will share his or her leadership and expertise about these cultural dimensions with the family. The family members will share their experiences and explanations about the uniqueness of their family.

- *Explanations:* The therapist needs to attend to the experiences the family members describe and to the explanations they give about their experiences. These explanations will provide a window into the beliefs and attitudes that shape their behavior toward each other and society's institutions.

- *Values:* Both the family and the therapist are influenced by culturally determined values. Therapy is not a value-free context. Therapists need to be responsible for their own views and share them openly, directly and respectfully with the family.

- *Politics:* Therapy is a political context; both the therapist and the family try to influence each other. Both have explanations about what is acceptable, appropriate, and healthy. The process of influencing each other is best done in a mutually validating manner.

- *Expanding Options:* Therapy is the process of expanding both the family and the therapist's perspectives. This is best done when therapists view cultures in a perspectivistic way.[2]

- *All Cultures Sanction Change:* Families tend to narrow their perceptions about change because of their painful circumstances. The therapist needs to remind family members that they can make choices, and that their culture provides for many more options.

- *Minority Issues:* Therapists who are members of a majority group working with minority families need to be mindful of this distinction. In order not to impose their majority-constructed perspective, they need to allow families to define themselves racially, ethnically, and socieconomically.

- *Perceptions:* Therapists need to acknowledge that their perceptions about autonomy, loyalty, the timing of life-cycle events, gender roles, and the degree of proximity and distance in relationships may differ from those of the family. An accommodation between the two cultural perspectives needs to take place.

- *Therapist's Role:* As an agent of change, the therapist should challenge the family members to move toward new ways of viewing themselves that may promote better adaptation to their environment and functioning within the family. He or she needs to challenge the family to recognize those aspects of its culture of origin that represent strengths and competencies as well as opportunities for change.

The therapist needs to challenge the family to recognize those aspects of its culture of origin that represent strengths and competencies as well as opportunities for change.

Case Study: A Perspectivistic Cultural Approach With a Mexican-American Family

The following case illustrates the interrelated dimensions of cultural transition, cultural evolution, ethnicity, gender, and socioeconomic and regional background.

The Gonzalez family came to treatment because their oldest boy was rebellious and out of control. The family originated from a small, rural town in northern Mexico. They had been in this country for 8 years. The father worked as a butcher and the mother worked at home caring for the two children: a boy, age 14, and a girl, age 10. Their rationale for coming to the United States was to save money in order to go back to their native village and start a small business. Recently, however, their immigrant dream had been put into question, because the father's job had been reduced from full-time to part-time. This loss in income prompted a reevaluation of their dream. Why had they come, leaving family and friends? What were the risks of returning home without enough money?

The son was questioning the parents' discipline, complaining that they were too old-fashioned and did not allow him to have any independence. He resented the curfew time and the fact that he had to inform his parents of where he was. His school performance, which had been high, had begun to deteriorate within the past 3 months. The parents were particularly worried about this development, since it activated the other part of their immigrant dream—that of providing a good education for their children. The daughter was complying with their rules but watching how the brother paved the way toward autonomy in

[2] Ludwig von Bertanlanffy, the father of General Systems Theory, defines perspectivism in two ways: as "the many flavors of truth," and more formally, as a "viewpoint that the validity of knowledge depends on the perspective from which that knowledge is perceived" (Davidson, 1983). The latter definition is particularly relevant to therapy because it emphasizes that each individual's perspective (members of the family and therapist) is an equally valid reflection of reality. Translated into how we perceive cultural beliefs, perspectivism emphasizes that the distinctions we make about the cultural values of others say as much about ourselves as they do about others.

Loss in income prompted a reevaluation of their dream. Why had they come, leaving family and friends? What were the risks of returning home without enough money?

this family. Neither the son nor the daughter wanted to go back to Mexico.

When discussing the initial phase of therapy, it is important to mention that in our therapeutic team we frequently find that children of immigrants (and particularly adolescents) often present behavior symptoms that function as "smokescreens," i.e., the adolescent presents some behavioral or school problems (usually something not too serious) but after exploration these symptoms seem magically to disappear. Since we do not believe in magical results, we look for alternative explanations. What we have found is that either one or both of the parents is usually depressed because of the loss of relatives and friends due to the immigration. In addition, we have also found that parents experience confusion about how to raise children because of the incorporation of new values and the dropping of old values.

As immigrants incorporate the values of the host society with the beliefs of their country of origin, they go through a process of destructuralization of values, that is, some beliefs come into question and are subsequently dropped, but not readily supplanted. Parents frequently doubt their own perceptions as they contrast them with mainstream society, because they temporarily lack points of reference that are provided by peers. While an accommodation is developed between old and new beliefs, there is ambiguity and confusion. During this time, it is common for parents to become inconsistent and ineffectual. This situation is even more painful if they are besieged by their adolescent's generational challenge for autonomy.

The first phase of therapy with this family was to address the son's misbehavior, but it was soon evident that the parents had no difficulty knowing how to set limits. However, they had been questioning themselves as a result of the uncertainties that the reduced income had raised for them, particularly regarding their long term-plan to go back to their village and start a business. Once they began discussing the economic plans and returned to their clear communication of parental expectations, the lack of consistency with their son ceased. The improvement in the son's behavior was so fast that it was perceived by the therapist as a kind of a "smokescreen" that had brought the family into treatment.

The ideological difference between the parents that surfaced immediately after the son settled down was a different definition of what type of marriage each spouse wanted to have. The traditional definition of Father as the breadwinner and Mother as the caretaker of children was the father's definition but no longer the mother's. Although the husband acknowledged that if his wife got a job, it would simplify their dilemma, he was hesitant. This was understandable, given that neither his original village, his socioeconomic group, nor his neighborhood in Chicago provided historical patterns to sanction this type of relationship.

The wife, on the other hand, could not understand why she could not help the family economically. She was also questioning the patriarchal nature of their relationship and had begun challenging her husband in order to develop a more balanced relationship. She was gradually able, with the therapist's support, to pursue a new definition of their marriage. The husband explained that he was reluctant, not knowing what repercussions it would have for the family if his wife went to work. It could affect the children, he would say. The son would go back to misbehaving; the daughter would start challenging their authority. The mother, on the other hand, would argue that this view no longer fit their situation, that their dream required a two-income family. The children allied themselves along gender lines. The couple spent some time discussing the costs and benefits of making this decision.

In the process of becoming a more balanced couple, there were some intermediate steps. At first, the wife negotiated a different, although unbalanced, relationship, since she would have two careers: one as a housewife and the other as a partial breadwinner. The wife got a job after 6 months of therapy. In time, they were able to balance the housekeeping and child-rearing activities to some extent; the wife remained the primary caretaker throughout the process of therapy, however. The children did not test their parents' authority during this time.

The next therapeutic phase focused on the exploration of the meaning that a traditional marriage had for both spouses, as well as the consequences that redefining their marriage would have for the family. Since they were planning to return to their native village, not only did they need to consider each other's views, but also the views of their extended family.

The couple continued in therapy for 2 years until they were ready to consider the possibility of starting a new business back in their native village. A trip to Mexico was planned to explore business opportunities. This forthcoming trip was utilized to explore the extended family's expected views about the changed roles and expectations that the couple had developed. When the trip took place, the couple was surprised to find out that some relatives of their generation had also evolved in similar ways. Their parents' generation, however, attributed the client couple's change to being Americanized. Ironically, they did not seem to notice the similar changes in the relatives who had stayed at home. Somehow, the people who had stayed had changed imperceptibly, unnoticed. It is not uncommon for physical or emotional growth and change in people to go unnoticed by those who see them every day.

This case illustrates a perspectivistic approach toward cultural thinking. The therapist was able to view this traditional family as able to evolve and its culture as providing various opportunities toward evolution. This might not have been possible if the therapist had conceptualized it as a traditional, rural, low-income Mexican family, unable to move from a patriarchal to a balanced organization. The perspectivistic approach permits sensitivity to differences while recognizing that cultural values are neither static nor impenetrable.

The wife could not understand why she could not help the family economically. She was also questioning the patriarchal nature of their relationship and had begun challenging her husband in order to develop a more balanced relationship.

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Culturally Sensitive Treatment of the Inner-City African-American Adolescent: A Multisystems Model[1]

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There is a great deal of cultural and socioeconomic diversity among black adolescents and their families (Boyd-Franklin, 1989). However, this article focuses primarily on the cultural and treatment issues for African-American inner-city adolescents and their families.

These families are confronted with poverty, racism, discrimination, high school dropout rates, teenage pregnancy, crime, homelessness, and drug and alcohol abuse. These realities create a level of fear in many of these families that must be addressed in the treatment process. For black inner-city adolescents, mental health and alcohol and other drug abuse (AODA) treatment services are either nonexistent or in short supply. The services that are available are usually provided by the public sector. Many of these inner-city adolescents and their families also experience a constant level of intrusion from, and/or involvement with, outside agencies, such as schools, courts, child protective agencies, welfare departments, police, clinics, hospitals, and so forth. Most of these agencies have a tremendous amount of power to make decisions in the lives of these adolescents and their families. Any model of family-centered treatment that is to be effective with this population must include and address these realities. This article presents a multisystems model for the treatment of African-American inner-city adolescents and their families that includes familial, cultural, and broader systemic interventions that have proved effective.

This article addresses the following areas: (1) adolescence in inner-city African-American communities; (2) the cultural and family context for African-Americans; (3) the "resistance" of African-American adolescents and families to treatment; (4) the multisystems model: the treatment process; and (5) the multisystems model: working with outside systems.

We begin by discussing the community and developmental context of African-American youth in inner cities and how it differs from other cultures and communities.

Adolescence in Inner-City African-American Communities

Adolescence is a distinct period in the life cycle usually associated with considerable change and turmoil. However, there is a tendency in the mental health field to see adolescence as a monolithic "stage" that is the same across cultural and socioeconomic levels. This is a serious error. Many important differences in the adolescent period exist between inner-city African-American adolescents and those from other cultural, racial, and socioeconomic groups (Jones, 1989; Franklin, 1989). First of all, "adolescence" often begins at a much younger chronological age in African-American inner-city communities—on both biological and psychosocial levels. Black female children

[1]Many of the concepts presented here have been previously introduced in the book, *Black families in therapy: A multisystems approach* (Boyd-Franklin, 1989), which is included in the Annotated Bibliography.

Many inner-city African-American youths have major adult responsibilities as "parental" children long before they actually reach teen age. They may care for younger children, clean their homes, cook, and help parents who are often overwhelmed. Many of these children are also wage earners. Frequently, these roles are essential to their family's survival.

often experience their menstrual cycles as early as 10 years old. Black male children often grow very tall at the early age of 9, 10, or 11, and are perceived and treated as adolescents by their families and communities long before they reach the traditional age of onset of adolescent growth and maturation, around 13-14. Kunjufu (1985) has referred to these black male children as an "endangered species." Because teachers, counselors, police, and therapists often become intimidated by the physical size of these children and fear physical aggression from them, they react in ways inappropriate for adults dealing with children. Many of these children are labeled by their school systems or have come into conflict with law enforcement agencies long before they reach their "official" adolescence.

Children in many cultures experience childhood as a protected period. Adolescence is seen as the time when the young person has more contact with the peer group and the outside world, independent of the family. For many inner-city African-American youths, these norms do not apply; they have major adult responsibilities as "parental" children long before they actually reach teen age. They may care for younger children, clean their homes, cook, and help parents who are often overwhelmed. Many of these children are also wage earners. Frequently, these roles are essential to their family's survival. However, as children approach preadolescence and adolescence and become more involved in their peer groups, they often rebel against these demands.

Inner-city children are exposed to the influences of the streets much earlier than their suburban counterparts. Consequently, many of the social and peer pressures of adolescence are also experienced much earlier. Boys and girls are often exposed to sexual knowledge and experiences long before they are biologically or emotionally prepared. In addition, many youth have been recruited as drug "runners" or drug abusers—or have friends who have—as early as the elementary school years. By the time African-American inner-city youths have reached the typical age of adolescence (13-18), they are often already exposed to experiences that far exceed their chronological ages (and the experience of their suburban counterparts).

Service providers should also be aware that the approach of adolescence is often accompanied by a great deal of fear for many African-American families. Parents and family members become extremely concerned about the safety of their children, because inner-city housing projects and neighborhoods are often very dangerous places. Many parents are afraid that their daughters will become pregnant at a young age. Often there is a fear that a tall, black, male adolescent will be mistaken for an adult and be at risk of being shot by a policeman. The underworld of street drugs is also very violent. Parents are terrified that these children will become drug dealers or abusers, or will be killed in the random violence of this world. Parents often feel overwhelmed and unable to protect their adolescents.

When an adolescent begins to act out, parents may feel completely powerless to stop the behavior. A therapist must help put the parental figures in charge and should mobilize the other powerful figures in the family to help. In order to do this effectively, however, therapists, agencies, and service providers must understand the cultural context of African-American families.

The Cultural and Family Context

In order to understand fully the cultural context of African-American adolescents, the therapist, administrator, or service provider must first expand his or her concept of "family." Many African-American families are in fact complex extended kinship networks. In these families, many significant adults may be involved in raising and/or disciplining the adolescent. These family members might

include mother, father, sisters, brothers, grandmothers, grandfathers, aunts, uncles, cousins, and so forth. These family members may also be giving conflicting messages to the adolescent. It is a basic tenet of family systems theory that when these mixed messages occur adolescents often act out (Minuchin, 1974).

Albert

Ever since Albert was 12 years old, people have been frightened of him. He was tall, black, muscular, and looked 16 then. Now that he is 16, he is quite used to people being intimidated by him, even when he just wants to be friendly. Grandma has watched people react to Albert with fear for 4 years now, and she wonders if it adds to the anger he seems to show all the time lately.

This process is further complicated by the fact that in many African-American families there are also a number of possible "nonblood" individuals who are considered "family" and who may have considerable power in decisionmaking. For example, these individuals might include "play mamas or papas" and may be close friends, babysitters, or neighbors of the family who are very intricately involved in the adolescent's life. Other nonblood family might include boarders who live in the home, stepmothers or fathers, and boyfriends or girlfriends of the parents or grandparents. In addition, because of the strong religious conviction of many African-American families, members of the "church family," such as ministers and their wives, deacons, deaconesses, and "sisters" or "brothers" in the church may also be involved.

This rich fabric of family involvement is a strength in many African-American families. However, many traditional service providers and family therapists have never been trained in a family systems model that allows them to work effectively with and treat these complex extended family systems. Therefore, when faced with this extended family system, therapists quickly become overwhelmed and ineffective. For many traditionally trained service providers, the response has often been to see the adolescent alone and ignore this large family. For many "family therapists," the response has often been to see a small subsystem of the family, such as the mother and the children, and to ignore other very influential extended family members. In the treatment of African-American adolescents, both of these strategies can undermine the treatment process.

The therapist must identify which extended family members are involved with the adolescent and which members have decisionmaking power in the family. Often, if these individuals are not involved, lasting change does not occur. Important questions for therapists and other service providers to ask are "Who are the people who are important to your son (or daughter)" "Who will he (or she) listen to?" These extended family members can then be invited into the family therapy sessions or, if necessary, home-based sessions can occur.

Many African-American families are in fact complex extended kinship networks.

Therapists who work with inner-city families have often found that home visits, if done with the family's permission, are the only way to involve reluctant family members. Traditionally, African-American families have proven "resistant" to treatment efforts. A successful therapist must deal quickly with the variety of causes of such resistance.

The "Resistance" of African-American Adolescents and Families to Treatment

Before we can discuss effective strategies for the treatment of black adolescents and their families, we must understand their attitude toward treatment. In many African-American communities, treatment is seen as "for crazy

people," or "because you're sick," or "because you're weak." African-American families are far more likely to go to an extended family member, a very close family friend, or their minister for help because of the widespread cultural prohibition against "airing dirty laundry in public." Many service providers are surprised to discover that therapy is considered very "public" by African-American adolescents and their families. For many inner-city families, there is also what Grier and Cobbs (1968) have described as "healthy cultural paranoia." This translates into a fear of "white institutions."

The attitudes discussed above are extremely important because most of our clinics, mental health centers, and therapists operate on the premise that our clients *want* treatment. When dealing with many African-American adolescents and their families, this is a very erroneous assumption. Many of these adolescents and their families are "forced to come" by schools, courts, juvenile justice systems, hospitals, and child welfare agencies.

In many African-American communities, treatment is seen as "for crazy people," or "because you're sick," or "because you're weak."

Because these dynamics have not been understood, many of these adolescents and their families have been mislabeled as "resistant" to treatment. They often drop out before real therapy can begin. A family-centered, multisystems model of treatment can successfully reverse this trend and engage African-American families in the treatment process.

Multisystems Model: Treatment Process

Boyd-Franklin (1989) gives detailed case examples illustrating a multisystems model treatment process. Since it is not possible to describe these in their entirety here, the following general guidelines may be helpful in treating these adolescents and their families. Many of these initial interventions are consistent with the structural family therapy model (Aponte, 1976; Minuchin, 1974; Haley, 1976).

- Take the time to join with the adolescent and each member of his or her family. It is often helpful to ask the entire family or "everyone who lives in the home" to come in for the first session. Many families will typically respond to this by sending in the "problem" adolescent and the mother. Often, therapists must first join with these family members and trust must be established before other important "family" will come in. If the adolescent seems very cut off from the family, it may also be helpful to see the adolescent alone briefly after the first session (or for future sessions) in order to connect. Although many family therapists do not see adolescents individually, it is often a necessary step in order to "join" with inner-city African-American youth who may be very alienated from their families as well as society.

- The therapist's use of himself or herself is a crucial element in connecting with African-American adolescents and their families. Therapists must be both true to themselves and "real" with the family. Respect should be conveyed to all family members. On the one hand, if the therapist is white, it may be helpful to find out how the adolescent and the family feel about working with a white therapist. On the other hand, black or other therapists of color should not assume that they will automatically be accepted by African-American adolescents and their families. A process of trust building must occur.

- Discuss with the family members how they came to therapy, who referred them, and their feelings about treatment. Often, they will have questions about the process and what they can expect to happen.

- A problem-solving approach is very helpful in the beginning because it helps the family and the adolescent to identify the problem as they see it. (This may lead to different views of the problem being expressed by different members.) Poor inner-city families are often overwhelmed by a number of problems. Helping them to establish priorities is empowering and can lead to a focus for the session. These sessions may be used to explore if there are problems with other children or family members, thereby taking the central focus off of a "scapegoated" adolescent.

- Avoid extensive history-taking initially. Often, African-American adolescents and their families are put off by intake procedures that they perceive as "prying into their family business" before trust has been gained. After trust has been created, a genogram or family tree can be done in a later session. This should *not* be done in the first session.

- Have the adolescent and other family members talk to each other and interact with each other (rather than only talking to the therapist). This is a very significant contribution of family-centered treatment because it allows the therapist to witness interactions between the adolescent and the family firsthand and to change the family structure and the destructive patterns of interaction right in the session. With this powerful intervention, many African-American families experience the potential of therapy for the first time.

Multisystems Model: Working With Outside Systems

In addition to the treatment strategies described above, the multisystems model addresses another central issue in the lives of African-American inner-city adolescents and their families—the unwanted intrusion by other outside agencies and social systems into their lives. Most African-American adolescents are not self-referred. They are sent by schools, juvenile justice systems and courts, child protective agencies, hospitals, and clinics that have a tremendous amount of power in the lives of these adolescents and their families. For example, the child protective agency can remove the adolescent from his or her family. Juvenile justice systems or courts can incarcerate an adolescent. Therapy is often presented to these adolescents as an alternative to a jail term. Given these realities, many African-American families enter treatment feeling very powerless and unable to effect change in the many systems that impact upon their families.

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There are multiple levels of systems at which a therapist or service provider must often be prepared to intervene if they are to produce change for an inner-city, African-American family. (See diagram 2, page 17, illustrating the many levels of systems in the ecology of the adolescent.) These might involve the individual, the family (household), the extended family, the church family, the community, and the social service agencies. It is crucial that the therapist not become central in effecting these changes but rather empower the family to intervene successfully with these systems. For example, if the adolescent is having difficulty in school, the therapist would help the family to arrange a meeting at the school in which all parties could discuss strategies for helping the adolescent. Often, different systems are working at cross-purposes in the adolescent's life. For example, child protective services might be working to place a child in residential treatment, while a therapist is working for a return to the family. A meeting involving the family, the agency, the therapist, and the adolescent can promote effective communication and facilitate change.

Another aspect of the multisystems model is that the therapist must be flexible on a number of levels, both in terms of the definition of the

problems and in the levels of intervention. Poor inner-city families often rank the severity of their problems quite differently from mental health professionals. For example, the therapist may feel the need to address the adolescent's acting-out behavior in school and truancy. The family may see its homelessness or the threat of eviction as the most pressing problem and a major contributor to the adolescent's misbehavior. In order to work with inner-city families, therapists must be willing to address these broader environmental issues as an integral part of a family-centered treatment approach, thereby helping us to build credibility with these families and often reinforcing the strength of the parental unit. When this is done, the adolescent may feel less intense pressure from home and he or she may be able to concentrate on school.

Another aspect of the multisystems model is that the therapist must be flexible on a number of levels, both in terms of the definition of the problems and in the levels of intervention. Poor inner-city families often rank the severity of their problems quite differently from mental health professionals.

Mental health and AODA treatment of inner-city black adolescents offers challenging problems for the family-centered therapist. By adopting a multisystems approach, a therapist may take advantage of the unique resource opportunities available in the African-American family and community and help the adolescent and his or her family use their own power to help themselves. With therapist awareness of these important cultural and environmental issues, treatment of black adolescents and their families will be much more effective.

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Selected Family-Centered Models for the Treatment of Specific Adolescent Problems

How are family systems concepts and techniques combined to treat specific common problems? In this section, family therapists who have developed models of treatment for specific adolescent problems describe those models. The problems and the treatment models included were selected because they represent problems encountered every day by professionals who work with adolescents and illustrate important aspects of family systems work. There is a strong emphasis on alcohol and other drug abuse, a difficult problem when presented and often a factor in other presenting problems. The models also represent both established, longstanding approaches and recent innovations.

Thomas Todd and Matthew Selekman's model represents the application of a traditional family therapy approach, the structural-strategic approach, to the treatment of adolescent abuse of alcohol and other drugs. Todd and Selekman have recently elaborated on this model by incorporating other brief strategic approaches, but here they describe the basic model.

Howard Liddle presents another model for treating adolescent drug abusers. He built on the foundation of structural-strategic work to develop his multidimensional model for treating these youngsters. Liddle's approach is a recent innovation and is still evolving as the results of his 6-year National Institute on Drug Abuse (NIDA) study are analyzed. He presents here the model as it is informed by his findings to date.

Carol Anderson's and Douglas Reiss' model for treating adolescents with schizophrenia and James Alexander's model for treating delinquent or acting-out youngsters (which has also been applied to drug abusers) are long-established, well-researched, and rest on sophisticated theoretical bases. These models have long been the basis for organized programs of treatment.

A Structural-Strategic Model for Treating the Adolescent Who Is Abusing Alcohol and Other Drugs[1]

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Introduction and Overview

Families of adolescents who use alcohol and other drugs typically feel angry, desperate, and helpless in the face of their youngster's destructive behavior. Often, they have become locked into a pattern of interdependent behaviors that helps to maintain the adolescent's drug use even as they struggle to change it. This paper presents a structural-strategic family therapy model for treating the drug-abusing adolescent in the context of the family in order to achieve lasting change in the adolescent's behavior and relief from the family's despair.[2]

In the strategic tradition, this therapy model focuses attention on the presenting symptom and the behavior surrounding it and employs the extensive use of directives. Some paradoxical techniques, such as recommending that adolescents and families "go slow" and predicting relapses, are employed as well. The therapist avoids any temptation to work on issues that are not clearly and directly related to the drug abuse.

Many of the moment-to-moment interventions in this model are more structural in nature. The model employs insession enactments of both problem behaviors and alternative behaviors, focuses on intensifying and resolving conflicts, and restructures the family so that parents are in charge.

The therapy is goal-oriented and short-term. Data are gathered early in the process, particularly concerning drug use and family interaction around drug use. As data accumulate in the early sessions, the therapeutic team attempts to formulate hypotheses linking the drug abuse to the family system. Based on these hypotheses and data, the therapist develops both intermediate and outcome goals and negotiates explicit goals with the family.

Therapeutic goals should be consistently related to the drug abuse, but they should also relate to broader issues, particularly to interpersonal issues. Marital and family issues should be linked to the overall goal of reducing drug abuse. When symptomatic improvement occurs, it is crucial to shift the emphasis away from drugs but to anticipate possible relapse. Finally, when symptom reduction has been supported by important changes in the system, the therapist should gradually withdraw, giving appropriate credit to the adolescent and family.

Later in this paper we will discuss the stages of therapy in more detail.

Differing Conceptualizations of Adolescent Drug Abuse and Implications for Treatment

In our view, alcohol and other drug abuse (AODA) by an adolescent is an act having

[1] This paper was originally published under the title "Principles of Family Therapy for Adolescent Substance Abuse" in the *Journal of Psychotherapy and the Family, 6* (3/4), pp. 49-70. It has been adapted for inclusion here with the permission of Haworth Press.

[2] Editor's note: The model described here has been further elaborated by the integration of other brief, systemic therapy approaches. The full elaboration is described in *Family Therapy Approaches With Adolescent Substance Abusers* (Todd and Selekman, 1991), which is included in the Annotated Bibliography.

In our view, alcohol and other drug abuse (AODA) by an adolescent is an act having interpersonal consequences and must be seen in its social context rather than being narrowly defined as a matter of biology.

interpersonal consequences and must be seen in its social context rather than being narrowly defined as a matter of biology. There is little or no empirical evidence that the disease model of drug abuse treatment is effective with this age group. We are primarily concerned that these concepts are not useful for adolescents and may, in fact, be harmful. We avoid the use of permanent labels such as "addict," "alcoholic," or "chemically dependent," particularly early in the treatment before we have seen how responsive the youngster may be to our own approach.

Many studies have demonstrated that adolescents do not accept such labels because the labels are at odds with the values and norms of the youngster's social world (Glassner & Loughlin, 1987; Glassner, Carpenter, & Berg, 1986). Adolescents value self-control of drug use and detest the labels mentioned here. They generally expect that they will stop or greatly reduce drug use in their adult lives, and many cases bear out this expectation.

This is not to imply that a youngster cannot be in great danger or do great harm to himself or herself with drugs. Certainly even the adolescent who will later stop using drugs may have handicapped himself or herself significantly in terms of education, social skills, employability, etc. But adolescents can be helped to see the real-life consequences of their drug-taking without the prediction of a lifelong affliction. We believe that a discouraging long view can be harmful to adolescents, who are by definition struggling with the developmental tasks of identity formation and individuation.

In the case of the adolescent drug abuser who exhibits serious withdrawal symptoms or who fails to reduce or stop very heavy drug use, as agreed upon in the early stage of the therapy, we will arrange for a hospital detoxification and brief inpatient treatment. (The senior author does have an advantage not available to many outpatient therapists in being affiliated with an inpatient treatment unit and thus having access to inpatient treatment that is very compatible with our outpatient model.) Even those youngsters who require some hospitalization are often better classified as users or abusers than as addicts.

Consistent with this view, we do not routinely refer adolescents to 12-step recovery groups when we believe an "addict" or "alcoholic" label may be harmful; we do believe, however, that there are some cases in which a youngster needs the social support of such a group. This is particularly true for the adolescent who has been totally immersed in the drug culture and whose peers are all "users." We also refer some highly reactive parents to Al-Anon or Families Anonymous for additional support and guidance, although we believe it is important to avoid taking a rigid stance regarding family participation in self-help groups. We have found it more useful to determine on a case-by-case basis who might benefit from involvement in these groups. Certainly if a family member is already involved prior to commencing therapy or is otherwise positively predisposed and interested in 12-step groups as a vehicle for recovery, we support the client's selection of a positive strategy for dealing with his or her problem.

The Early Phase of Treatment

Engaging the Family

The first task in the therapy is to engage all members in the process. Stanton & Todd (1981,1982) have emphasized the importance of the "nonblaming message" in the recruitment of the families of heroin abusers into treatment. While it is true that the families of adolescent drug abusers are typically much easier to engage in treatment than those of adult heroin addicts, it is still important for the therapist to offer a rationale for the involvement of family members that is non-blaming. This message should be tailored to the particular clinical situation, and may involve any of the following elements:

1. It is always safe to stress the need for a maximum, coordinated helping effort on the part of everyone involved in the life of the drug abuser. While the therapist conveys the expectation that therapy can be helpful, the therapist should also make it clear that he or she "needs all the help he or she can get."

2. The therapist should imply a belief that the parents and other family members have a genuine desire to be helpful to the adolescent. The therapist also notes that, despite this desire, they may not know the best way to be helpful, or they may try to help in ways that turn out to have the unintended effect of promoting AODA or undermining abstinence. (This is similar to the idea of "enabling.")

3. Similarly, the therapist should not imply an underlying motivation on the part of the parents and family members to see the patient fail and use drugs. Instead, it is better to imply that significant others learn to accommodate to drug use and its consequences over a period of time, and that they may be unprepared for the upsetting effects of abstinence. The analogy is made to a broken leg or physical disability—no one wants such a handicap and anyone would like to get rid of it, yet the person having the handicap and those around him may be unaware of the complex accommodations that have been made to the condition that will be upset by a return to normalcy.

The abuser or another family member may propose some alternative basis for involvement in family therapy, such as improving communication, dealing with parental problems, or addressing problems of a sibling. The therapist should accept such contracts cautiously and regard such goals as secondary to the primary goal of reduced drug involvement. If difficulties develop with these goals, or if dealing with these goals seems to be overly stressing the abuser at an inappropriate time in relationship to the drug treatment, the therapist should always be ready to abandon or postpone them. (See Todd, 1988, for detailed consideration of such timing.)

Engaging the Adolescent

We have found that it is most advantageous for the therapist to provide the adolescent with ample individual session time in the early stages of family treatment in order to help establish therapeutic leverage. By joining well with the adolescent drug abuser, the therapist will not lose him or her when empowering the parents. Effective joining techniques with adolescents who abuse alcohol and other drugs include positive connotation; the use of metaphors, empathy, and humor; the therapist's use of self; and familiarity with street language. The joining process will occur much more rapidly if the therapist demonstrates a good grasp of adolescent culture, as well as the street names of drugs of abuse and drug paraphernalia.

Once the therapist has developed a good alliance with the adolescent, the latter can be employed as a "diagnostic tour guide" of her family system (Selekman, 1987). The adolescent drug abuser can provide the family therapist with invaluable diagnostic information about the function of the drug-abusing behavior for the family system. Since the adolescent drug abuser is often entangled in the parents' marriage, the family therapist can learn a great deal about the quality of the marital relationship and possible parental chemical abuse. It is useful to explore with the youngster what family problems are most troublesome to her. A "secret pact" can be made between the adolescent and the therapist regarding the latter's taking over sole responsibility for the resolution of the family problems. Throughout the family treatment process, the therapist should also convey to the teenager his or her commitment to serve as an advocate and arbitrator for the latter across generational lines.

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The therapist should take a careful drug history, obtaining information that offers clues about interpersonal factors. What effects have there been on others? How have family members and others tried to help? What shifts in relationships have occurred?

In some cases, the parents are initially unable to bring in the adolescent drug abuser for family therapy. This may be because the youngster holds power in the hierarchy, or because an overinvolved parent is being protective of him or her. Although it is helpful to have all family members present in the first interview, all is not lost if the adolescent fails to attend. The therapist can take advantage of seeing the parents alone by using this time to empower the parents and begin to correct the incongruent hierarchy. Homework assignments can be given to the parents to help disrupt the dysfunctional "family dance" around the drug abuser.

The Milan Associates have developed some very effective engagement strategies specifically tailored for resistant family members (Palazzoli et al., 1978). The paradoxical letter is an effective engagement technique that can be useful when the adolescent is absent for the initial session. In writing a paradoxical letter to a resistant adolescent drug abuser, the therapist should begin the letter by positively reframing his or her behavior as serving a helpful function for the family, such as a protective function for the parents' marriage. This is followed by a prescription that the resistant adolescent should continue the oppositional behavior by failing to show up for the next session. The letter should be worded to imply that refusal to participate in family therapy defeats the adolescent's own goals. The youngster quickly discovers that it makes more sense to be present than absent from family sessions. Weeks & L'Abate (1982) provide several examples of paradoxical letters that can be adapted for use with a resistant family. While such letters cannot be expected to "cure" a family by themselves, they may be useful in dealing with potential impasses, such as the absence of a family member or an early termination of treatment.

Data Gathering

The guiding principle in data-gathering is to understand the interpersonal significance of the abuse of alcohol and other drugs. It is, therefore, important to obtain data that allow the development and testing of hypotheses concerning the role of AODA and factors that may maintain the abuse.

Initially, a good deal of the data will concern the drug abuse itself. The therapist should take a careful drug history, being alert to time periods in which there were marked changes in the amount or kind of drugs used. Building on this base, he or she should attempt to obtain information that offers clues about interpersonal factors. What effects have there been on others? How have family members and others tried to help? What shifts in relationships have occurred?

Illuminating data in three major areas are needed: (1) *Function of the symptom.* What has happened in the family or marital system during periods of accelerated drug use, during financial or vocational crises, etc.? What has happened when the abuser has tried to reduce the level of use or "go straight"? In addition to the family, what other people seem to play crucial roles? (2) *"Solutions" that become the problem.* On a day-to-day basis, what do the abuser, the family and others do in an effort to reduce drug abuse? What is the usual effect? Historically, what previous treatment efforts have there been? What were the outcomes? (3) *"Organizational" issues.* The therapist should learn what other helpers, formal or informal, are currently involved with the patient (and with the family). This is especially important when the patient has recently been discharged from a residential program. If other "treaters" are involved, what sort of "program" has the abuser been given? What is the program ideology, and how easy will it be for the family therapy to coexist with the other components of treatment?

Finally, the therapist should not forget the other key figures who are not in attendance but may be important. If the interview is with an adolescent and the parents, how do the siblings

and the extended family fit in? What do they know or sense about the drug abuse? With respect to the families of origin, it is helpful to obtain basic information about who comprises the families and where the members are. How are they involved with the nuclear family? Is there any current or past history of AODA or other addictive behavior in other parts of the family?

Forming and Testing Hypotheses

When developing hypotheses, it is important for the therapist and any team members to keep in mind that the goal is to develop hypotheses that are useful therapeutically, as opposed to searching for "truth." Many possibly interesting hypotheses will have limited therapeutic value. The most important hypotheses, therefore, will be those having to do with the current role of the symptom in the family or marital system and in other interpersonal systems. Next, in order of importance, will be those hypotheses having to do with other factors that may be maintaining the drug abuse. These hypotheses may include the role of other helpers, the role of peers and the school environment, economic issues, etc.

None of this is meant to imply that hypotheses having to do with historical factors are useless. However, they need to be connected with current reality and current therapeutic strategies and goals. If, for example, there are issues surrounding the death of a significant family member who was linked to the abuser, which Stanton (1981) has frequently found to be the case, the issue for the therapist is to connect this event with the present and find some way to deal with it, even symbolically.

Goal Setting

The process of establishing and refining therapeutic goals is crucial to the structural-strategic therapy of AODA, a process that begins with the first session. If the abuser, parents, or other family members are demoralized, it may be necessary to "sell" them on the possibility that therapy will make a real difference. More typically, however, it is better in the first session for the therapist to take a more neutral and somewhat pessimistic position, especially if the abuser is newly abstinent and optimistic about therapy. Under these circumstances, the therapist (or, even better, the team behind the mirror, if one is available) will usually express some doubts about whether therapy will be helpful, and will send the family home to think and talk about it before the second session.

Typically, the formal goal-setting process begins in the second session. The stated goal of the couple or family is usually quite clear: to have the drug abuser stop taking drugs and stay off drugs. The therapist, on the other hand, will wish to establish goals in two major areas: the area of drugs and the area of interpersonal relationships, with a clear relationship between the two sets of goals.

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Often, as the therapy progresses, the family has difficulty translating its goals into action. The abstract idea of abstinence may be fine, but the realities of confronting the abuser or setting limits on him or her may be more difficult to achieve. Furthermore, as abstinence is achieved, other problems typically surface and may develop into new goals.

The Middle Phase of Treatment: Dealing With Symptomatic Improvement and Relapses

The handling of symptomatic improvement or relapse is far from simple. Changes in either direction must always be evaluated in terms of previous patterns of improvement, the stage of therapy, and the ideal stance of the therapist and other team members. Only after all of these factors have been considered can an appropriate therapeutic plan be developed.

When therapy is proceeding well and there are no mitigating circumstances, it is

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reasonable to expect significant improvement as early as the third or fourth session. When this improvement occurs "on schedule," it is crucial to consolidate the changes and shift to interpersonal issues. To consolidate positive therapeutic change, the therapist should usually adopt a stance of guarded optimism— that the changes appear desirable and real, but they may not last. If a supervisor or team is involved, they can act split on this issue the treating therapist supports the change and takes an optimistic stance, while the team members or supervisors serve as a pessimistic and skeptical "Greek chorus."

As symptomatic improvement occurs, interpersonal issues typically emerge. It is crucial for the therapy to begin to focus more directly on these issues. If the family is allowed to maintain an exclusive focus on the abuser and the possibility of a return to drug use, rather than focusing on more basic interpersonal issues, a relapse will typically occur.

The therapist has considerable latitude in influencing the stance taken by the family when a relapse or slip occurs. At one extreme, it may be appropriate to treat an early relapse as a major crisis, mobilizing the resources of the family to meet this challenge. Usually such a relapse has already been anticipated and planned for, and the relapse is the occasion for activating this plan.

In contrast, it is often desirable to treat a relapse later in treatment as a temporary slip rather than a permanent reversion to drug use. When the family has made solid progress, the therapist should convey the attitude that it already knows how to cope with this temporarys setback. Usually the relapse comes when the family is facing an interpersonal crisis, with the relapse functioning to divert attention away from the interpersonal issues. The therapist must recognize this pattern and prevent this diversion from occurring, even though it may also be necessary to deal with the relapse directly.

The Late Phase of Treatment: Techniques for Termination

Structural-strategic therapy is typically of brief duration. Whether or not it is formally time-limited, it usually lasts 10 to 20 sessions, over a period of 4 to 6 months. Within the context of such brief therapy, it is particularly important for the therapist to review goals periodically and be prepared to terminate when goals have been achieved. Even when goal achievement is less than perfect, the therapist may wish to move toward termination if therapy has reached a point of diminishing returns. Stanton (1981) has argued that it is important for the patient and family to receive most of the credit for change. The therapist should only take credit as a facilitator or catalyst, making it clear that the family has done the real work. It is also dangerous for the abuser to get too much credit for change, since this lessens the commitment of the parents to maintaining the changes and preventing relapse. In this respect, it is important to link drug improvement to changes made in interpersonal areas.

The family members should be warned in advance that life may not go smoothly and that future problems can be anticipated. It is useful to review the problem-solving skills they have learned in the course of therapy to create confidence that they can deal successfully with future problems or crises.

As termination approaches, longer intervals between sessions are appropriate. Usually, the final sessions are treated more as extended followup visits than as therapy sessions, e.g., having the family come at monthly intervals to review progress and ensure that there has not been any slippage. If therapy has ended ahead of schedule, the family can be told that it has a few sessions "in the bank," in the event that any problems develop during the followup period.

Case Example

William, a handsome 16-year-old, was referred for family therapy with one of the authors (MS) by his high school counselor because of his failing grades and coming to school heavily intoxicated on a variety of substances. Prior to this referral, William had received outpatient family therapy on two occasions, and had been hospitalized for 9 weeks for chemical dependency treatment. The mother called the therapist shortly after discussing the school problems with William's counselor. Mrs. Smith began the phone conversation crying and sharing with the therapist how she had "failed her children as a mother." She reported that "all hell broke loose" after her older son, Steven, moved out of the home 8 months earlier. The mother believed that William had begun heavy abuse of heroin, PCP, alcohol, and marijuana after Steven moved out of the home. William had allegedly been using chemicals since age 13. The therapist scheduled a family interview for later that week.

From the information the therapist had gathered in his phone conversations with the school counselor and the mother, the following tentative hypotheses were formulated:

1. The Smith family was stuck at the Leaving Home stage of the family life cycle (Haley, 1980).
2. William's drug-abusing behavior served a protective function for the mother by distracting her from her own worries and dysphoria concerning Steven's moving out.
3. An incongruent generational hierarchy existed in the family that placed William in a one-up power position over his mother.

First Session

Present in the initial family interview were Mrs. Smith, William, and his 14-year-old sister, Michele. Mother was quick to point out how "brilliant" and "helpful" her daughter was around the house and that she had been an honor student. The therapist employed humor and street language as a way of engaging William. William was impressed with the therapist's familiarity with rock music cult figures and his knowledge of street culture. It was interesting to note how Michele spoke for her mother and interrupted William without being restrained by her mother.

After joining with each family member, the therapist asked a series of circular questions to develop a clear picture of the "family dance" around the presenting problem, to elicit information regarding differences in relationships, and to confirm or discard initial hypotheses. The therapist found it helpful to ask Michele to give him a "motion picture" of what all family members did when William came home "stoned." The following sequence of interaction occurs: Mother lectures William about the dangers of using drugs; William becomes defensive and yells at his mother; Mother begins to yell and cry simultaneously; Michele intervenes as referee and tries to comfort both parties; William begins to cry and escorts his mother to her bedroom; finally, after everything returns to normal, William goes to his own bedroom. After reporting this scenario, Michele openly admitted that she was the "family peacemaker."

To help determine coalitions around the presenting problem, the therapist asked William to rank on a scale from 1 to 10 each family member regarding his or her degree of concern about his drug use, with a 10 representing the highest level of concern. William gave Steven a 10, his mother a 9, Michele an 8, his biological father a 2, and himself a 9. It was interesting to note how high the rank was for Steven. Surprisingly, William included himself in the ranking task, which gave the therapist a good indication of his motivation to change.

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The therapist found it helpful to ask Michele to give him a "motion picture" of what all family members did when William came home "stoned." "To help determine coalitions around the presenting problem, the therapist asked William to rank on a scale from 1 to 10 each family member regarding his or her degree of concern about his drug use.

Midway through the session, the therapist dismissed the children and met alone with the mother in order to demarcate generational boundaries and initiate the process of empowering the mother. The mother began by describing the many ways she had failed her children, being married three times to alcoholic men. The therapist provided support and empathy. In an attempt to redefine the problem and maintain maneuverability, the therapist shared his "crazy" notion that William's behavior might serve a "stress-regulatory" function for the family. The mother appeared to accept the therapist's relabeling of William's behavior by presenting a few examples of how William took on "too much responsibility" for her problems.

The remainder of the session was spent exploring with Mother what adult resources she had available to assist her in parenting. Unfortunately, Mother's family lived out of State, and most of her female friends were single mothers themselves. There was discussion of the need for outlets for Mother to pursue when her stressful nursing job and her parenting responsibilities began to get the best of her. She was given the homework assignment of doing "one nice thing" for herself over the next week.

The last 15 minutes of the session were spent alone with William to help solidify a therapeutic alliance with him. The therapist began by complimenting William on his "courage and devotion" to his family by serving as the "family stress regulator." The therapist then explored with William whether he had any worries or concerns about his family. William shared with the therapist that he thought his mother was "very depressed and lonely."

The therapist complimented William on being a "very sensitive and caring guy." William smiled and agreed to make a contract with the therapist regarding his "turning over a new leaf." This consisted of total abstinence from all chemicals and allowing the therapist to take responsibility for the family change process. William shared his feelings of ambivalence, and the therapist discussed this ambivalence and concluded the session by predicting that William would struggle to remain "straight" over the next week.

Second Session

William began by proudly reporting his ability to remain "straight" for a week. William also shared how he had fought off peer pressure to smoke "weed" with his friends. The therapist deliberately responded with disbelief and confusion. This was followed by a few "Go slow!" messages. The mother denied seeing any signs of drug use on William's behalf. Michele responded with pessimism about William's sudden change in behavior. Whenever Michele spoke for her mother or talked to her brother in a maternal way, the therapist challenged her power in the family with comments like: "How old are you? Are you sure you are not 64? That's very interesting .... How did you get so old in this family?" These provocative metacomments served to empower the mother and move Michele back into the sibling generation where she belonged. The mother admitted that she had virtually abdicated her position of authority in the family when Steven moved out. As she put it best: "I went to the sidelines and watched Michele and William take over."

After dismissing the children, the therapist quickly followed up on Mother's homework assignment. Surprisingly, she had done two "nice things" for herself: buying a new dress and registering for aerobics classes. The therapist complimented the mother on being so "ambitious." The mother shared that she planned to continue taking "better care" of herself from now on. Sensing that a relapse was inevitable, the therapist restrained the mother from moving too quickly.

The therapist decided to utilize the last 20 minutes of the session with the sibling subsystem. Like William, Michele was very concerned about her mother's mental health, and she was eager to do anything to help Mother. The homework assignment given to the children was to be placed totally in charge of "Mother's happiness" for 1 week. This included having each child do "one nice thing" per day that their mother would notice. On Friday night, they were instructed to prepare an elaborate candlelight dinner for her. Both Michele and William were excited about their homework assignment.

Third Session

The Smiths came into the therapist's office smiling and laughing. Mrs. Smith reeled off a long list of positive things her children had done around the house. The mother was most touched by the wonderful dinner her children had prepared, followed by the showing of a home video that the mother had been dying to see. Mrs. Smith reported that she had painted the family den singlehandedly, a house project that had been discontinued after Steven moved out. The therapist praised the children for doing a "fabulous job" of helping out their mother. He played dumb and explored with the children what had come over them to be "so super-responsible and loving." Both Michele and William shared with their mother how much they "cared" about her. No signs of drug use were reported, but the therapist concluded the session by predicting that William was due for a relapse. The rationale given to the family was that "change is three steps forward and two steps back."

Fourth Session

As predicted, William came into the session with "bad news" about a relapse over the past week. William had smoked a marijuana joint and drunk one beer. The therapist normalized the relapse by pointing out how it served as a "springboard" and "a building block toward further changes." The family was very supportive and provided William with encouragement to get back on track again. The therapist explored with the family members how they had responded to William's relapse. Mrs. Smith had contemplated giving William a severe consequence, but instead had him clean the entire garage. According to the mother, "the garage is now cleaner than it has ever been in the past." The mother reported that she was getting in "great shape" from her three-times-a-week aerobics classes.

In concluding the session, the therapist shared with the family how he and his supervisor (TCT) did not always agree on client progress. He pointed out to the family that his supervisor thought that William would start using "hard drugs" again in the next week or two. The therapist took the pro-change position by telling William that he was "doing real well" and how he thought his supervisor was "nuts." William responded to the supervisor's challenging remarks with "Your supervisor is full of crap!" The therapist shook hands with William, and they both agreed to work together to prove the supervisor wrong.

Fifth Session

The therapist began the session by exploring with the family whether there had been any signs of relapse or drug use. William reported with a big smile that he had encountered five opportunities to get "high" over the past week, but had successfully fought off the peer pressure to use. The therapist shook William's hand and shared with him how he would enjoy laughing at his supervisor. The therapist had William share with the family how he had managed to maintain his sobriety under tremendous peer pressure. William's main coping strategies were to avoid parties and certain peers who abused chemicals, and to spend free time practicing his electric guitar. The family praised William for doing so well.

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The mother responded to the therapist that Michele and William were getting along better. In fact, Michele shared with the therapist that she "no longer had the desire" or "felt the temptation" to "take over as the mother around the house." As a vote of confidence, the therapist scheduled the sixth session 1 month later. The therapist concluded by meeting alone with William. William was praised by the therapist and given the homework assignment of paying close attention to what he did to avoid the temptation to "get high" over the next 4 weeks.

Sixth Session

One month later, the Smiths came into the office smiling and pleased with the various changes they had made. Mrs. Smith responded that she had not seen any signs of drug use on William's behalf. In fact, she had thought about canceling the session because "things were going so well." William had secured a part-time job doing stock work in a bookstore.

The therapist explored with the family the various changes they observed in their relationships. Both children shared with the therapist how their mother was a "totally different person," socializing frequently and displaying no signs of being depressed. William pointed out to the therapist that he and Michele were now "good buddies." The therapist explored with the family what they would need to do to "go backwards." Each family member was clearly able to distinguish their old maladaptive ways of interacting from their new dance steps with one another. William read off a list of 10 things he did to help resist the temptation to "party" over the past 4 weeks. After praising William, the therapist asked the family how it would use the therapy session time if no further appointments were scheduled. Mrs. Smith shared with the therapist that she would go to an aerobic class. The children said that they would use their appointment time to be with their friends.

The therapist pointed out to the family that "life is full of ups and downs," and most likely they would run into difficulties down the road. He voiced his confidence in the family's ability to take on new challenges and quickly bounce back to their new positive pattern. The family mutually agreed to terminate therapy. Before leaving the office, William hugged the therapist and thanked him for helping him survive the earlier relapse.

Followup

One year later, the mother reported in a followup phone conversation that William had greatly improved in school and continued to remain drugfree. The mother shared with the therapist that she was "addicted" to aerobics.

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A Multidimensional Model for Treating the Adolescent Who Is Abusing Alcohol and Other Drugs

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Introduction and Overview

In the early eighties, the empirical establishment of a successful family therapy approach to the treatment of heroin abuse by young adults (Stanton and Todd, 1982) heightened interest in family-centered approaches to treatment of adolescents. In 1983, the National Institute on Drug Abuse (NIDA) initiated research to explore construction of relatively short-term, outpatient family therapy models to treat this population. This paper presents aspects of a model developed within the Adolescents and Families Project, a part of that NIDA research initiative (Liddle, et al., 1991).

The model, Multidimensional Family Therapy (MDFT), was developed within a research project and was built on a tradition of valuing research-based knowledge and applying it to clinical work. The model is informed by research findings about adolescent development and the course of adolescent drug use. MDFT also reflects an underlying belief in the complexity of human problems and emphasizes the importance of the multiple systems and subsystems in the adolescent's life. The conceptual background of MDFT, including key assumptions and research findings that underpin the model, are presented, and the Adolescents and Families Project is briefly described here. The MDFT model is explained and is distinguished from other approaches to treatment of this population.

Conceptual Framework: Key Assumptions and Relevant Research Findings

The Multidimensional Family Therapy model rests on several key assumptions about human existence and functioning:

1. There are numerous domains of human existence, which include the affective, behavioral, temporal, moral/ethical, spiritual, and interpersonal.

2. These domains of human existence are interconnected and overlapping.

3. Human problems are accessed through these interconnected and overlapping domains of functioning, and solutions can be generated by work in any one or all of them.

4. Therapists are handicapped if they conceive of the primacy of one domain over another, or intervene into only one domain.

In addition to these assumptions, the MDFT model is informed by major research findings on adolescence as a developmental stage and on the problem of drug abuse in this age group. Several specific findings have been particularly useful in building the model and will be presented briefly here.

The first set of relevant findings concern adolescence as a developmental stage. While traditional research contends that the central

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task of adolescence is separation from the family (Blos, 1979), contemporary adolescent and family research challenges this view. Also, the literature has increasingly suggested that positive family relations play a central role in the adolescent's ability to negotiate this important, sometimes difficult, developmental phase (Bell & Bell, 1982; Jurkovic & Ulric, 1985; Cooper & Grotevant, 1986; Hauser, et al., 1984; Hauser, et al., 1985). Cooper, Grotevant, and Condon (1983) have suggested that the major developmental tasks of adolescence are struggled with in the family context. And Steinberg & Silverberg (1986) report that emotional distance from parents results in heightened vulnerability to antisocial peer influences. Additionally, recent work has highlighted the importance of parenting style (Coombs & Landsverk, 1988) and parents' influence on adolescent behavior (Baumrind, 1987; Maccoby & Martin, 1983). In sum, it seems clear that adolescent development and problems are very much a family affair, a finding that guides the targeting and nature of the interventions in the MDFT model.

The development of MDFT has also been guided by the findings of researchers in the field of adolescent drug abuse. While many treatment professionals hold that drug abuse is necessarily *primary* and accounts for the other difficulties these young people experience, Kandel (1978) has warned about the major difficulties in identifying and differentiating between antecedents, concomitants, and consequences of adolescent drug abuse. Others have identified a "network of influences on adolescent drug involvement" (Brook, Nomura, & Cohen, in press) and a network of correlated deviant behaviors (Jessor & Jessor, 1977; Dishion & Loeber, 1985; Elliot, Huizinga, & Ageton, 1985; Newcomb & Bentler, 1988a, 1988b, 1988c). Still others have found multiple causal factors related to initiation and maintenance of drug use (Newcomb, Maddahian, & Bentler, 1986; Pandina & Scheule, 1983).

These and other related findings underpin the MDFT conceptualization of adolescent alcohol and other drug abuse (AODA) as one problem within a complex of many problems that are interrelated in ways that are not yet well understood. This conceptualization differs from the addiction or disease model of adolescent AODA and leads to different emphases in the therapy. This will be discussed further later.

Thus, poor relationship skills, learning and behavior difficulties in school, poor self-esteem, family disorganization or dysfunction, and movement in a trajectory of failure that places them outside the mainstream of their peer culture are typical patterns in these youngsters. The MDFT model addresses this myriad of issues through interventions in each of the multiple dimensions of the adolescent's existence. Within this conceptual framework, the MDFT model was designed and implemented in the Adolescents and Families Project.

The Adolescents and Families Project

Started in 1985 at the University of California in San Francisco and moved to Temple University in April of 1990, the six-year Adolescents and Families Project is nearly complete, with all treatments and most 6-month and 1-year followups done. Adolescents in the study were assigned to three treatment groups consisting of 40-42 randomly assigned cases each — the Multidimensional Family Therapy model, a group therapy (for the adolescent alone) model, and a multifamily treatment model. A nonclinical sample from the normal population served as a comparison group.

A presenting problem of drug abuse was a requirement for admission to the study, but these adolescents, ranging in age from 13 to 18, invariably had multiple problems. They evidenced deficits in school performance and behavior, interpersonal relationships, job skills, etc. More than 50 percent were probation-

referred and were not in mainstream schools or had dropped out entirely. Their families were involved with multiple social systems.

The family therapists in the project were trained in MDFT and were live-supervised throughout the research project. All treatments were 16 sessions and took place over 5 or 6 months. None of the adolescents were involved in 12-step or other self-help programs, so that outcomes would not be effected by interventions other than those in the treatment under study.

Several individual and family subsystems believed to be of importance were assessed pretreatment, posttreatment, at 6 months, and at 1 year. These included each individual in the family, the parental unit, the sibling subsystem, and the marital relationship. The assessments consisted of standardized instruments that measured change in individuals, dyads, and the whole family. Self-report, biochemical (urinalysis), and observer ratings (videotaped family interaction) were all used, reflecting the multimodal assessment philosophy.

Treatment outcome data are still being collected and analyzed as a few families have yet to complete the 1-year period following treatment. In developing outcome measures, simply looking at the level of adolescent drug use at specified intervals was considered inadequate. Just as MDFT conceives problems as being complex and multidimensional, it also conceives outcomes in this way as well. As the remaining families complete the 1-year posttreatment period and more data are analyzed, the findings will be incorporated, and the model will continue to evolve.

Distinguishing Characteristics of Multidimensional Family Therapy

The Multidimensional Family Therapy model exists in the structural-strategic family therapy tradition but incorporates additional notions about the targets, mechanisms, and methods of change. While the traditional structural-strategic approach stresses a continued focus on the presenting problem of alcohol and other drug abuse, MDFT by design addresses a wider array of behaviors. This development was driven by the perceived need to build a specialized, clearly defined treatment model to address the particular complex of problems presented by drug-abusing adolescents as demonstrated in the research in this area.

MDFT emphasizes individuals and subsystems as opposed to focusing on the family as a whole more than many other contemporary family therapy approaches. The model rejects family reductionism whereby the family is credited or blamed for the health or pathology of its members. The family is important, but individualistic developmental aspects of the adolescent's existence are also considered important (Liddle, Schmidt, & Ettinger, in press).

In this model, the therapist views the adolescent's involvement as important to the therapy and advocates active engagement of the youth in the treatment. While some family therapy models presume that work with the parents is the route to change in the adolescent, and the youngster's personal involvement is less important, the MDFT model advocates helping the teenager to see the therapy as a place in which his or her own needs can be met. Indeed, MDFT recognizes, values, and cultivates distinct therapeutic alliances between the therapist and the adolescent, and between the therapist and the parents. Using developmental norms, another distinct and essential alliance is cultivated between the adolescent and the parents.

Multidimensional Family Therapy: The Work

Because MDFT conceptualizes adolescent AODA as one problem within a complex of

While some family therapy models presume that work with the parents is the route to change in the adolescent, and the youngster's personal involvement is less important, the MDFT model advocates helping the teenager to see the therapy as a place in which his or her own needs can be met.

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problems and conceives all problems as being multidimensional, many avenues for intervention are presented. As in any therapeutic approach, the first task is to frame the problem as solvable and enlist the participation of key actors in the solution efforts.

As stated above, MDFT does not subcribe to the conceptualization of adolescent drug abuse as a disease or an addiction. The research evidence to date simply does not support this notion, and the notion is fraught with problematic implications of a lifelong battle. The disease model has been applied to adolescents because alternatives that fit the developmental stage of adolescence have heretofore been absent. This observation does not imply that there is no such entity as "addiction" or a "disease process"; it simply says that the traditional addiction model does not fit adolescents very well and is not clinically useful.

While we do not frame adolescent abuse of alcohol and other drugs as a disease, neither do we advocate telling an adolescent that he or she does *not* have such a problem. By all means, if the family has been exposed to the disease notion and accepts it, we suggest the therapist take a pragmatic, solution-oriented approach. He or she can support the observation that many problems have been associated with the youngster's abuse and that continued abuse and further problems are likely without major change. The therapist should never be argumentative or negative about the family's disease conception of the problem as it is consistent with the goals of the therapy. We simply do not see it as a generally useful conceptualization of the problem and do not introduce the idea into the therapy.

The Early Work

The early work of the therapy is to establish an alliance with both the youngster and the parents. These are distinct relationships, with their own courses, expectations, and contracts for what therapy can and will be. Success with one in no way guarantees success with the other. The alliance between therapist and parent, for instance, does not necessarily predict an equal working relationship between therapist and teenager. An effective therapist-parent relationship may, in fact, lead to difficulties in the therapist-teenager alliance. (We are currently exploring the relationship of various alliances in family therapy to outcome and attempting to define in more detail what we mean by multiple therapeutic alliances.)

At the outset, the teenager is helped to feel that therapy can address his or her own concerns. The adolescent is helped to formulate personal thoughts and feelings about his or her life and family, and over time is helped to express some of this to the parents. In the beginning phase of MDFT, the therapist assists the teenager to articulate an agenda different from that of his parents (Liddle, 1991).

At the same time, he or she sees the parents alone and helps them to define their parental belief system and preferred parental style(s), paying close attention to the developmental aspects of their ideas. We look for opportunities to insert developmental content into these discussions. Findings that indicate how adolescent identity development is fostered through a continued familial interdependence rather than emotional separation (Grotevant & Cooper, 1983) and the influence of different parenting styles on adolescent personality are interwoven in our clinical work. For example, a parent might be told, "Your son *does* need you to talk to him about his concerns and worries. You can be the best medicine in the world for him." Interdependence and the necessity of both parents and adolescents negotiating the youngster's transition to adulthood (Steinberg, 1991) become content themes and goals of the therapy.

Parental belief systems (Goodnow, 1987, 1988; Sigel, 1985) and parenting styles (Baumrind & Moselle, 1985; Steinberg, 1990) become important topics of discussion with parents as we help them articulate and reassess their own parenting philosophies and styles. These themes are useful in helping parents cooperate with one another and build the parental coalition long considered by family therapists to be important (Minuchin, 1974).

Parents and teenagers are seen both together and alone at all stages of this therapy. We assume change can occur at individual, dyadic, multiperson, or familial levels, and can be promoted in myriad ways. Care must be taken not to expect too much of the parent or teenager at the early stages of relationship repair. Change is thought of as being phased in a bit at a time. Seeing the teenager and the parents individually and working in a number of domains of functioning (i.e., working in the behavioral and cognitive domains as well as in the affective and interpersonal) assist the therapist to manage the pace of change in the proximity of the parent(s)-child relationship.

In a sequence in which a parent is helped to respond more adequately to his or her teenager, after being hurt and angered by the adolescent's behavior, several methods are likely to be used. Reformulating cognitive attributions, behavioral rehearsals, and working for increased acceptance of each other through emotional expression and clarification, for example, are seen as complementary techniques.

The Ongoing Work

The MDFT therapist intervenes not just in the family but in the multiple systems and subsystems in the adolescent's life. Some of these systems overlap and affect each other. The school, the juvenile justice system, and the teenager's peer group are primary foci of assessment and intervention. The therapist assists the family to contact school officials, including teachers, school counselors, and administrators. They should be cultivated as friends of the family, all of whom care about and are working in the best interest of the adolescent. Probation officers are called in regularly to bolster treatment by providing information and input into the teenager's formulations about his or her life. Peers are included in sessions as potential sources of strength, identity formation, and support.

To accomplish intervention in these various systems, the therapist must be active, persistent, and upbeat about the possibilities for change. The therapist may assume a convening or networking stance, a position with a long history in family therapy. In some cases, the therapist can work preventatively, being sure that all concerned extra-familial agents are working in a manner consistent with the therapeutic goals.

Another aspect of the work is the exploration of many and varied themes during the course of treatment. The multiple content realms in which personal and relationship problems reside are vitally important to understand and use. Clinicians can, in their quest for certainty and self-efficacy, delude themselves into believing they know the precise locale of a problem. Alcohol and other drug abuse, conduct disorders, and developmental problems all point the way toward precise definitions, but also potentially limit the therapist's conceptualization.

There are occasions when the therapist must focus more specifically and almost exclusively on the drug abuse, however. When the drug use is very advanced, the youngster may need much direction and support especially around this issue. Still, emphasis is given to the intrapersonal and interpersonal contexts of the teenager's drug use. We tell adolescents that their use of drugs makes them ineffective at expressing their legitimate concerns and complaints. Our stance is that teenagers do

Another aspect of the work is the exploration of many and varied themes during the course of treatment. The multiple content realms in which personal and relationship problems reside are vitally important to understand and use.

Content is frequently related to generic issues of family life that are manifested in this family's idiosyncratic "big questions" ... core issues for each family presented by the family members' beliefs about what families are and what each member expects from his or her intimates.

have some valid reasons for their behavior and unhappiness, and that these problem behaviors are related to their inability to explain competently their thoughts and feelings (that is, identity struggles, past hurts) to the adult world (parents, teachers, etc.). The therapist works with the adolescent to convince him or her that therapy can be a forum in which such communication ability improves.

Core themes might remain constant (e.g., parental competence and developing a new relationship with their teenager), but the content that comprises these themes changes over time in treatment. The content is frequently related to generic issues of family life that are manifested in the family's idiosyncratic "big questions" (Liddle, 1985). These are core issues for each family presented by the family members' beliefs about what families are and what each member expects from his or her intimates. Family members are helped, for instance, to clarify for themselves *their* definition of "family." What does it mean to be a parent, a father or a mother, in this family? What does the adolescent think about his or her role in the family?

Additionally, the MDFT model incorporates the temporal realm by dealing with past hurts and trauma in the lives of teenagers and families. Sometimes ignoring this content keeps the therapist stuck in an ineffective, present-centered problem-solving quest.

Finally, the question arises as to whether there are instances in which the teenager must be hospitalized for the treatment of alcohol or other drug abuse. MDFT is an outpatient approach, and we have the same reservations about hospitalization that are standard concerns of family therapists. Families are separated; the inpatient and outpatient care are often inconsistent with one another; and parents are not adequately involved and are not treated with respect. Still, there are times when an adolescent is in danger of overdose or refuses or fails to abstain or cut down enough to comprehend and participate in the therapy. In these cases, a short hospitalization may help to establish a drug-free state. The nonphysician therapist can be limited in his or her impact on the inpatient treatment and the way the family is included (or not), but he or she works to support the family and pave the way for the outpatient work to be done after discharge.

Termination in Multidimensional Family Therapy

In the Adolescents and Families Project, the number of sessions (16) was controlled for research purposes. Thus, the preparation for the termination had to take place at a specified time. In nonresearch settings, however, the duration of the therapy, while intended to be relatively short, would vary somewhat depending on several factors. The most important factor would be problem severity, which is often related to the duration and frequency of drug use and the nature of the drugs used.

In any case, change is expected on many fronts. Just as problems are conceived as arising within multiple, interrelated domains, so is change seen as being reflected in multiple domains. Does the adolescent demonstrate improved judgment? Improved relationships? Has his drug use stopped or been greatly diminished? Is he or she able to problem-solve and avoid escalation of troublesome encounters with others? Has the family process of handling difficult situations changed in a way that increases the likelihood of problem resolution? The therapist looks for multiple confirmations that there has been significant change in fundamental aspects of functioning. At termination, the therapist helps the family assess and summarize its progress and change. The applicability of its new attitudes and skills to a variety of situations is emphasized.

This work, like the interventions of therapy, is accomplished in multiple domains. Working in the cognitive realm, the therapist may help

the family members to articulate the ways in which their beliefs about each other have changed (as well as some that have stayed the same). The parents typically alter their negative stereotype of the teenager's behavior and attribute his or her actions to more normal processes, rather than to "teenager acting-out" or "psychopathology." In the affective realm, the therapist might have the family members reminisce about a particularly difficult crisis point in the therapy, one in which they persevered and negotiated through to a solution together. In the behavioral domain, the therapist might review the problem-solving strategies that have been learned during therapy, as well as discuss some of the key events on which they were used. The focus at termination is on sealing the changes that have occurred in these various domains and helping all of the family members to see that each has contributed significantly to the treatment's outcome. Just as the outset of therapy emphasizes both individual and collective (that is, subsystem: marital/parental, adolescent) responsibility, termination also stresses responsibility and credit-taking in these same ways.

Sometimes, the adolescent and family present the therapist with dramatic evidence of change that can serve as an appropriate focus for the summary and termination. This was the case with Linda, a 16-year-old girl in the study, who originally presented with multiple behavioral problems, including heavy drug use and two suicide attempts. Linda's mother wanted her to terminate her relationship with a boyfriend who was using and dealing drugs. Linda eventually decided to terminate the relationship, stressing that she would do so "in my own time and my own way." She described to the therapist how she had explained this to her mother. Linda said her mother had supported her, even as she had admitted her own fears and discomfort with the situation. Her mother had shared a story of her own teenage experience in breaking off with a boyfriend and they had talked long into the night. The girl was touched and pleased with this kind of interaction, which was dramatically different from their pattern on entry into treatment. The mother independently reported the same episode and expressed her own pleasure and satisfaction. Thus, this family presented the therapist with a powerful focal point for summary and termination.

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Summary

Multidimensional Family Therapy is a specialized approach to treating adolescent drug abusers that focuses on the many interrelated domains of human functioning, including cognitive, affective, behavioral, temporal, moral/ethical, spiritual, and interpersonal. The model was developed within a research project and was shaped by research findings regarding adolescent development and adolescent drug abuse. It addresses the many systems and subsystems that are important in the life of the adolescent and values the full engagement and participation of the adolescent himself or herself in the therapy.

MDFT is a model that accepts and uses the complexity of human existence and experience. It aspires to make multidimensional change possible, and helps teenagers and their families to work together in the various realms to achieve these changes. Because families of teenagers in trouble have often been having problems for some time, powerful comprehensive models are needed to address their problems. The systems models of tomorrow will need to be empirically based and sufficiently broad in conception and scope. The families who come for help need and deserve no less than this.

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An Integrative Model for Treating the Adolescent Who Is Delinquent/Acting-Out

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Introduction

Functional Family Therapy (FFT) is a family therapy model that applies concepts from the systems, behavioral, and cognitive approaches to the treatment of the delinquent or acting-out adolescent. It has also been applied to numerous other presenting problems, but has achieved its greatest popularity and been most widely researched in its application to this population. Because the current focus of concern is on alcohol and other drug abuse (AODA) as well as other mental health problems and behavioral disorders, the application of the model to adolescent AODA will also be addressed briefly.

This model is a short-term, outpatient approach to treatment that Bruce V. Parsons and I developed at the University of Utah. It has since been further developed and refined by numerous colleagues, most notably Cole Barton. The model was initially defined as a systems-behavioral family intervention and has since been expanded to reflect the influence of the cognitive approach to therapy as well.

Functional Family Therapy has been applied to youth at risk for delinquency, youth who have already been treated in inpatient facilities but continue to express problems, youth on probation, and hardcore criminals whose annual base rate of recidivism had been virtually 100 percent. The model has been well researched in its application to all these populations, with followup periods ranging from 1 to 3 years, and outcome variables such as recidivism and out-of-home placement, as well as process variables such as rates of defensiveness and equality of talk time among family members. These well-controlled studies in numerous contacts have demonstrated reductions in recidivism of 30 to 50 percent when compared with alternative treatments (Alexander & Parsons, 1973; Barton, Alexander, Waldron, Turner, & Warburton, 1985). The program also demonstrated impressive temporal generalizability (Wahler, Berland, & Coe, 1979) within families by significantly reducing subsequent delinquency in siblings by one-third to one-half, significantly better than the controls of no treatment and alternative treatments (Klein, Alexander, & Parsons, 1976). FFT has been applied to many ethnic and racial groups and to both males and females, and no ethnic, racial, or gender limitations in its applicability have been demonstrated.

How the Adolescent, the Family, and the Problem Are Viewed

Functional Family Therapy recognizes that problematic behavior is developed and maintained by both "inner" forces, which may include genetics, biology, learning, attributions, and emotions, and "outer" forces, which include interpersonal and social effects. The

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Functional family therapy. In A. S. Gurman and D. P. Kniskern (Eds.), *Handbook of family therapy*, with permission of Brunner/Mazel, 1981.

theoretical underpinnings of the model address these two aspects of behavior.

Functional Family Therapy reflects the belief that behavioral processes are circular and reciprocal and that the meaning of behavior lies in the relational context rather than in the individual. Behavior is communication and serves an interpersonal function. Interpersonal behavior is believed in general to distance one person from another person or draw one closer to the other. The function of a behavior is inferred from the relational outcome it produces. That is, if Daughter's withdrawing to her room is usually followed by Dad following her to inquire what's wrong and to soothe her, then the function of Daughter's behavior is seen as creating closeness between her and Dad. If, on the other hand, her withdrawal into her room is usually followed by Dad angrily leaving the house, then her behavior is seen as creating distance between them. The behaviors themselves are seen as processes that are purposive in nature, even if they are so automatic that little thought or attention is paid to them.

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An aspect of overriding importance in FFT is that the function of behavior is not in itself seen as inherently bad or good, healthy or unhealthy, desirable or undesirable, even if the processes or behavior that are used to attain them are problematic. All relationships require both distance and closeness in varying degrees. The interpersonal processes or behaviors represent the most presently available means to attain the needed interpersonal functions or outcomes. Certain behavioral processes may be problematic but still represent effective means of achieving distance or intimacy. The delinquent adolescent and his or her family are stuck in a pattern of such processes.

Functional Family Therapy is also predicated in part on attributional theory. People have a need to explain, predict, and control events, especially the interpersonal events that happen around them. They therefore engage in analysis of causation and economy of effort that requires that a single sufficient cause be discovered. Trait labels are often seen as sufficient explanation for behavior. Family members can "explain" one another's behaviors with trait labels like "He's just a lazy, good-for-nothing, irresponsible young criminal," or "She's a chronic liar and a thief." People do not account for or attend to all relevant information but pay most attention to that which is salient for them. The salience of information is increased if it is believed to be relevant to one's own life or directed at or specifically related to one's own self. For example, a war in a far-away country may be more important on the world scene than a man's delinquent son's behavior, but because the son's behavior is far more relevant to the man's life, it is more salient for him. If the man also believes the behavior to be his son's expression of anger toward him it will be even more salient. Arousal may increase attention to salient stimuli (Taylor & Fiske, 1978), so the arousal associated with family conflict may lead to unacceptable behavior by a family member "pulling" increased amounts of attention.

People may respond to salient stimuli with little thought (Taylor & Fiske, 1978). In this "automatic processing" (Schneider & Schiffrin, 1977) mode, information coming in through the senses may be processed quickly and lead to an interrelated set of cognitive, behavioral, and emotional responses with little attention or conscious thought. In conflicted families, individuals may be very familiar with a pattern of behavior that has taken place many times. The onset of such behavior may trigger automatic processing, complete with well-practiced thoughts, feelings, and behaviors. For example, Mom saying "John, I've told you a thousand times...." becomes a cue for a script that is extremely well rehearsed. Seen in this way, family life is an arena in which people enact behavior that produces and maintains functional outcomes of interpersonal closeness or distance.

The functional patterns of behavior are complex. The outcomes desired by people differ from relationship to relationship and the various functions of behavior are interrelated. For example, one daughter's behavior that distances her from Dad may draw Dad closer to another daughter. The outcomes desired may also change over time. When a child is young, both the child and the parents may spend a good deal of time engaged in behaviors that produce closeness; when the child enters adolescence, distancing behaviors become more common. Both are necessary and appropriate and are needed in varying mixes over time.

Spending more time with friends, arguing with Father, or saying "Mother, please, I'd rather do it myself!" may be acceptable and productive ways of achieving distancing from parents. Running away, stealing, or getting into trouble with the law are destructive means to achieving the same legitimate function or outcome. Delinquent adolescents acknowledge pessimism about their ability to negotiate directly for what they want in their families (Cheek, 1966), and FFT assumes that problem behaviors have to date been the only way to achieve some legitimate interpersonal functions.

Given this understanding of human interpersonal behavior, the FFT therapist must help the family make both cognitive changes (which are often accompanied by affective changes) and behavioral changes. The therapist helps the family members stop their mutual blaming, providing relief and a new openness to a different view. He or she must then help them find new, nonproblematic behaviors that still achieve the desired functional outcomes of their old behaviors.

How the Treatment Is Conducted

Functional Family Therapy consists of two main phases: the "therapy" phase, in which cognitive change takes place, and the "education" phase, in which behavior change occurs. These are preceded by the assessment phase and followed by the termination phase. After the two phases of treatment have been described, it will be clear why the therapist attends to certain aspects of family interaction and individual behavior in the conduct of the assessment. For that reason, the treatment phases will be discussed first, followed by discussions of the assessment and termination phases.

The Therapy Phase

As alluded to previously, family members typically enter treatment with punitive, blaming explanations for their problems. This view often interferes with the therapist's attempt to institute behavior changes. Therefore, the therapist must move the family from an individualistic focus to a nonblaming, relationship focus. The therapist must help the family members to see themselves and one another as parts of a malfunctioning system, rather than malevolent agents, and to recognize that change can benefit everyone.

In the FFT model, relabeling is a primary method of establishing these new perspectives within the family. A relabel can be described as the verbal portrayal of any "negative" family or individual behavior in a benign or benevolent light by describing the "positive" properties of the behavior and by portraying the family members as victims rather than perpetrators (Barton & Alexander, 1981). For instance, the delinquent may be portrayed as someone who is confused about his or her identity, who is struggling to be independent, and who is afraid to attempt more productive or socially acceptable behavior.

Relabels operate on at least three levels: the interactional level, the motivational level, and the systemic level. At the interactional level, the relabel may provide a benign description of

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Appropriate relabels seem to have a way of stopping people midsentence, evoking puzzled or surprised looks, and prompting them to say things like, "Hmmm, I never thought about it like that before!"

Tommy

Tommy's aunt said he had seemed angry ever since his parents' divorce. "It probably started long before, what with all the screaming and hitting." At 15, he began to steal from family members and then from local gas stations and stores. "The police would bring him home and his mom would cry and yell, but nothing seemed to get to him."

the interpersonal impact of behavior: "So, Mom, when Matt gets discouraged and throws things, you generally try to calm him down by leaving the room. Dad, where are you while all this is going on?" At the motivational level, the relabel may recast motivations in a benign or benevolent (rather than malevolent) light: "Mr. Jones, it seems from what you've said that you really care for your son and that by grounding him you are simply trying to protect him." At the systemic level, the relabel emphasizes the similarities among people or develops family "themes": "For various reasons you all seem to be crying for attention but doing it in different ways. Dad, your bid for attention is to... (and so on for each member)." "Even though you each express it in your own unique way, all of you seem to want the same thing from each other."

Clinical experience with families suggests that the power of the relabel as a therapeutic technique may lie in its apparent ability to disrupt automatic processing and force family members to engage in a more controlled form of processing, either by searching for existing response alternatives or by forming new ones. Appropriate relabels seem to have a way of stopping people midsentence, evoking puzzled or surprised looks, and prompting them to say things like, "Hmmm, I never thought about it like that before!" These responses often lead to a melting away of counterproductive affect and to the willingness to consider new alternatives. A father, for instance, might be extremely angry and frustrated with his delinquent teenage son, who is frequently truant, comes home at all hours, and was recently arrested for burglary. After hours of therapy and numerous attempts to change their perceptions of each other, the father begins to shed silent tears when the son is portrayed as a lonely, confused, hurt young man who is still grieving over his parents' recent divorce.

Since plausibility is a crucial characteristic of any effective relabel, the therapist must fit the relabels to the needs and worldviews of the family members as they have divulged them in the session. Another important characteristic of effective relabels is that they point up any benefits of symptomatic behavior. For example, delinquent behavior could be identified as a last-ditch attempt on the child's part to protect the parents' marriage by focusing attention on himself and thereby keeping the parents distracted from their own pain.

It is also necessary to bear in mind that the "truth" of a relabel is not the most important issue. The role of the therapist is not necessarily to focus on objective reality but rather to understand and operate within the phenomenological experience of the family members. The therapist must be creative and willing to attempt several relabels in the search for one that finally achieves the desired results. Even an inaccurate relabel might be serviceable, since it could disrupt automatic processing through simple confusion.

Relabeling, then, is an important aspect of the early part of the therapy, because it disrupts the automatic processing whereby the family members attribute blame and assume malevolence leading to the assumption that things can only be the way they are. Relabeling leads the family to entertain thoughts of new behavior.

The Education Phase

Behavior change is accomplished in the educational phase of intervention. Through the relabeling process, the therapist may have already begun to create adaptive change in the family. But positive relational views of their behavior may not be enough to maintain long-term change in families. They must learn to behave differently if therapeutic gains are to persist. Education allows family members to learn new behaviors that will substitute for old ones and thus prevent old maladaptive patterns from resurfacing.

The type of education a family receives depends on the functional outcomes of the family members' behavior and the relabels that the therapist has created within the family. The essence of FFT is this effort to fit the educational strategy to family members' functions and their new attributions. A change program that attempts to change behavior without regard to the family member's functions is likely to elicit resistance and fail. For example, if the function of a delinquent teenage daughter's behavior toward her father is distancing, the change techniques must respect the daughter's need for distance. That is, the change is to be induced in the behavior, not in the function of the behavior. Multiple change techniques might be employed at some point to legitimize both the intimacy and the distance functions of the father's and daughter's behaviors.

Given that functional family therapists are aware of this complicated set of "fit" issues, they are trained to use a variety of techniques that promote overt behavior change. Before applying any given technique, the therapist offers a rationale so the family members can see how it will help them. The rationale must be consistent with their goals and values.

Behavior change techniques include teaching communication skills, implementing the use of technical aids, and designing interpersonal tasks. Each is discussed briefly here and some examples are given. Education is not restricted to these techniques; there are many options. The only restriction is that any technique must be consistent with family functions.

Communication skills, including negotiation skills, facilitate the appropriate expression of family members' feelings, thoughts, ideas, desires, and needs. Successful communication or negotiation typically requires brevity, source responsibility, directness, specificity, feedback, and active listening. Thus, successful teaching of communication skills addresses all these issues.

Technical aids are props that facilitate change, including timeout procedures (Patterson, 1971), reminder cards and message centers (Alexander & Parsons, 1982), token economies (Ayllon & Azrin, 1968), recording charts (Patterson & Guillion, 1971), and contingency contracting (Stuart, 1971). Detailed descriptions of these techniques are outside the scope of this article, but many of them are familiar to professionals who work with adolescents. The therapist can conceive other creative technical aids to suit the situation. Sometimes these aids are as simple as installing an answering machine so that the family members may make contact but still respect the need for distance. By and large, these procedures are products of social learning research and are capable of producing changes in behavior when family members' functions are taken into account.

Interpersonal tasks are therapist-directed activities designed to enhance communication and family relationships. They may include practicing communication skills at home, taking a family outing, or beginning a project together. Interpersonal tasks, derived from functions, allow the therapist to create learning patterns in the family (Alexander & Parsons, 1982).

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The therapist must be able to identify the ways each family member is linked to the others and be able to identify the reliable, repetitive sequences or processes that represent ritual-like behavior.

As stated earlier, the functional family therapist must carefully assess the family before proceeding into the therapy enterprise, and the process by which this is done can be understood in light of the basic understanding of the interventions used in the treatment model. With that understanding now established, the essentials of functional family therapy assessment are presented below.

The Assessment That Precedes the Therapy

Simply stated, the functional family therapist must determine both the amount and kind of information contained in the family that will allow him or her to assign meaning to behavior. He or she must understand how the behavior change of an individual must be created and maintained while embedded within the powerful processes of family relationships, and how behavior and other changes will consistently meet each family member's outcomes or functions. The therapist questions the family about behavioral sequences and about who agrees with whom cognitively or emotionally, who's left out of interactions, who initiates with whom, who is the "peacemaker," and so on. He or she pays attention to the similarities and differences in meaning attributed to behaviors and presumed motives. The therapist must be able to identify the ways each family member is linked to the others and be able to identify the reliable, repetitive sequences or processes that represent ritual-like behavior.

Next, the therapist must come to understand the functional rewards of the behavioral sequences. It must be remembered that the behavior of any one family member may serve different relational functions between two other members. A full description of the exploration and the therapist's thinking process in this effort is outside the scope of this article, but, ultimately, the therapist must identify the inherently complex array of functions served through ongoing family processes and determine which functions maintain each family member's behaviors.

Finally, the therapist assesses individual characteristics of family members to identify how each might serve to initiate or constrain change. For example, if contingency contracting has been planned to accomplish necessary change, the functional family therapist will see a disengaged, distant father as a poorer choice to monitor the contract than a doting mother. The therapist must take into consideration the individual characteristics of each family member and maintain respect for the functions of their behaviors.

Because of the complexity of family processes, the therapist is encouraged to plan before the first session how to garner the necessary assessment data. Therapists are cautioned against omissions that occur when the family's behavioral process is assessed before every family member is involved. This makes it impossible to identify functions for each member. Therapists are urged to consider their assessments after each session to determine which assessment information seems consistent with previous hypotheses, which does not, and what is missing. Given the conceptual bases of the model, the therapist cannot really proceed into the therapy until the assessment is complete. Once the assessment is complete and the therapy has been conducted as described above, the therapist helps the family prepare for termination.

Making It On Their Own: The Termination Phase

Most families are willing to terminate therapy when their pain is replaced with hope and when they are experiencing productive new interactions. However, the therapist must ensure that the changed behavior can endure in the face of inevitable future challenges. Therefore, during the termination phase, the therapist helps the family anticipate problems and formulate solutions. Often, the therapist uses cognitive rehearsal and role play, that is, anticipating a likely problem and rehearsing the handling of it. He or she must also recognize

the need to help the family handle outside agents such as school or legal authorities, who may not recognize and appreciate the changes the family has made. For example, after an adolescent who had been labeled a troublemaker at school had adopted a new attitude, the therapist anticipated that school authorities would still be punitive for the least little infraction. Because the boy's parents were both rather intimidated by authority figures, the therapist helped them prepare for possible interviews with the school principal using cognitive rehearsal and role play. The therapist may also help the family imagine a worst case scenario and plan for handling that. All these approaches force the family to exercise its ability to respond to challenges and help it to gain confidence.

Functional Family Therapy In the Treatment of Alcohol and Other Drug Abuse

Across treatment populations that have received FFT, the percentage of alcohol and other drug users/abusers has ranged from roughly two-thirds to virtually 100 percent. As a result, FFT intervention with acting-out youth is almost always an alcohol and other drug use/abuse program. However, with some populations (e.g., at-risk youth), problems with drugs can be treated as merely a concomitant of the larger family systems issues. With other heavily abusing populations, an additional direct intervention (e.g., detoxification, structured inpatient program) must at times be added to the FFT component. For example, in the major "hard-core delinquency"study (Barton, Alexander, Waldron, Turner, & Warburton, 1985), prior to receiving FFT all of the youth (most of whom were heavily involved in drugs) had been institutionalized — and, in fact, had begun their treatment in maximum security. Thus, in this context, FFT is best utilized as a reentry transition program that, compared with institutionalized youth who reentered through different programs, reduced recidivism by 33 percent at the 16-month followup period (Barton, et al., 1985).

Training the Functional Family Therapist

The Functional Family Therapy model has been used in numerous training contexts. These have included academic professional programs, such as schools of social work and university departments of family therapy and clinical psychology, and staff trainings for child care workers, social services workers, child protective services workers, probation officers, and rehabilitation counselors. The most effective training format consists of 25 hours of didactic training, including numerous handouts, videotaped demonstrations, and lecture materials, interspersed with applied activities such as role-playing.

Following the didactic phase, trainees usually enter into a phase of carefully supervised intervention with their first two or three families. If possible, supervision is direct (e.g, via one-way mirrors). If budgetary or other practical constraints prohibit this, peer supervision is helpful. Following the intensive supervision stage, experience has shown that established professionals need only occasional supervision to solve problems with respect to particular families and to get feedback regarding therapist stylistic issues.

Summary

The Functional Family Therapy Model is an approach that integrates the systems, behavioral, and cognitive perspectives into a coherent framework for assessing families and helping them change. The interpersonal function of behaviors, that is, whether behavior tends to create distance or create intimacy, is believed to be of prime importance, and the functional family therapist attempts to understand and respect each family member's functions when interventions are being planned. The therapist explores the worldviews of the family members, their beliefs and values, the motivations they attribute to one another, the repetitive sequences of problematic behavior, and the interpersonal functions of

Most families are willing to terminate therapy when their pain is replaced with hope and when they are experiencing productive new interactions. In the termination phase of the model, the therapist helps the family plan for meeting the expected challenges to their new behaviors.

their behaviors. Then, in the "therapy" phase of the model, he or she uses relabeling consistent with the family members' values to reduce blaming and to open their minds to the model, possibility of new behaviors. In the "education" phase of the the therapist applies interventions that teach the family members new behaviors that accomplish their functions without the problems associated with their old behaviors. Finally, in the termination phase of the model, the therapist helps the family plan for meeting the expected challenges to its new behaviors.

This model of family therapy has been well researched and proved effective in helping delinquent adolescents. This treatment model allows the family members to achieve a shift in their views of one another, helps the adolescent to change the delinquent behavior, and assists the family members in changing behaviors that have helped to maintain that delinquent behavior. Families that present in great pain can thus achieve stable change through Functional Family Therapy.

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A Psychoeducational Model for Treating the Adolescent Who Is Seriously Emotionally Disturbed[1]

Carol M. Anderson, M.S.W., Ph.D. and Douglas J. Reiss, Ph.D.

Schizophrenia, one of the most serious and chronic mental illnesses, is likely to begin in adolescence. Whether its onset is insidious or arrives as a bolt from the blue, its impact is always catastrophic. Young and seemingly healthy individuals begin to perceive the world differently and to behave in inexplicable ways that confuse and frighten the family members who love them. Every aspect of individual and family functioning is affected, in most cases permanently. While approximately 20 percent of those having a first episode never have another, 80 percent begin to experience a series of recurrent acute and chronic symptoms that will last well into middle age—symptoms that will impair their ability to work, socialize, marry, and lead normal lives.

Not surprisingly, this illness has long held the interest and attention of professionals in the mental health field. A variety of treatments, individual and family, biological and psychological, inpatient and outpatient, have been employed in attempts to eliminate the disorder or reverse its downhill course. In recent years the use of psychotropic medications has made it possible to mitigate, at least much of the time, some kinds of symptoms, such as voices and visions, permitting many patients to spend more time in the community. Even patients who respond well to medication, however, continue to have other symptoms, such as lethargy, disinterest, excessive sleep, and amotivation, which tend to persist with a devastating impact over time. Despite the best efforts of generations of clinicians and researchers, no cure has been found.

Coping with these problems has been complicated for patients and families by the major changes that have occurred in the way mental health care is delivered to those who are severely disturbed. Much-needed policies and procedures supporting deinstitutionalization have also caused minimally functional patients to be returned to the community after very brief hospitalizations. Many of these patients do not cooperate with plans for aftercare treatment and fail to attend at all or drop out after only a few visits. Consequently, families have become the long-term primary care agents for very disturbed patients with little professional support. What the family does in this process has a documented impact on the course of the disorder. British studies of the "expressed emotion" of families have demonstrated that measures of high expressed emotion in family members correlate with high relapse rates for patients (Brown & Birley, 1968; Brown, Birley, & Wing, 1972; Vaughn & Leff, 1976; Leff & Vaughn, 1980). It has become important, therefore, to develop treatment programs that help families to cope with stress and perform this caretaking role, programs that are not dependent solely upon the motivation of patients.

A family psychoeducational model was developed in Pittsburgh as a part of a larger research project that attempted to investigate the impact of various strategies of intervention for patients with schizophrenia. The larger research design randomly assigned schizophrenic patients with "high expressed emotion" families to one of four treatment cells

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This model assumes that schizophrenia is a disorder of unknown, but probably biological, origin. Rather than assuming the family plays a role in the etiology of the problem, the model assumes the nonblaming stance that a vulnerable individual may find the normal inevitable stresses of family life (or work or school for that matter) difficult, if not impossible, to negotiate.

(all of which included medication): family therapy, social skills training, family therapy and social skills training, and medication alone. Patients and their families were followed in these treatment modalities for 2 years with various measures of individual and family functioning taken at periodic intervals.

The results of this research demonstrate that our model of family psychoeducation (Anderson, Hogarty, & Reiss, 1980; Anderson, Reiss, & Hogarty, 1986) alters the course of the illness (Hogarty, et al., 1986, in press). Those patients receiving only medication experienced a 1-year relapse rate of nearly 40 percent, while those receiving the family psychoeducation or the social skills treatment each experienced a relapse rate of approximately 20 percent. None of those patients receiving the family psychoeducation *and* social skills training relapsed during the first year. After 2 years, the family psychoeducation group continued to demonstrate a persistent and significant positive effect on relapse rates, while the impact of the social skills intervention diminished (Hogarty, et al., 1986, in press).

While this model was developed for schizophrenic patients of all ages, it is, of course, relevant for psychotic adolescents and their families. The use of such interventions early in the course of the disorder may well help to minimize its impact on patients and families over time, preventing the secondary negative effects of chronic institutionalization or community alienation. Furthermore, the structure of the model can be used to develop similar interventions for those experiencing other serious mental and physical disorders. In fact, beginning attempts have been made to apply the method to affective disorders, alcohol and other drug abuse, attention deficit disorders, and various chronic physical disorders occurring in children and adults such as diabetes, asthma, and cancer.

The psychoeducational model differs from other family treatment models in a number of important ways. It is based on different assumptions about the causes of the problem, different views about the need to collaborate with medical and rehabilitational treatments, and a different concept of the role of therapists and their relationships with patients and families. It involves a relatively long-term treatment contract but employs a series of interventions that are not particularly labor intensive.

Assumptions

Specifically, this model assumes that schizophrenia is a disorder of unknown, but probably biological, origin. It is assumed that whatever the "cause" of schizophrenia, patients with schizophrenia appear to have a "core psychological deficit," which appears to increase their vulnerability to internal and external stimuli (Broen & Storms, 1966; Lang & Buss, 1965; Payne, Mattussek, & George, 1959; Rabin, Doneson, & Jentons, 1979; Shakow, 1962; Silverman, 1972; Tecce & Cole, 1976; Venables, 1964; 1978). Rather than assuming the family plays a role in the etiology of the problem, the model assumes the nonblaming stance that a vulnerable individual may find the normal inevitable stresses of family life (or work or school for that matter) difficult, if not impossible, to negotiate.

Furthermore, when patients have become acutely psychotic, their families usually report feelings of anxiety, guilt, anger, and sadness (Kreisman & Joy, 1974; Hatfield, 1978). The model assumes these emotions are likely to increase the intensity of family life and, since the illness is a chronic one, this intensity is likely to increase over time as family members are unable to find ways to help the patient. It might be hypothesized that family members in such chronic crises would come to respond to patients in one of the two ways Brown describes as components of high expressed emotion: (1) becoming overinvolved and attempting to constantly monitor and protect

patients from themselves or the environment, or (2) becoming frustrated, angry, rejecting, and withdrawn from patients and treatment systems. Either of these emotional responses would appear to both decrease family ability to cope with patient behaviors and be problematic to a patient who is vulnerable to intense stimuli. In summary, these two forces—the patient's vulnerability and the natural turmoil of families—probably interact to the patient's disadvantage in a spiraling manner: the patient's vulnerability to stimuli causing symptoms that upset family members, who in turn upset the patient and so on.

The Treatment Model

Because of this relationship between patient vulnerability and family anxiety or behaviors, a program of patient and family intervention has been designed to accomplish two goals. The first is to decrease the patient's vulnerability to stimuli through a program of maintenance chemotherapy; the second is to decrease the intensity of the family environment by providing the family with support, information, structure, and specific coping mechanisms for dealing with a psychotic family member. A highly structured and directive approach was designed to increase the predictability and stability of the family environment. An educational component was included to increase family knowledge about the illness and confidence in coping with it, thus decreasing family anxiety about the patient and improving the family's ability to react helpfully. The program has five basic overlapping phases, separated here for the sake of clarity. Since the entire program is discussed in more detail elsewhere (Anderson, Hogarty, & Reiss, 1980; Anderson, Reiss, & Hogarty, 1986), only the major points are stressed here.

Phase I—Connecting With the Family

Based on the assumption that no intervention can succeed unless the family can accept it or use it constructively, the first phase of treatment, which emphasizes the establishment of a collaborative alliance with the family, is designed to begin during an acute psychotic episode, usually immediately after the patient's admission to a hospital. Since many families are likely to have had unsuccessful contacts with other hospitals and professionals, special attention is given to the creation of an atmosphere that builds trust and increases the family's receptivity to treatment interventions. Phase I interventions first involve joining with the family members by eliciting reactions to the patient's illness and to past attempts to cope with it, as well as by listening to the perceptions of family members of their own current needs and problems. Hopefully, these discussions communicate to families that clinicians care about what they have been through, are not critical of how they have attempted to cope with patients, and genuinely want to know their ideas and views about what is helpful.

Once the family has begun to form a relationship with the therapist, he or she is established as the family's ombudsman or representative in the health care system. Since staff members of inpatient facilities are primarily involved with the patient on a daily basis, it is easy for them to neglect families or to fail to see family perspectives and needs. The creation of a family representative serves to balance this skewed perspective and to prevent the alienation of families from the treatment team. Thus, the family clinician becomes an ombudsman to keep the family informed of decisions about the patient, ensure the input of family concerns and needs into treatment planning, and provide the family with structure and concrete help in coping with the illness and the hospitalization. In this way, the clinician also begins to mobilize the concern of family members into constructive attempts to help themselves and the patient. By the end of a hospitalization (which in today's health care climate is usually less than 3 to 4 weeks), the family, patient, and therapist arrive at a treatment contract that roughly specifies the

A highly structured and directive approach was designed to increase the predictability and stability of the family environment. An educational component was included to increase family knowledge about the illness and confidence in coping with it.

goals, content, length, rules, and methods of ongoing treatment. This program then should continue for as long as is necessary, a minimum of 1 to 2 years after the patient is first discharged from the hospital.

Mark

"We were really frightened when all this began," says the father of 18-year-old Mark. "He never seemed really close with us, but suddenly he totally withdrew and started to talk to voices that weren't there....Sometimes we were angry and other times we just felt helpless."

Phase II—The Survival Skills Workshop

The survival skills workshop seeks to provide families with as much information as possible about the nature of schizophrenia and how to manage it most effectively. It is a day-long event attended by all the members of four or five families new to the program. It is designed as a multiple-family enterprise in order simultaneously to promote interactions with other families, to decrease stigma and sensitivity about the subject of mental illness, and to begin to develop a natural support network. Every attempt is made to encourage an informal atmosphere in which families can both question professionals and interact with one another. The workshop is held as early in the treatment process as possible because it also serves to establish the basic themes of the entire family program. The workshop focuses on two categories of information.

- *Information About the Illness*: The most recent data about the phenomenology, onset, treatment, course, and outcome of schizophrenic disorders is presented in clear, understandable language. Theories of etiology, ranging from genetic and biochemical to family and cultural, are explained. What is known about the prognosis of the illness is also outlined, as are various methods of treatment: psychotherapy, pharmacology, megavitamins, and hemodialysis. Every attempt is made to discriminate among facts, theories, and opinions about each of these issues. Because medication maintenance is viewed as a crucial component of the program, the importance of antipsychotic medication is given special attention. Mechanisms of action of the medication, possible negative side effects, and the use of anti-Parkinsonian agents are explained. Statistics about the risk of relapse on and off medication are shared. In particular, the critical importance of family support for, and feedback about, the medication program is stressed.

- *Information About Management of the Illness*: Following the presentation of general facts and theories, families are introduced to a series of techniques for managing various difficult behaviors and situations. Families are told that although there is no evidence that families cause schizophrenia, there is reason to believe that families have the power to influence the course of the illness. They are helped to see the need to create barriers to overstimulation of the patient by establishing firm, clear, and appropriate boundaries. Families are encouraged to set limits on unacceptable behaviors, while allowing patients to set their own pace in moving toward recovery. This theme is translated into specific suggestions for responding to the patient's fears, delusions, paranoid thoughts, obsessive rituals, or threats of violence. Finally, families are strongly encouraged to avoid centering their lives around the member who is a patient. They are asked to attend to their own needs and to the needs of other family members and to mobilize a social support network to maintain their own ability to cope and survive over time.

Phase III — Reentry Into Community and Application of Workshop Themes

Highly structured, low-key individual family sessions are held as soon as the acute phase of the illness has been controlled sufficiently to enable the patient to attend. Once patients have left the hospital, these sessions occur once every 2 to 3 weeks. The interventions of these sessions are based on the themes established in the survival skills workshop and relate largely to the reinforcement of family boundaries and the gradual resumption of responsibility by the patient.

Three types of boundaries are stressed throughout: the interpersonal boundaries between family members, the generational boundaries between parents and offspring, and the boundary between the family and the larger social community support system. The first two types of boundaries are reinforced, largely by encouraging families to establish clear expectations, rules, and limits. However, an attempt is made to diffuse the third type of boundary, between the family and the community, by stressing the family's need for the development of a support system beyond the nuclear family.

Over time, patients are gradually encouraged to assume more responsibility for their lives and functioning. This is initially accomplished by the assignment of small household tasks or tasks that involve a minimal amount of socialization with outsiders. Later, more ambitious tasks are assigned and families are encouraged to increase their expectations of patients. Since progress on these issues is exceedingly slow, a great deal of support is given to family members to enable them to tolerate patient inactivity, amotivation, and apathy.

Phase IV — Work and Social Rehabilitation

Initially, the entire treatment focus is on helping the patient to survive outside the hospital. As patients begin to show signs of increased ability to function, the sessions gradually begin to emphasize a return to effective work and social functioning. Tasks are extended to involve highly structured social contacts, volunteer work, rehabilitation programs, and paid employment in a series of supported, graduated steps. A rule of "one change at a time" is stressed to avoid overwhelming the patient. The pace continues to be slow, requiring a great deal of patience on the part of the patient, the family, *and* the therapist. When patients appear to have reached their maximum level of functioning, the therapist begins to discuss Phase V.

Phase V — Maintenance or Disengagement

Once the goals for effective functioning have been attained (and these goals differ depending on the patient's abilities, the length of impairment, and the tolerance level of families), this treatment model originally called for the family to be offered two possible options: (1) traditional family-oriented treatment to resolve long-term family conflicts or unfinished business, or (2) periodic supportive maintenance sessions of gradually decreasing frequency leading to termination.

This design was created because the first three phases of this model of family intervention did not offer families the opportunity to deal with family issues and problems that did not immediately relate to the patient's survival in the community. In fact, the first three phases of the model specifically discourage the discussion of upsetting topics, such as marital discord, unresolved losses, or major moves toward emancipation. Nevertheless, some of these issues could interfere with the ongoing growth and development of family members, and it was believed that, once the crisis had passed, family members could be offered the opportunity to devote their energies to resolving them. However, since patient and family agreement to work on specific patient problems does not give the therapist the right to determine the family's general goals or methods of attaining them, families were to be given the option of

A rule of "one change at a time" is stressed to avoid overwhelming the patient. The pace continues to be slow, requiring a great deal of patience on the part of the patient, the family, and the therapist.

The important components of the program include the establishment of a collaborative relationship between therapist and family, the provision of information and support, and the creation of highly structured predictable environments in the treatment setting and in the home.

terminating treatment when things had stabilized. Actually, most patients and families did not appear to be particularly interested in working on general family issues that did not directly relate to their immediate survival, but neither were they particularly interested in terminating contact. What appeared to work best is the scheduling of sessions at ever-increasing intervals without a formal termination. Even those patients and families who used the program as needed—less than once in 6 months—preferred to have the "lifeline" available in case it might be needed.

Training Therapists To Apply This Model

In order to minimize crises and maximize functioning, while using very little clinician time and relatively limited resources, therapists must know up-to-date information about mental illness and its impact on individual and family functioning. They must also be aware of and sensitive to the issues and problems of families of the mentally ill and be knowledgeable about practical strategies for managing difficult behaviors. Knowledge about psychotropic medications and their effects is also essential. Each of these training components requires exposure to particular experiences and knowledge not often found in basic family therapy training programs.

This is, above all, a collaborative model. Collaboration with psychiatrists—along with frequent and updated literature reviews—is useful in learning about recent research findings that could be relevant and of interest to patients and families. Collaboration with family self-help and advocacy groups is useful in learning about the impact of the illness on family life and about the mistakes more traditional therapists make that alienate this population.

Several good models have been established for providing relevant education for professionals (Cohen & Terkelsen, 1990; Wasow, 1990). It is our belief that professionals require this kind of education in order to work effectively with adolescents with schizophrenia and their families. Certification procedures should be established to ensure proper training and adequate credentials for those who work with this population.

Discussion

This program for families of patients with schizophrenia appears to be effective in maintaining patients in their communities, avoiding the need for psychiatric hospitalization. The important components of the program include the establishment of a collaborative relationship between therapist and family, the provision of information and support, and the creation of highly structured predictable environments in the treatment setting and in the home.

These components are present in similar projects that have produced similar results (see Goldstein, 1981, for a review of several family-oriented projects). Although the programs and the results differ in small ways, all of these treatment experiences seem to have resulted in greater numbers of patient members who were well at followup, and more relatives who moved from high to low expressed emotion over the course of treatment.

It remains unclear, however, exactly why these programs are more effective than other programs that have been attempted in the past. Although the common element of these projects is some sort of education for families, it seems unlikely that information itself causes sufficient family change to prevent patient relapse. The personal reports of families in our program would seem to indicate that most do not recall the specifics of what they were taught, so much as they recall learning that they were not to blame, that the patient was not malingering, and that there was hope for a better life in the future. It may also be that a

more equal and collaborative relationship with professionals made a more supportive and less intense family environment possible.

Summary

This article has presented an outline of the family-centered, psychoeducational model of treatment for the schizophrenic adolescent and his or her family. In this model, a good deal of time and attention is focused on teaching the patient and family members about schizophrenia and about the social skills they will need to deal with it effectively. It is important to recognize that while families regard receiving information as important, they also stress the importance of a lifeline—some sort of ongoing support—to sustain them during the long process of the patient's gradual reintegration into community life. In the end, schizophrenia is a chronic illness that inflicts chronic pain on patients and families. Psychoeducational programs have no miracles to offer, but they do provide ongoing possibilities for keeping crises at a minimum and patients functioning at the highest level possible.

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Part III:
Transforming the Larger System

How can an entire service system adopt a family-centered approach and incorporate treatment programs and models like those described above? How can the existing service system train its personnel and adapt to the changes required to implement a family focus? How does the current system for financing adolescent treatment help and hinder the establishment of family-centered services? These and other issues in the organization and environment of service provision are explored in Part III.

Many State and local governments have undertaken efforts to implement family-centered programs on various scales. In some cases, family therapists are involved as consultants, administrators, or project leaders. In other cases, family therapists are involved in the training and clinical work only. The change to a family orientation sometimes happens from the top down, sometimes from the bottom up, and sometimes the inspiration comes from both directions at once. Change comes bit by bit in some places and by quantum leaps in others.

Families themselves can be an invaluable asset in planning the systemwide changes discussed here. Part III presents discussions by Glenda Fine and Sue Rusche about the parents' movement in child and adolescent mental health treatment and drug abuse prevention. These discussions will help the reader conceptualize how parents can be partners not only in the treatment of their own children, but in planning for improved treatment services in general.

Patrick McCarthy and Peter Luongo discuss the innovative efforts of their respective State and local agencies in striving to coordinate services to adolescents and to implement a family perspective in those services. The efforts toward organizational change presented here were chosen because they represent planned, fully conceptualized, systemwide change in which family therapists were instrumental in planning and designing programs and services and providing training and clinical consultation. In a related discussion, Frances Lynch examines the state of financing for adolescent drug abuse and mental health treatment and the implications for further development of a family focus in services.

Finally, Marian Lindblad-Goldberg examines the issues in securing training services for the agency or program that wants to implement a family-centered approach. She explains what the agency or program must consider in preparation, how to seek training services, and how to select the most appropriate and qualified training consultant.

Parents as a Resource in the Fight Against Adolescent Abuse of Alcohol and Other Drugs: "Treating" the Community

Sue Rusche

Ms. Rusche is the executive director of National Families in Action.

Grassroots parent volunteer groups and organizations have been fighting the war on drugs in communities all across America. They have urged public officials and treatment professionals to think more broadly about how to reduce adolescent abuse of alcohol and other drugs. It is clearly not sufficient to punish the drug pushers and interdict supplies. And it is also not sufficient to provide more dollars to existing treatment bureaucracies. The entire community surrounding young people must be targeted because the community is the source of powerful environmental, peer, and social pressures to drink alcohol and use drugs. An investment must be made in State and local community-based intervention strategies to prevent initiation of drug use by teenagers and to reduce incentives to relapse for those youngsters who have been treated for a drug problem. Effective and reliable treatment of adolescents who are abusing alcohol and other drugs requires a change in the context that promoted the initiation of drug use and supported and sustained continued use.

The parent movement strongly supports the family orientation to treatment that is the focus of this monograph. Parents can be a resource to treatment and must be involved in helping their youngster to stop using drugs. But parents must be involved in an additional way; they can and must be active in the treatment of the social and community context that all too often creates and sustains teen drug use. Parents, when banded together collectively, are the best resource for helping teenagers avoid alcohol and drugs. Fewer teenagers using drugs may mean a decrease in the social acceptability of drug use and diminished social and peer pressure to use. Thus, parents can be a resource not only in the treatment of an individual child who has been abusing substances, but in the "treatment" of the community that fosters drug use among young people in general.

This article focuses on the goals, history, activities, and achievements of the parent movement in drug abuse prevention and recommends a nationwide strategy—the creation of a National Drug Corps—for building on its success to reach into every community in America, including, most important, our inner cities. (Rusche, 1990).

Everyone is familiar with the surge in illegal drug use among all ages in the population that occurred in the late sixties and seventies. In 1962, less than 2 percent of the nation's population had had any experience with any illicit drug (NIDA, 1977). As this pattern changed, alcohol, cigarettes, and marijuana served as a special gateway into the burgeoning drug culture (Du Pont, 1984). By 1978, one-third of all teenagers (NIDA, 1979) and two-thirds of all high school seniors had tried marijuana; one in nine smoked it daily (NIDA, 1989). But marijuana use among teenagers peaked in 1978-79 and began a steady decline thereafter. Adolescents' use of other drugs began a similar leveling off and decline soon after. Government officials generally credit the parent movement with stopping that trend cold and turning it around.

Currently, there is both good news and bad news on the adolescent drug abuse front. The good news is that high school seniors' cocaine use has dropped, and daily marijuana use has

fallen to 3.3 percent. However, the bad news is that more than 5 percent of high school seniors are serious drug abusers, in that they report use of one or more illicit drugs on a daily basis. Rates of serious alcohol use—bouts of heavy drinking—remain very high, at epidemic levels on some high school and college campuses (Ooms & Herendeen, 1989; Rusche, 1990; National Families in Action, 1990). And for too many youth at risk—most of them school dropouts who are often inner-city, low-income minorities—or members of alcoholic families, including many Native Americans—serious drug use is higher than ever. In addition, there is a new scourge: crack. The easy availability of crack is destroying individuals and devastating family life in many communities.

The central premises and goals of the parent movement are as follows: Information and education about drugs can change behavior and successfully prevent illegal drug use. Young people can be taught to know right from wrong and to obey laws.

In the midst of concern about these troubling patterns, the parent movement emerged. The movement, which has relied almost totally on volunteer activity, has grown and flourished primarily in middl- and high-income suburban communities, where its success is clear. It has tremendous potential in the low-income and inner-city communities and on the Native American reservations; but apart from a few demonstration efforts, this promise will not be realized without the investment of substantial resources.

Goals of the Parent Movement

The central premises and goals of the parent movement are as follows:

- The parent movement's goal is to prevent all use of illegal drugs, which now includes alcohol for youth under 21 years in all 50 States and the District of Columbia, and also includes tobacco for those under the age of 17 or 18 in a majority of States. As dreadful as the current illegal drug use is, the Nation's two legal (for adults) drugs, alcohol and tobacco, kill far more people than all illegal drugs combined. According to the National Institute on Drug Abuse, alcohol alone is the leading cause of death among young people ages 15-24.

- Information and education about drugs can change behavior and successfully prevent illegal drug use. Parent groups first set out to educate their children against becoming involved with drugs by telling them about the harmful effects of these drugs. They soon realized they needed to educate entire communities—other parents, community leaders, legislators, and law enforcement officials.

- Young people can be taught to know right from wrong and to obey laws. They need to experience the consequences of engaging in illegal behavior.

- The parent movement opposes organized attempts, which have been popular among school and other Government agencies, to focus on promoting "responsible" use. For example, it opposes certain aspects of the Students Against Drunk Driving (SADD) movement which, in focusing only on stopping drunk driving, may give teenagers under the legal drinking age the message that it is OK to drink as long as they don't drink and drive. It is important to note that SADD's board of directors is made up primarily of representatives of the alcohol industry, which has traditionally provided major funding for the organization. SADD is just one example of the efforts of the alcohol industry to educate children. Sadly, the alcohol industry's public education effort, including curricula it designs for school-children, fails to distinguish between underage and legal drinkers and promotes responsible consumption to an age group that is not only too young to consume the industry's product legally but is suffering an excessive amount of premature and unnecessary death as a result.[1] (Little known

[1]Two recent events indicate this may be beginning to change. SADD's founder, Bob Anastas, recently announced

is the fact that many alcohol-related deaths among youth are not caused by motor vehicle accidents. They are caused by alcohol overdose, falls or other accidents, and drownings while under the influence.)

Parent Organization Activities

With these premises and goals in mind, parent groups have formed in local communities to engage in a variety of activities:

- They have promoted public education activities targeted to youth themselves, their parents, and members of the public at large. These activities provide information about the harmful effects of drug use, how to recognize drug use, the legal risks, liabilities and consequences of drug use, and the ways parents and other adults facilitate drug use by minors. They have developed pledges for parents and their children to sign saying they will not permit alcohol or drugs at parties given in their homes.

- Parents have worked with employers to provide information and education about drug abuse to parents in their workplace—where it is often easier to reach them than in their neighborhoods—and to help employers create a "drug-free" environment at the workplace.

- Parent groups have organized successfully to educate local public officials about drug use and the pernicious spread of "head shops," which serve as drug learning centers for children. They have urged legislators to pass laws to ban these paraphernalia shops.

- Parents have organized to put pressure on school officials and law enforcement officers to enforce laws, and have assured them that parents will support them, rather than attack them, for their efforts. Many parents have established Neighborhood Watch Programs to assist police in apprehending drug dealers.

- Parent prevention leaders have stopped further efforts to decriminalize marijuana. Between 1972-78, 11 States decriminalized marijuana; no State has decriminalized since then, and some are actually "recriminalizing" the drug.

- Parent prevention groups have lobbied for thousands of other local, State, and Federal laws as well, including laws to raise the drinking age to 21, to revoke young people's driver's licenses if they are convicted of a drug or alcohol offense, to increase funding for prevention and treatment of chemical dependency, and so forth.

Organization and Role of State Parent Group Networks

The first parent groups to form usually did so in capitals of States where they could influence legislators, work to ban drug paraphernalia sales, and lobby for other legislation. The publicity given to their activities led to the creation of networking services to concerned parents and community leaders throughout the State. These State networks are the heart of the American prevention movement and constitute the vitality of the movement (Sledge, 1990). Examples of these networks are the Texans War on Drugs, Tennessee Families in Action, Florida Informed Parents, Drug Resource and Education Alliance of Mississippi, the New Jersey Federation for Drug-Free Youth,

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that his organization had placed "a moratorium"on accepting any more funding from Anheuser-Busch. SADD also somewhat changed its Contract for Life, although the clarity parents are seeking is not yet there.

Anheuser-Busch now offers a parents' guide that is accompanied by a letter from August A. Busch III in which he states that the people in his company "strongly oppose illegal drinking by minors." If the brewery follows up that statement with marketing and advertising policies that reinforce rather than contradict it, progress will truly have been made.

Michigan Communities in Action for Drug-Free Youth, and Illinois Drug Education Alliance.

Many of these parent organizations have created youth drug prevention organizations and work in close collaboration with them. These youth groups have been formed in communities and some have spread state- and nationwide to target their peers and work towards similar goals as the parent groups. Among the best known of these are Youth to Youth in Ohio, Rocky Mountain Youth Who Care in Colorado and Utah, Texas Youth in Action, and Drug-Free Youth in California.

The unique feature of both the parent and youth prevention movement organizations is their almost total reliance on volunteer activity and donated resources. Some of the groups have received very modest funding from private foundations and other sources. Only the Texas group received any stable funding—a combination of State funding and a generous grant from H. Ross Perot.

The State parents' networks provide training and technical assistance to help parents form new groups, conduct annual conferences or other meetings, publish statewide newsletters, encourage coalition building, monitor legislation, and lobby for legislative reform or new laws.

At the local level, parent drug prevention organizations also lobby the legislatures. In addition, they are involved in programs to help parents learn skills to use in their own homes to prevent drug abuse and in the referral of individuals to local resources for support, counseling, and treatment.

At the national level, National Families in Action, the Parents' Resource Institute for Drug Education (PRIDE), and the National Federation of Parents for Drug-Free Youth play a significant role in helping local groups form, linking State groups together, and doing some advocacy work at the Federal level. National Families in Action is taking a leadership role in spreading the parent movement to inner cities.

National Families in Action (NFA) was founded in 1977 in Atlanta, Georgia. It operates the National Drug Information Center, which currently houses some 500,000 documents on drug abuse. The center operates an information clearinghouse, provides advice about forming new parent groups, and issues a number of publications, including the *Drug Abuse Update*, a quarterly 24-page digest of information about data, research, programs, books, films, and pamphlets. The *Update* also describes the work of three Federal agencies—the Office for Substance Abuse Prevention, the Federal volunteer agency ACTION, and the National Institute of Drug Abuse.

National Families in Action is currently working to establish the parent movement in inner cities by adapting the current models to the needs of low-income, inner-city communities. In 1990, it received a 5-year grant from OSAP to help start a grassroots campaign of families living in public housing to organize drug prevention groups to address the devastation that crack has brought to the inner city. NFA has helped residents of Bankhead Courts, an Atlanta public housing community, to form such a group. Through a community survey, the group identified a number of serious problems that were linked with crack use: unemployment and hunger; parents needing drug treatment; lack of youth activities; and failure to identify and mobilize housing tenants' skills, talents, and resources. This new organization plans to find ways to address these various problems that indirectly cause or help sustain the problem of drug abuse.

The Role of High-Risk Youth and Their Families

Some youth are at much higher risk of alcohol and other drug abuse than others, and

ironically both prevention activities and treatment resources for them are usually non-existent or in extremely short supply. In fact, for youngsters who use or deal drugs, the primary contact with programs is through the law enforcement system. Minority youth who live in drug-infested communities and Native American youth who live on reservations with extremely high levels of alcoholism are especially at high risk. In these communities, drug use—especially crack use—is only one of a number of interrelated problems associated with poverty, high rates of single-parent households, unemployment, housing decay, and lack of recreation programs. Prevention and treatment strategies developed to serve middle- and high-income communities—"Just say No" campaigns, for example—are not effective for youth with so many strikes against them and so few opportunities for recreation, jobs, or other productive activities. There have been no Federal efforts on a national scale to develop these activities specifically for inner-city, minority youth. The U. S. Congress has mandated OSAP to fund demonstration grants focusing on high-risk youth, but there has been no attempt as yet to replicate the programs more widely. An unplanned but very positive byproduct of the OSAP projects was the formation of the National Network for High-Risk Youth by the concerned and knowledgeable people who came together. The organization focuses on programs for minority communities.

Few stable parent groups or organizations have emerged in these inner-city neighborhoods to fight the war against drugs. While it is often believed that minority, inner-city parents do not care or want to be involved in drug abuse prevention or in drug treatment programs, this is patently untrue. However, a successful parent volunteer organization depends on having a few leaders and activists being able to provide a great deal of time to the organization. Only in the suburbs do such parents, nearly always mothers, have the time and resources to devote to full-time volunteer activity. (Although with the increasing numbers of mothers getting paid employment, the supply of volunteers is becoming scarcer in the suburbs as well.)

The parent movement will not spread to these neighborhoods or other low-income communities unless they receive the financial support required to sustain the kind of full-time effort it takes to plan, train, coordinate, and spread the prevention effort in these communities. Only with such support will real change happen at the local level, block by block, family by family, where it counts. The wisdom of parents and children to stop drug abuse must be respected and enlisted in the effort to stop drug abuse.

The Reagan administration built much of its antidrug strategy on the achievements of the parent movement, with which Nancy Reagan was strongly identified, but it is not widely known that the Federal Government provided no money to fund parent organizations directly. The new infusion of Federal dollars provided by the Anti-Drug Abuse Acts of 1986 and 1988 continues to fund the treatment and education bureaucracies, mostly headed by men. There is virtually no funding of nonprofit or volunteer groups, mostly headed by women. Many parent group mothers feel they are not being taken seriously enough to be considered worthy of funding, in spite of the fact that they are doing an important job and doing it well.

It is imperative that a mechanism be found to fund the organization of parents and families at the grassroots level in all communities, but especially in low-income communities where the need is greatest, the problem most complex, and the volunteer resources most scarce.

Create a National Drug Corps

National Families in Action proposes the creation of a National Drug Corps to empower families to prevent drug abuse by providing

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them with training, resources, and support to reduce the demand for drugs (Rusche, 1990). This Drug Corps would be modeled after the Peace Corps. It would provide mothers, fathers, young people, and others with an opportunity to give 2 years of service to their country to fight the war against drug abuse in communities across America. The volunteers, who would be given a stipend sufficient to cover basic living expenses, would be trained in successful drug abuse prevention techniques, adapted to their own communities. After this basic training, the Drug Corps volunteers would go to work in their own communities.

Suggested goals and activities that corps volunteers would work on have all been tried and tested as model demonstrations:

1. Strengthen families. For example, corps volunteers could work with churches to identify congregation members who would "adopt" families at risk and teach them parenting skills and how to cope better with the many other problems they face.

2. Develop alternative activities for children and youth. Either through mentorship programs or community-based afterschool activities, corps volunteers would mobilize residents to work directly with youth to help them achieve in school, set high expectations for themselves, and learn to use their leisure time constructively. They could help to establish new recreation activities in the community.

3. Develop alternatives to drug dealing. Involve local or nearby businessmen in providing training and job opportunities.

4. Empower families and community residents to exercise the responsibilities of citizenship by organizing Neighborhood Watch groups to get drugs off the city streets.

5. Identify gaps in treatment services and help private and public treatment sources work together to make more efficient use of existing beds and outpatient slots. Help redirect outpatient programs so they more effectively meet the needs of recovering persons by helping to create day treatment programs, and self-help groups such as Alcoholics Anonymous, Alateen, Toughlove, and Narcotics Anonymous, in churches and other accessible neighborhood locations. Design some of these services specifically for teenagers. Consult with members of minority groups about ways to make these treatment programs more culturally sensitive.

It is the plan of National Families in Action and other leaders of the parent drug prevention movement that this National Drug Corps should be created through national legislation, but should involve a partnership of public, private, and voluntary groups pooling resources and funding. Public revenues for the National Drug Corps program could come from seizure of all assets purchased with illicit drug profits, increased excise taxes on alcohol and cigarettes, fines against banks that fail to report deposits larger than $10,000, and other related sources.

The National Drug Corps is an imaginative, feasible strategy for mobilizing the resources, motivation, expertise, and talents of parents and other citizens to help win the war against drugs. Teenagers can be effectively helped to desist from drug use, but many forces pull them in the opposite direction. The "treatment" of the drug-plagued context or setting of today's adolescent may be a key element in the recovery of the youngster who is abusing alcohol and other drugs and that of his or her family. It is surely a key element in helping others prevent drug abuse problems. The knowledge and experience gained in the parent prevention movement must be carried to every community at risk in the Nation.

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Developing a Partnership With Families: Parent-Professional Collaboration

Glenda Fine

Parents of children with emotional problems come from all walks of life and from all cultural backgrounds. They are housewives, teachers, bricklayers, bankers, and doctors. These parents are rich and poor, formally educated and educated by experience. They are your friends and neighbors and maybe even your sister or brother. The one thing they share in common is that they have children who are experiencing emotional problems and they care very much what happens to them (Donner & Fine, 1987).

Parents of children and adolescents with emotional disturbances and the professionals who treat those children have much to offer one another. Historically, relationships between these parents and professionals have been tenuous at best. Recently, however, a number of organizations have advocated for parent-professional collaboration and focused efforts on facilitating the process. There is much to be gained through this collaboration, though there are a number of impediments to be overcome.

In discussing this topic, some controversy exists about the term "emotional disorder." Several terms—including "mental," "emotional," or "behavioral" in conjunction with "problem," "disorder," "illness," or "disturbance"—are used to refer to specific conditions or a a set of conditions that affect many children and adolescents. Confusion and controversy about the terminology and about the conditions themselves reflect the limits of current knowledge and understanding. For present purposes, the terms "emotional problems," "emotional disorders," and "emotional disturbances" will be used interchangeably here. They are meant to refer to any and all of the conditions that might be described by the other terms. This is not to say that there are no differences between the terms or the conditions, or that the differences are not important. It is meant to say that, for the discussion of parent-professional collaboration, the similarities are more important. That is, parents of children with any of the disturbances, disorders, or problems—whether mental, behavioral, or emotional—are the most important people in those children's lives. They must be respected and collaborated with in the treatment of their children and adolescents.

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What Does Collaboration Mean? Two Levels of Involvement

What does parent-professional collaboration mean? How can these two groups work together for the benefit of children and adolescents? There are two levels on which parents and mental health professionals can come together. First, parents can be involved in the treatment of their own child in a meaningful way. Second, parents and professionals can collaborate on program planning and evaluation and on policymaking. Both levels of involvement hold promise for making treatment of these children more available and effective.

Collaboration means that parents and professionals first and foremost respect one another and share information and authority with one another. It means creating opportunities to meet regularly and share ideas. Specific strategies for fostering this respect and facilitating this sharing of ideas and authority are presented later.

Parents have an intimate knowledge of their child's experience and development and their own family's needs, capacities, and resources. When parents seek professional help, they seek to join their own expertise with that of the professional.

Why Collaborate?

There are numerous reasons for parents and professionals to work together. They share many of the same objectives in the care of adolescents who are emotionally disturbed. They each have knowledge of some things the other needs to know. Parents have an intimate knowledge of their child's experience and development and their own family's needs, capacities, and resources. Professionals know how to help families change patterns with which they are unhappy and build their own problem-solving skills. Working together, parents and professionals can assure that services will be appropriate, available, and adequately flexible to serve the real needs of adolescents and their families. Without this kind of collaboration, services are less likely to be responsive to the priorities of the families whom professionals intend to help. Parents may become skeptical, frightened, intimidated, and therefore not committed to the treatment in which they could make a critical difference.

Barriers to Collaboration

While it is clear that collaboration has much to offer both parents and professionals, there are a number of barriers hindering the effort. There are certainly practical concerns—the most universal of which is the time required to facilitate parent involvement. Other, perhaps more subtle but undoubtedly more profound, factors stand in the way of collaboration, however. Both groups may bring some unhelpful attitudes, perceptions, and experiences to their relationships with one another.

When parents seek professional help, they seek to join their own expertise with that of the professional. Parents are responsible for their children 24 hours a day and know their needs and habits well. Often, however, they feel as if their expertise and rights are being denied and they are being blamed or patronized. One parent reflected the blame she had felt for many years when she wrote poignantly, "Despite differing vocabularies and differing emphases, it all boils down to the same thing. The troubled child comes from a troubled family. Trouble begins with a troubled mother" (Wilson, 1968).

It is not hard to imagine how parents come by these feelings. There is a long and pernicious history of parent-blaming in the mental health field, stemming from Freud's notion that the family (particularly the mother) was to blame for the child's problems. Even well-meaning professionals may be influenced by this history and the assumption that if children have problems, their parents are at fault. Parents who have encountered blame from their friends and relatives and who have wondered or felt guilty about their own role in their child's troubles may be especially sensitive to this implication.

In addition, parents are often tired and desperate by the time they seek mental health services because they have been dealing with a frustrating and difficult responsibility around-the-clock. In some cases, families end up receiving services from several sources with no mechanism for coordination among them. These families are subjected to an array of confusing and possibly contradictory expectations and many demands on their time and energy. Under these difficult circumstances, parents may defend and assert themselves and consequently be considered aggressive and pushy. On the other hand, they may hold back or withdraw and consequently be considered unconcerned and underinvolved. Often, parents who have dealt with the mental health or social service systems in the past are confused about what is expected of them and perceive themselves to be in a no-win situation. At the same time, professionals may be suspicious or discouraged, having worked hard in the past to help a troubled teen only to feel undermined by the actions of the well-intended parent(s).

Socioeconomic and cultural differences, too, may contribute to the distance between parents and professionals. If each participant perceives himself or herself to be very different from the other, the gap to be bridged seems very wide. If parents perceive disapproval of their socioeconomic status or cultural beliefs and values, they may be offended or intimidated and find it difficult to feel invested in their child's treatment.

Another aspect of culture that directly affects the parent-professional relationship is education. Parents may be intimidated by the highly educated professional or may have unrealistic expectations of the professional because they attribute an unrealistic power to his or her education. Professionals may be uncomfortable or intimidated by highly educated parents and may be impatient with or skeptical of the abilities of uneducated parents. In every case, though, parents are an irreplaceable resource. All parents, regardless of level of education, have knowledge of their own children that no one else can have. Parents will continue as a constant factor in their child's life long after the treatment professional has faded from memory. Thus, cultural differences and differences in religious and moral values and in levels of education are not issues of right or wrong, better or worse. They are simply factors to be dealt with in the effort by parents and professionals to understand one another and work together.

Strategies for Collaboration

There are a number of specific and concrete things a professional or an agency can do to facilitate collaboration with parents. At the level of treatment, the professional can maintain the parents' central position in the therapy itself and in all decisions about medications, referral to other services, and so forth. That is, the professional acts as a consultant to the family in the areas in which the professional has expertise, but the family is "in the driver's seat." The professional can help the family locate and secure needed services in a way that respects the family's primacy in the child or adolescent's life. The professional must include the family in all treatment planning efforts with other professionals, rather than meeting privately and presenting the family with pronouncements. The latter approach teaches the family members to expect others to make the decisions about their child and effectively diminishes their personal investment in the treatment.

At the level of program planning and policy-making, agencies should include parent members on the relevant boards, committees, and task forces, and have parent representatives review proposals for new policies and programs. They can regularly include parents in staff trainings in order to sensitize staff to parent issues and concerns and foster a collaborative atmosphere. True collaboration means that parents and professionals do not merely come together in these forums, but that they share information, identify issues, set goals, and make plans mutually. In order for this to happen, philosophical and conceptual leadership must come from the top down. Thus, administrators at the highest levels must be invested in parent involvement and must support, facilitate, and model collaboration. "Thus, the strategy for increasing the participation of family members must include changes at all levels of the organization or system and be seen as a goal in which the administrator has considerable investment" (Friesen & Koroloff, 1990).

True collaboration means that parents and professionals do not merely come together in these forums, but that they share information, identify issues, set goals, and make plans mutually.

In order to prepare themselves to work with parents in a collaborative way, professionals should openly examine their own assumptions and values and attend workshops on topics related to parent-professional collaboration. They must be willing to ask parents what they need and want and what would be helpful to them. Professionals must be sensitive to the demands already burdening many families and work with them to determine what it is realistic

and reasonable to expect from one another. Most important, professionals need to recognize that accepting the parents' rightful position of authority in their children's lives in no way undermines the professional's ability to do his or her job.

Initiatives Toward Collaboration

A number of initiatives have focused attention on the need for collaboration between parents and professionals and have sought to facilitate that process. Listed here are a Federal initiative, a local/State initiative, a national grassroots parents' initiative, and a university-based research and training initiative. They reflect the diversity of influences and, at the same time, the unity of purpose in the movement for parent-professional collaboration.

The Child and Adolescent Service System Program

The Child and Adolescent Service System Program (CASSP), funded by the National Institute of Mental Health, has played a major role in the development of parent-professional partnerships. CASSP funds State efforts to develop coordinated systems of care for children and adolescents with emotional disturbances. An important focus of these grants has been to encourage parent-professional collaboration and parent participation in policymaking and program planning at the State and local levels.

Parent Self-Help and Advocacy Groups: Parents Involved Network

Another important initiative in the effort to foster collaboration is the development of parent advocacy and self-help organizations in the area of children's mental health. One such organization is the Parents Involved Network (PIN), which was started in Philadelphia, Pennsylvania, in 1984 as a pioneering project sponsored by the Mental Health Association of Southeastern Pennsylvania. Since its second year in operation, the organization has been partially funded by CASSP. PIN is a parent-run, self-help/advocacy, information and training resource for parents of children and adolescents who have emotional, behavioral, or mental disorders. PIN enables parents to come together, share common concerns, exchange information, identify resources, and influence programs and policy development affecting the treatment, education, and service needs of children and adolescents.

PIN activities include:

- Providing parents with support, telephone information and referral, advocacy training, case advocacy, assistance with group organization, and linkage with other parents and parent organizations.
- Establishing PIN groups in many communities across Pennsylvania.
- Distributing the PIN newsletter, *SHARING* to parents and professionals.
- Influencing policy and program development by participating in State and local CASSP committees, the State mental health planning committee, and other State and national advisory committees.
- Influencing legislation by testifying at legislative hearings.
- Promoting public awareness of related issues through the various communications media.
- Sensitizing tomorrow's professionals by serving as guest lecturers in schools of social work and other professional training programs.

PIN has long been recognized for its assistance to parents in Pennsylvania and across the country. Increasing interest in the development of a State organization led to the incorporation of PIN of Pennsylvania in December of 1989. Similar organizations are springing up all across the country.

The Federation of Families for Children's Mental Health

The Federation of Families for Children's Mental Health is a newly formed, national

parent-run organization focused on the mental health needs of children and adolescents with emotional, behavioral, and mental disorders. Its mission is to provide leadership; to develop necessary human and financial resources to meet the families' goals; to address the unique needs of children and youth with emotional disorders from birth through transition to adulthood; to ensure full rights of citizenship; to support community-based services for these children and youth; and to provide information and advocate for research, prevention, early intervention, family support, education, transition services, and other services needed by these children and their families.

The Research and Training Center on Family Support and Children's Mental Health: The Families as Allies Project

A group that has actively promoted the concept of parent-professional collaboration on a nationwide scale is the Portland Research and Training Center on Family Support and Children's Mental Health of Portland State University. This organization conducts various research and training activities, one of which is the Families as Allies Project, a national training program to help both parents and professionals examine attitudes and develop skills that promote a working relationship among them.

In addition to these formal initiatives on collaboration, there are many organizations being established and activities taking place that will result in parents and professionals coming together to address specific issues in the treatment of children and adolescents with emotional disorders. One such organization is the recently formed National Alliance for the Mentally Ill Child and Adolescent Network (NAMI-CAN), a network within the older organization, the National Alliance for the Mentally Ill. NAMI-CAN strives to help children, adolescents, and families through advocacy for increased research efforts, public education, and family-to-family support. Efforts such as this strengthen the resolve and the preparedness of parents to participate fully in the treatment of their children.

What Can Happen When Parents Are Involved

When parents are involved in policy and program planning and evaluation efforts, the efforts of professionals can be grounded in the reality of the lives of the children and adolescents they are meant to serve. Two Pennsylvania experiences in which parents had a profound impact are illustrative.

Raising the Awareness of an Existing Situation and the Need for Change

Since 1984, the PIN Project in Philadelphia has been persistent in its efforts to inform and educate policymakers, program planners, and legislators about children's mental health issues. One specific issue is that residential treatment services *are not* available through the mental health system *but are* available through the child welfare system. Therefore, parents of children who have emotional problems must relinquish legal custody of their child to the child welfare system in order to obtain these services. Even then, the programs available do not always address the child's problems and often do not address the concerns and issues of the parents.

PIN's advocacy efforts over the years helped to create a constituency to change the requirement that parents relinquish custody of their child to access services. Policymakers, program planners, and legislators now recognize the need to change this practice. They also recognize the need for residential services to be provided as part of a continuum of services available through the mental health system. Administrative and legislative efforts are under way to remedy this situation. This experience can serve as a model for others, as similar situations prevail in many States.

Developing a Comprehensive Children's Mental Health Case Management Model

Another impressive effort that took place recently in Pennsylvania is an example of parent-professional collaboration at its best. A subcommittee of the State CASSP Advisory Committee, made up of both parents and professionals, met over a period of several months to develop a model for the coordination of services to be delivered to a given child. They produced the Children's Case Management Service Model for the State. One of the unique provisions of the model, agreed upon by all members, is that "parents are partners in the treatment and coordination of services for children and adolescents and that they are included in the treatment planning and review sessions; that they are not mere spectators or recipients of recommendations but are essential members of the treatment team with the knowledge and experience about the child or adolescent that no one else possesses" (Subcommittee on Children's Case Management of the Pennsylvania State CASSP Advisory Committee, 1989). Thus, Pennsylvania now has a state-of-the-art children's case management model that reflects the philosophy and principles of collaboration espoused by CASSP.

Summary

The history of parent-professional relations in child and adolescent mental health is filled with skepticism and blame. This history is one of a number of barriers impeding collaboration between these groups, even though the many advantages inherent in collaboration are apparent. Still, seeds of change have been sown. Several initiatives have focused attention on collaboration and facilitated collaborative efforts. Some strides have been made—and there is much still to be done.

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Financing Family-Centered Services for Adolescents

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Introduction

There is a growing push to involve families of adolescents with mental health and alcohol and other drug abuse (AODA) problems in their child's treatment. Alcohol, drug abuse, and mental health (ADM) professionals, policymakers, and parents have all expressed interest in developing a more coordinated system of care that incorporates family-centered services. One important factor influencing the availability of family-centered services to troubled adolescents is the financing for these services. Existing financing mechanisms have limited family involvement in a number of ways. However, concern over the appropriateness of current utilization patterns and rising expenditures for mental health and AODA services for adolescents has influenced policymakers to begin to change financing incentives to expand family-centered services.

Mental health and drug abuse services for adolescents are primarily funded through private and public insurance, State general revenues , and public and private grants, such as Alcohol, Drug Abuse, and Mental Health (ADM) Block Grants. This article explores the prevailing financing patterns and how they affect the services available and the opportunity for family involvement in the treatment of the troubled adolescent.

Sources of Financing for Adolescent Alcohol and Other Drug Abuse and Mental Health Treatment

Insurance

Both public and private insurance are important sources of financing for adolescent AODA and mental health treatment. Approximately 74 percent of adolescents aged 10 to 18 were covered by private health insurance in 1984; 19 percent were covered by public insurance (that is, Medicaid and the Civilian Health and Medical Program of the Uniformed Services [CHAMPUS]); and 14 percent had no insurance.[1] Of 19 to 24 year olds, about 26 percent had no insurance (Newacheck & McManus, 1989; McManus, Greaney, & Newacheck, 1989). Insurance coverage is often a problem for young adults in the latter age group because they are too old to be covered by their parents' policies but may not be fully enough employed to have this benefit on their own. In the former group, problems may arise when the youngster hesitates to seek needed services because he or she cannot finance the services without the parents who are the owners of the insurance.

Other Types of Financing

State general revenues are the primary source of funds for the public mental health care; approximately two-thirds of total public mental health expenditures comes from State Mental Health Authorities (SMHA) (U.S. Office of Technology Assessment [OTA], 1986). Because States are greatly concerned with limiting expenditures, they impose supply constraints on mental health and alcohol and other drug abuse services by restricting their budgets.

Federal ADM Block Grants provide funds to Community Mental Health Centers (CMHCs) and some other outpatient mental health and

[1] The figures add up to more than 100 percent because some adolescents are covered by both public and private insurance.

AODA programs. Although these grants require that 10 percent of the funds be spent on new programs for underserved populations, which include children and adolescents, it is unclear exactly how much is going to programs for this specific group.

Another Federal program, the Child and Adolescent Service System Program (CASSP), was developed to encourage coordination and comprehensiveness among a variety of child and adolescent services (child welfare, social services, mental health, juvenile justice, and so forth). While this program has had a major impact on thinking about child and adolescent services, it represents a fairly small funding source and its focus is on the coordination and comprehensiveness of services and not on the services themselves (OTA, 1986).

In addition, other public funds from local systems, such as social welfare departments and school systems, provide some financing for adolescent mental health and AODA treatment. These programs may offset some demand on the mental health system. However, they may also generate more demand by identifying adolescents in need and referring them into the system. The extent and type of specialized mental health services provided by these systems is unknown (OTA, 1986).

Limitations of Available Financing for Mental Health and Alcohol and Other Drug Abuse Services

A growing share of health expenditures is being spent on mental health services (APA, 1988; Frank & McGuire, 1986). Concern over these increasing costs has led insurers and government payers to use various methods of controlling the utilization of mental health services. Insurers have implemented a number of direct controls on utilization through limits on benefits. Government agencies have also limited expenditures, but usually less directly, by limiting the total amount of funds provided for these services and by constraining new programs. The following discussion focuses on the limitations imposed by insurers, but many of the strategies and reasons for the limitations apply to other financing sources as well as insurers.

Insurance coverage for mental health and AODA treatment is typically lower than for other health problems. Only 37 percent of participants in private health insurance have equal coverage for inpatient care of psychiatric illness versus other medical problems, and only 6 percent have outpatient psychiatric coverage equal to general medical outpatient coverage (Scheidemandel, 1989).

Public insurance programs exhibit similar coverage limitations. Medicaid benefits, which are designed by the States within broad Federal guidelines, require States to cover some psychiatric services, such as inpatient and outpatient services, in acute care general hospitals. However, States can provide fewer hospital or outpatient visits for psychiatric disorders, and they sometimes set reimbursement rates so low that few providers will supply services to patients covered by Medicaid. In addition, because of the broad discretion allowed the States, they often do not offer some optional services, such as case management, nonphysician providers, clinic services, and personal care services. These optional services may be especially appropriate for treatment of adolescents with emotional disturbances (Stroul, 1988), but benefits offered by insurers are generally designed for adults and may not adequately meet the needs of adolescents and young adults (Horgan & McGuire, 1988).

There are several explanations for why insurers single out mental health coverage for special limitations. First, insurers fear "adverse selection," the process whereby people with high-cost chronic mental disorders, such as chronic mental illness, may be able to predict their use of services over time and select

policies that have more comprehensive coverage for these services.

Second, misconceptions about mental health and AODA problems and the stigma long attached to them have caused both purchasers of insurance and designers of insurance benefits to undervalue mental health coverage. Because the stigma and lack of understanding lead purchasers to underestimate their own potential need for these services, and to underestimate the effectiveness of treatment, they may favor policies that lower costs by limiting these benefits.

Finally, many insurers are concerned that the presence of insurance benefits for mental health will decrease the price of treatment to consumers to such an extent that participants will inappropriately increase the use of services; this phenomenon is referred to as "moral hazard" (Frank & McGuire, 1990). Insurers respond to moral hazard by imposing a variety of constraints on the insurance benefits that control both the demand for services and the supply of services.

Typical demand constraints include coverage limits and cost sharing, which are common in all benefits for mental health and AODA coverage. In 1986, more than 60 percent of participants were limited to total annual expenditures of less than $1,500 for outpatient services, and most employees paid 50 percent coinsurance (Scheidemandel, 1989). Public insurances control demand not only through coverage limits but through eligibility standards as well. Thirty-two States set their eligibility standards at or below 50 percent of the Federal poverty level, thus eliminating many poor children and adolescents from coverage by these programs (Fox & Yoshpe, 1987). Additionally, States are concerned about increased expenditures and so often do not fully utilize services that are available under Federal regulations. For instance, the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) program for children age 21 and under allows States to cover a comprehensive set of services for adolescents and children with mental health and drug abuse problems, yet few states take advantage of these options (Fox & Yoshpe, 1987).

Various forms of managed care, such as health maintenance organizations (HMO's), also constrain demand for these services in a number of ways (Gabel, et al., 1988). Patients in these plans are restricted in their choice of providers, and the provider's treatment plans are often reviewed and treatment is not covered if it is deemed by the insurer to be unnecessary (DiCarlo & Gabel, 1989). Further, many HMOs exclude care for chronic or severely mentally ill people and only cover diagnosable disorders that can be treated with short-term therapy (Scheidemandel, 1989).

Besides constraining the demand for services, insurers also constrain the supply of mental health and AODA services in a number of ways. Limitations that exclude coverage for the services of certain types of providers, such as family therapists or social workers, are very common. Often coverage is limited to care delivered in traditional mainstream settings such as general hospitals. For instance, recent estimates indicate that less than 25 percent of people who are privately insured have coverage for care in specialty psychiatric facilities (Scheidemandel, 1989). Supply is also constrained by the price insurers pay for a given service. For example, Medicaid rates of reimbursement for inpatient care come closer to covering the provider's costs than do reimbursement rates for ambulatory services (Taube, Goldman, & Salkever, 1990). Providers will not treat Medicaid patients when reimbursement rates are too low. The current structure of reimbursement favors the provision of inpatient services and discourages the provision of ambulatory services such as community-based, family-centered treatment. (This may be one factor in the increasing rates of hospitalization of adolescents that is discussed later.)

Misconceptions about mental health and alcohol and other drug abuse problems and the stigma long attached to them have caused both purchasers of insurance and designers of insurance benefits to undervalue mental health coverage.

The linkage between public and private financing systems for adolescent mental health and AODA treatment is also problematic. Although there is some overlap between the provision of publicly and privately funded services, coordination between the two systems is poor.

The linkage between public and private financing systems for adolescent mental health and AODA treatment is also problematic. Although there is some overlap between the provision of publicly and privately funded services, coordination between the two systems is poor. As mentioned previously, some adolescents are without any coverage, public or private, and other adolescents quickly exhaust their private insurance benefits. These adolescents must depend on out-of-pocket payments by themselves or their families or on public programs to receive services. But many of these adolescents are poor or near poor, and few treatment options are available to them. For example, when a seriously disturbed adolescent's insurance coverage is exhausted, he or she may be transferred to a State hospital, so a private hospital can avoid subsidizing costly additional treatment. In this way, loss of private insurance or other change in benefits can force a break in treatment or a change in the setting of care that can adversely affect the treatment of the adolescent. This can place a further strain on the family and interfere with its ability to provide other important financial and social support to the adolescent.

Some of these adolescents can become eligible for Medicaid once out-of-pocket expenses reduce family income to State Aid to Families With Dependent Children income limits. However, this "medically needy" option is not available in all States (Medicaid and Medicare Data Book, 1988). In addition, adolescents covered by this program are subject to frequent changes in their eligibility because their family income status changes each accounting period. Finally, States often provide a more limited package of services to "medically needy" recipients.

Current Financing Incentives That Limit Family-Centered Treatment

Several aspects of the current financing patterns constitute barriers to a family-centered approach to adolescent treatment services. First, financing patterns have emphasized hospitalization or other institutional treatment in spite of research findings questioning its superiority over outpatient care (Friedman & Street, 1985; OTA, 1986; Miller & Hester, 1986). Second, financing patterns have constrained the development of community-based, family-centered services because reimbursement is often tied to the diagnosis of a mental "disorder" in a specific individual. This effectively limits the coverage of psychoeducational services, conjoint family psychotherapy, respite care, and other services that would be helpful to the families of teenagers with mental health and AODA problems.

Bias Toward Inpatient Services

Many mental health professionals and others have expressed alarm about the skyrocketing rate of adolescent hospitalization for mental health and AODA problems in recent years and concern that financing policies may have resulted in inappropriate hospitalizations and overutilization of inpatient services by adolescents (Goldstein & Horgan, 1988). Several recent studies have indicated that adolescent admissions to private psychiatric hospitals have increased by as much as 154 percent between 1980 and 1986 (Burns, Taube, & Taube, 1990).

Both current insurance benefits and State Mental Health Authority policies favor the use of inpatient services. Insurers fear overuse of outpatient services because individuals have greater discretion in their use. In 1986, more than 99 percent of employees covered by private insurance in 300 firms surveyed by the Bureau of Labor Statistics had some inpatient psychiatric coverage, and 97 percent also had some outpatient benefits. However, 91 percent had some type of restriction on their outpatient benefits, while 60 percent had restrictions on inpatient coverage. Additionally, outpatient limits are in general more stringent (Scheidemandel, 1989).

Sandy

Sandy is 20 years old. Last year, when she dropped out of college, she no longer qualified as a dependent on her parents' insurance policy. Unable to work regularly because of her schizophrenia, she has been on medication and in outpatient therapy at her parents' personal expense. Today she said she knew her parents were trying to kill her and God was telling her how to protect herself. She's wielding a knife and needs to be taken to a hospital, but where will the money come from?

Many mental health professionals and others have expressed alarm about the skyrocketing rate of adolescent hospitalization for mental health and AODA problems in recent years and concern that financing policies may have resulted in inappropriate hospitalizations and overutilization of inpatient services by adolescents.

Complicating this picture in recent years is the trend for private, for-profit psychiatric hospitals to market themselves directly to patients through, for example, television advertising. Playing on the fears and misgivings of parents, "advertisements such as these may lead well-meaning parents to believe that failure to react to normal adolescent adjustment problems with an intensive remedy such as hospitalization is poor parenting" (Weithorn, 1988). These marketing strategies are successful in part because patients are much more likely to admit themselves without physician referral, or, in this case, parents are more likely to admit their children (Dorwart, Schlesinger, Horgan, & Davidson, 1989). Thus, recent skyrocketing rates of adolescent psychiatric and AODA treatment admissions may reflect the combination of better coverage for inpatient than outpatient services and the fact that parents are seeking more inpatient psychiatric services for their children.

Public programs have a similar structure. All State Medicaid programs cover hospitalization in acute care general hospitals, often with no limits on services, and 34 States also cover psychiatric hospital services (Medicaid and Medicare Data Book, 1988). CHAMPUS is known to be a generous provider of mental health services and favors the use of inpatient services. Seventy-five percent of CHAMPUS mental health expenditures in 1985 were for inpatient care (OTA, 1986). In addition, the majority of SMHA funds go to support State hospitals (Lutterman, Mazade, Wurster, & Glover, 1988).

Constraints on Community-Based, Family-Centered Services

Current financing mechanisms constrain the development and use of family-centered services in several ways. Public and private funding mechanisms seriously limit the use of mental health and alcohol and other drug abuse services that do not conform to the traditional individual diagnosis-based model of care. Generally, a standard diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a requirement for reimbursement. These diagnoses apply only to individuals. This is consistent with the usual definitions of insurance benefits, which generally specify so many visits per time period per person, requiring that one individual's benefits be "charged" for days or hours of care or "visits." Family-centered services focus on the family as the unit of concern and are often difficult to "count" in the traditional way. In addition, many services that are needed by families may not be clearly "mental health" or "drug abuse" services in the traditional sense, but may be considered social services that do not fit the traditional medical classifications.

Since insurers have less experience with innovative services like family therapy than with traditional services, the innovative services are subject to greater limitations. Only a little more than half the participants covered by private insurance plans surveyed in 1986 had some type of coverage for outpatient family therapy; approximately 13 percent were covered by policies that excluded family therapy; and the remainder were covered by policies that didn't specify whether this type of

While financing policies tend to limit funding for mental health and AODA services, favor inpatient care, and limit the expansion of family-centered services in some ways, there is some good news.

care was covered. Most Blue Cross and Blue Shield policies did cover some family therapy services (Scheidemandel, 1989). HMOs in general did not specify if this type of coverage was available. Similar situations prevail in public insurance. Medicaid regulations do not explicitly define coverage for family-centered treatment and, although some of the optional services that can be included in Medicaid coverage (such as the personal care option) could be used to cover such services, they are often not selected by the States. Likewise, the EPSDT requirements can help States to offer a wide range of noninstitutional services that can provide treatment and support services to adolescents with mental health or AODA problems and their families, but few States take full advantage of these options.

Future Trends

While financing policies tend to limit funding for mental health and AODA services, favor inpatient care, and limit the expansion of family-centered services in some ways, there is some good news. Most Blue Cross and Blue Shield policies did cover some family therapy when private insurance plans were surveyed in 1986 (Scheidemandel, 1989). Also, while HMOs often do not specify coverage for family therapy, they are increasingly using individual benefits management whereby they authorize on a case-by-case basis the use of services not normally covered under the policy when such services are expected to circumvent hospitalization (Fox & Newacheck, 1990). This practice opens the door to the coverage of services like home-based crisis intervention and family therapy. These are encouraging signs, although these expansions in coverage for family therapy may be offset somewhat by other cost controls such as constraints on numbers of visits and dollar limits. Also, insurance policies generally continue to reimburse for individual or group (or family) therapy, but not for other services such as transportation, social rehab, education, and home-based crisis intervention.

Other privately funded programs may help to expand family-centered services. As of late 1989, the Robert Wood Johnson Foundation had awarded grants to eight States to develop and improve the system of services for children's mental health. Home-based services, case management, and day treatment will be emphasized. Although this program will not expand financing for family-centered services to a significant number of adolescents, outcomes of the demonstration may provide evidence of the effectiveness and financial feasibility of these services (Florida Mental Health Institute [FMHI], 1990).

A number of public sector initiatives are also increasing the availability of community-based services. Many States are gradually picking up optional Medicaid services that allow a more flexible package of services for adolescents with AODA and mental health problems. Changes in the EPSDT program in 1989 provide for substantial expansion of community-based services that can enable family support and involvement in treatment. Although this program has the potential to greatly increase services to adolescents, full use of the services offered under these changes will be very expensive for some States (FMHI, 1990).

States can also have an important influence on employer-based insurance coverage through mandates that require coverage for mental health services. As of December 1988, 28 States had laws mandating some kind of psychiatric benefits for at least some group of employers. Although mandates could require coverage of some community-based services, current State mandates reinforce the trend of more generous coverage of inpatient care over other types of services (Scheidemandel, 1989).

Finally, Federal legislation currently under consideration could substantially expand

family-centered services. The Community Mental Health Services Improvement Act of 1991 is strongly supported by a number of members of Congress and various national organizations that provide children's mental health services. The bill focuses on providing a range of family-centered community services.

Summary

Treatment of adolescents with alcohol and other drug abuse and mental health problems is primarily funded by public and private insurance, State Mental Health Authorities, and Federal Block Grants to the States. Insurance coverage for these services is uneven, and many young people have no coverage at all. The existing financing mechanisms have tended to foster the use and proliferation of inpatient services and have generally not supported the development of family-centered services. Several recent trends and developments hold promise for changing this situation. In some cases, the design of insurance benefits now favors outpatient care and allows for coverage of family-based services to circumvent hospitalization. Public programs and private grants are establishing demonstration projects to determine the benefits and feasibility of more extensive community-based, family-centered treatment options. It remains to be seen what these demonstrations will indicate and what will be done with the information.

It seems certain that the financing mechanisms for the treatment of adolescent alcohol, drug abuse, and mental health problems will continue to undergo change. As the economic incentives change, so too will the types of services that predominate. However, considerable effort will be required on the part of Federal, State, and local policymakers to transform early attempts into the permanent changes necessary to establish a more appropriate and coordinated system of care for adolescents and their families.

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Steps and Strategies at the State Level: The Delaware Experience

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Overview

How can State government give life to the idea that children, families, and society are best served if families are helped to deal with the problems of their children and adolescents and are kept together whenever possible? While many high-risk families are both more likely to produce difficult children and less likely to be able to deal with them effectively, often such families can be helped to develop their own hidden resources and thereby become well-functioning, supportive, and fully capable of meeting the needs of their children.

With this in mind, officials in the State of Delaware recognized that the concept of family preservation is "larger" than the effort to simply avoid hospitalizations or foster care placements. In order to really "preserve" families, all child and adolescent services must focus on the family rather than on the individual child. A shift to family-focused services requires a fundamental reorientation and expansion of perspective to include the family and its environment. This new perspective must be integrated into the initial conceptualization, plans and designs, and delivery of all services. A family-focused philosophy cannot simply be inserted into the complicated network of children's services. Moreover, a shift to family-focused practice requires more than just the introduction of family therapy techniques or special family-focused programs to an otherwise unchanged service system. The expression "family preservation" is most often used to refer specifically to special, separate programs established within a department designed to avoid out-of-home placements. The State of Delaware project was called the Family Preservation Project with a broader definition in mind: it encompasses the total operations of an entire department.

To support this new perspective, a sympathetic context had to be developed—a context that would ensure continuing development of family-focused programs after the initial project ended. This article describes that experience and elucidates the issues inherent in such an undertaking, the strategies used to address those issues, and the various components of the organizations that needed to change.

The Delaware Experience

In 1982, the State of Delaware, in response to advocacy both within State government and the community, decided to consolidate most children's services into one unified department. The new Department of Services for Children, Youth, and Their Families (DSCYF) included protective services, child mental health, and juvenile corrections (youth rehabilitative services). (Note that in Delaware, child systems include services to adolescents generally up to age 18. Alcohol and other drug abuse treatment services for adolescents are a part of this same service system, with programs for adolescents in the juvenile justice system falling under youth rehab services in both "secure care" and "alternatives to incarceration" programs and others falling under child mental health.) The goals of this consolidation were to—

While great progress has been made, the task has been formidable; each division consolidated under the umbrella department brought its own history, tradition, and agenda with it. This diversity has presented administrative and organizational obstacles, as well as opportunities for new solutions to old problems.

- Focus resources on children's services.
- Promote the planning of systems of care for children.
- Eliminate duplication of services.
- Facilitate joint planning of services to children needing several types of services.

While great progress has been made toward these goals, the task has been formidable; each division consolidated under the umbrella department brought its own history, tradition, and agenda with it. This diversity has presented administrative and organizational obstacles, as well as opportunities for new solutions to old problems.

The Family Preservation Project

The Family Preservation Project has been a major part of the department's response both to the challenges of creating an integrated department and to the demand for effective, cost-effective services.

Project Goals

The Family Preservation Project's aim to strengthen families and keep them together required a major revamping of child, adolescent, and family services. Project goals included the following: first, to develop and implement effective alternatives to out-of-home care and treatment in child protective, mental health, and juvenile justice systems, and second, to shift the focus of all departmental services from individuals to whole families.

Project Strategy

In defining our strategy, we defined five areas for attention (see diagram 4, page 147):

- Fiscal reform
- Staff development and training
- Law, policy, and administrative structure
- Community awareness
- Program development

Beginning in the fall of 1986, each of these areas was explored by means of a subcommittee, composed of department and nondepartment members with interest and expertise in the subject area. It was critical that the membership of each subcommittee include representatives of each of the three divisions of the department: child protective services, child mental health, and youth rehabilitation. The subcommittees conducted research and produced reports and recommendations.

A necessary task early in the project was to study the factors that influence placement practices in Delaware. The results of this study were used to guide the formulation of the project's overall strategy, which was implemented in the following phases:

- Study of current systems to evaluate the extent to which existing policies and procedures undermined family preservation (July 1986 to October 1986).
- Development of a blueprint for change (September 1986 to July 1987).
- Program development and pilot testing (April 1987 to present).
- Community awareness (July 1987 to present).
- Training for senior staff (July 1987 to present).
- Implementation of intensive home-based services (under contract) (Summer 1987 to present).
- Training for direct service staff (September 1988 to present).
- Family-focused demonstration program sites (December 1989 to present).
- Continued improvement of existing programs and addition of new projects (ongoing).

Fiscal Reform: Project Funding

Initial funding for the Family Preservation Project came from U.S. Department of Health and Human Services and Edna McConnell Clark Foundation grants. In the original grant

Diagram 4

Transforming the System Toward Family-Centered Care in Delaware

CHILD/ADOLESCENT-FOCUSED SERVICES → **FAMILY-FOCUSED SERVICES**

Tools, Components, and Processes of Change

Fiscal Reform	Staff Training and Development	Review, Revise, and Initiate Legislation and Administrative Structures	Develop Community Support	Program Development
• Flexible Dollars • Noncategorical • Reinvestment[1] • Recovery[2]	• Ideology: Pro-family Orientation • Support • Skill Development • Supervision • Job Descriptions • Evaluation	• Law • Structure • Mission • Planning • Reviews • Evaluation • Procedures • Forms	• Budget Office • Legislature • Courts • Agencies • Media • Public	• Community-Based Prevention • Case Management • Intensive Home-Based Services • Day Treatment • Respite • Crisis • Emergency Financial Support

[1]Reinvestment: Reinvesting dollars saved on out-of-home placements and hospitalizations into family-focused programs.
[2]Recovery: Recovering costs from the federal government.

The success of the Family Preservation Project, like that of any service initiative, depends on the capabilities of the staff who carry it out because they work directly with the clients. If they do not have the understanding, motivation, and skills to provide family-focused services, even the most farsighted policies and best-designed programs will fail.

application, the department opted to request funds for planning organizational change rather than for instituting pilot programs. We believed then, and our experience has confirmed, that if a family focus was to prevail as a stable and abiding force, basic shifts in the strategic planning and budgeting processes would be required. The family preservation services would have to assume a high profile in the overall service array.

The Fiscal Reform Subcommittee was created to explore strategies for establishing a stable base of funding. Both the subcommittee and project staff received invaluable assistance from the Center for the Study of Social Policy, which helped us focus on three tasks. The first was to find ways to increase baseline funding for family preservation services. Since the project began, the department has included family preservation initiatives as central elements in proposals for new and expanded services. Several large appropriations have been made for specific services in fiscal year 1990, in some cases with increases built in for fiscal year 1991.

The second task was to create budget devices that would permit funds saved by avoiding unnecessary placements to be reinvested in expanded family preservation services. This has been done through legislative approval for budget mechanisms that allow the funds to be reinvested without a formal budget transfer.

The final task was to establish improved cost recovery from Federal entitlement programs, thereby permitting a shift of State funds to family preservation services. The department established the Revenue Enhancement Project to develop means of obtaining Federal reimbursement of administrative and programmatic costs for which the State could legitimately qualify. The project identified four chief areas of potential cost recovery:

- Cost sharing with the Federal government for certain services now fully supported by State dollars.
- Interagency agreements to permit greater participation of department clients in Federally supported programs administered by other departments.
- Enhanced screening of departmental clients for Federal program eligibility.
- Administrative and direct cost allocation plans.

Two projects are already under way as a result of the Revenue Enhancement Project, and several others are being planned.

Staff Development: Training Everyone Involved

The success of the Family Preservation Project, like that of any service initiative, depends on the capabilities of the staff who carry it out because they work directly with the clients. If they do not have the understanding, motivation, and skills to provide family-focused services, even the most farsighted policies and best-designed programs will fail.

The introduction of family-focused practice cannot rely solely on purchasing such services from the private sector. The staff in the public agencies must understand and support the family-focused approach if the purchased services are to succeed, that is, if they are to receive appropriate referrals, ongoing coordination, and consistent followup. Moreover, line staff of the public agency in many ways actually determine State policy, in that they make critical decisions that require them both to interpret existing policy and to improvise in the many areas where policy is silent. In short, the sum total of their many day-to-day case decisions are the real policies of the public agency.

The Staff Development Subcommittee proposed strategies for developing a family-focused perspective and skills among our staff.

After a very careful planning and competitive bid process, the department contracted with the Philadelphia Child Guidance Clinic to provide a comprehensive program of training in the family-based approach to services. (See the article by Marion Lindblad-Goldberg in Part III, page 163.)

While the training was based on the theory and practice of structural family therapy, it was specifically not intended to teach staff to become family therapists. Instead, the goal was to present basic family systems concepts and practice techniques for working with families as appropriate to the roles of staff within the department. The training was also not intended to teach staff how to provide a specific intensive family-based program, but rather how to apply and utilize a family-focused approach within their jobs. Specifically, we wanted to teach juvenile justice staff how to provide family-focused juvenile justice services, child protective staff how to provide family-focused protective services, and mental health staff how to provide family-focused mental health services.

In addition, we wanted to create a departmental culture based on family-focused understanding and values. Thus, we decided to provide every employee with at least some level of training in family-focused practice. Spread out over a period of several months, this training was provided to every single member of the department, more than 700 persons.

The training was divided into five levels. Each staff member was required to participate in levels according to the nature of his or her job. Participation in the highest training level—Level 5—was voluntary and determined by the degree of interest shown in continuing to learn. The levels were structured to provide an increasing amount of detail on both philosophy and practice:

1. Level One (half a day per person) was an orientation for all staff, at all levels of the organization, that presented the goals of the project in relation to the department's mission.

2. Level Two (2 days), provided to all direct service staff and their supervisors, focused on the basic concepts of family systems thinking and intervention.

3. Level Three (3 days) was attended by all case managers, social workers, psychologists, and supervisors and focused on the application of the family-focused approach to the problems of families commonly served by the department. These included drug abuse, violence, neglect, conduct disorders, and mental illness.

4. Level Four (3 days), provided to everyone who had participated in Level Three, applied family-focus skills specific to the functions of workers from all the divisions and to cross-divisional cases and issues.

5. Level Five (5 days) provided advanced training and consultation to a select group of clinicians and supervisors. Staff were able to focus indepth on specific cases and prepare to serve as onsite consultants to other staff in their locations.

We took a unique approach to training administrators and upper management. We decided against the typical "family focus for administration" approach, which tends to be very global and bland as we wanted this group to be "turned on" by an experience of real training and clinical exposure to what a family focus can accomplish. To that end, we held a retreat for 25 people at which Dr. Salvador Minuchin, the director of Family Studies, Inc., conducted live sessions with a family that had been involved with all three service divisions in our department. Followup meetings were held during which the staff heard explanations of what they had seen and were able to ask questions and get involved in a personal way.

Specifically, we wanted to teach juvenile justice staff how to provide family-focused juvenile justice services, child protective staff how to provide family-focused protective services, and mental health staff how to provide family-focused mental health services.

The goal was to identify areas of potential or actual conflict between laws, policies, and structures and the family-focused approach, and to develop recommendations for change.

As crucial as the initial five levels of training were in establishing family preservation within the department, planning for continuing training of both new workers and previously trained staff was necessary to sustain the initiative. The department has established a family-focused Center for Professional Development and a training center located at Terry Children's Psychiatric Hospital. Continuing training is being provided in two ways: by incorporating family-focus concepts into the core curriculum being developed for training of all new staff in the department, and by allocating funds for family systems training and consultation for previously trained workers throughout each year.

Law, Policy, and Administrative Structure: A Necessary Review

Services to children and adolescents are provided within the context of the laws and policies that shape the organizational structure, which can either facilitate or hamper family-centered approaches. For these reasons, the department undertook an examination of the laws and policies relevant to the Family Preservation Project's agenda. The goal was to identify areas of potential or actual conflict between laws, policies, and structures and the family-focused approach, and to develop recommendations for change. The task of developing a legislative and policy agenda supportive of family-centered services is, however, complex and sometimes difficult. Policies may be so interwoven into the fabric of an agency that attempts at change are met with conflict and resistance. Change may require the participation of a wide range of actors with quite different interests and agendas. Some policies may be unwritten, forming an underlying and invisible structure that is difficult to grasp and is resistant to change.

The exploration of the department's policies, procedures, and legal context was done through the Law, Policy, and Structure Subcommittee. This group made several major recommendations, some of which resulted in specific policy changes. The department did develop a number of policy initiatives, including development of a family-focused mission statement, family-focused strategic plans and budgets, the addition of several policies on case management, and a total revision of the policy manual for child protective services.

Through these efforts, we came to appreciate the complexity of attempting to affect line staff behavior through top-down directives. Thus, we also decided to work from the bottom up. We initiated the Family-Focus Demonstration Site Project, which targets three sites: a protective services unit, a probation unit, and a psychiatric hospital. The project calls for staff from each site to receive intensive training in family-focused practice and for ongoing consultation to be established. The staff will evaluate all aspects of their own operation, including intake, assessment, service planning, and delivery through termination to identify opportunities for improvements in their family focus.

Community Awareness Effort

Because the shift to a family-centered philosophy and practice was clearly so significant, it was essential to involve the broader community in Delaware in planning for these changes, in assessing the needs of families, and in determining the direction of the project. The department wanted to inform the community about the Family Preservation Project, as well as to get valuable input from the community. We asked the Community Awareness Subcommittee to help design strategies to accomplish both of these goals.

The subcommittee created two work groups, the General Audience Task Force and the Client Task Force. The first group developed a variety of visual aids, including a video,

demonstrating the power of the family-focused approach to help families. It created a speaker's bureau to promote the family-centered approach and to explain the Family Preservation Project. The group also sponsored two conferences to educate the professional and advocacy communities about the project. It solicited an agreement from the United Way to feature family preservation as a key theme, further underscoring the importance of the project in many presentations throughout the State. The members of this group also reviewed the department's budget submission and monitored the budget process to advocate for family-centered programs. The efforts of the task force were critical in creating a climate in which the philosophy and practice of the department could be shifted.

The second work group, the Client Task Force, served as the vehicle for community input into the Family Preservation Project. The group prepared and conducted a survey of frequent users of Delaware social services to learn what they saw as needs and problems. The task force then made specific recommendations that informed decisions throughout the project.

Program Development

The department's full commitment to family preservation as a philosophy and practice formed the context in which specific programs have been developed and launched. The goal is to ensure that these programs are embedded in a continuum of services to families. (See diagram 3, page 49.)

As with the other elements of the Family Preservation Project, work in the program development area has progressed through two stages: the Subcommittee on Program Development met for more than 6 months to generate ideas and propose strategies, and the department has continued since then to develop family-focused programs throughout the continuum of services.

The subcommittee proposed the development of programs at three levels of intensity, each targeted to families at different levels of crisis or dysfunction. The subcommittee recommended development of differential diagnosis and classification of families to assist in determining the appropriate level of services to be provided. The formats and goals for each level of service recommended by the subcommittee are described below.

Level 1: Diversion from Long-Term State Intervention. Cases that are assessed as low risk at the point of entry into the system should be diverted from long-term involvement with the department. Clearly defined, time-limited, and goal-focused programming is a means to serve these clients effectively. However, low risk often translates as low priority because of caseload pressures. Families that do not present in crisis tend to be underserved, and a negative cycle may be established. Lack of timely intervention often leads to a worsening of the family problem and a subsequent need for more intensive service or the placement of children. In order to aid this underserved population and yet not involve it further in State services, the subcommittee recommended purchase of time-limited diversion services from the private sector. These cases would have no department staff assigned. The model proposed is similar to the process by which families access outpatient child mental health services: based on criteria set by the department, families may receive service from private providers on a sliding scale basis, with the department supplementing the cost. The family does not become directly involved with department staff.

Level 2: At Risk of Placement. Intensive home-based service (IHBS) reaches high-risk families in crisis in which children are identified as being at risk of placement. Families that may be helped by a less intensive service are not considered appropriate for this

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service. IHBS is a short-term (4-12 weeks), crisis-intervention program that provides in home therapy, teaches parenting and life skills, and aids families in meeting their basic needs. The frequency of contact and around-the-clock availability ensures the protection of children.

Level 3: Ongoing Case Management. The decision to provide short-term intensive home-based service does not ignore the fact that many families require long-term support. While some workers refer to this population as "chronic," a more accurate definition includes those families with no connection to extended family, church, or community. Isolation, lack of parenting skills, and family and environmental stresses combine to increase the risk of serious neglect of children. The service continuum must provide assistance to families that need ongoing support and also those that need reunification services for children in placement. Many of the families that need this ongoing support have complex problems and are involved with more than one service division of the department. Accurate assessment, timely intervention, and case coordination are essential. The Unified Case Management Pilot Project, described below, was initiated to test one approach to serving this population.

The subcommittee also offered as recommendations a framework of principles that would support and extend family preservation services in the State. Based on these recommendations, as well as input from many other groups and a review of effective programs from other States, the department has developed and implemented a full array of family-focused programs.

Family-Focused Prevention Programs

Over the past 3 years, the department's Office of Prevention has successfully shifted its focus from direct provision of community education programs to becoming a catalyst and funder for community organization and neighborhood-based program development and delivery. To accomplish this, program staff reach out directly to parents by making regular home visits and phone calls, establishing newsletters, and offering frequent joint parent-child activities. Parent support groups are also encouraged. Such extensive family involvement helps rebuild dormant neighborhood networks that can be mobilized to attack various community problems. The purpose of these efforts is to help improve family self-esteem, communication, and integration with neighborhood resources in order to prevent drug abuse, delinquency and other youth problems. (See the articles by Glenda Fine and Sue Rusche earlier in Part III.) We are conducting research, in collaboration with the University of Delaware, both to validate successful approaches for involving families and to measure the impact of this approach to prevention.

Intensive Home-Based Services

The Family Prevention Project identified intensive home-based services as a promising part of a continuum of family-centered services. A unifying theory and a model for the practice of integrating dysfunctional families was developed. It furnishes a paradigm for service delivery and a philosophical framework from which social service staff can approach service planning and delivery.

This model, presented in a manual entitled *Home-Based Family Services,* was developed by Jorge Colapinto, Salvador Minuchin, and Patricia Minuchin, based on their work in New York and Delaware. It is an 8-week intervention based on structural family therapy and is targeted to those families at risk of having children placed out of the home.

The department decided to develop and implement several programs, each geared to the needs of particular populations and the mandates of different divisions. The programs are being evaluated, and early results indicate

high rates of success in avoiding out-of-home placement.

- *Child Protective Services:* The Division of Child Protective Services was the first to develop intensive home-based services as an alternative to placement for families in crisis. Purchase of service agreements have been entered into with two private agencies to provide intensive short-term, crisis-oriented, home-based services based on family systems theory. Each agency has developed a variation on the basic model.

- *Child Mental Health Services:* The Division of Child Mental Health developed the Brandywine Project as a short-term, intensive, 24-hour crisis-intervention program offered to adolescents as an alternative to psychiatric hospitalization. While hospitalization is sometimes necessary to guarantee the safety of aggressive, psychotic, or suicidal adolescents, recent research has demonstrated the effectiveness of intensive programs that serve as a safe alternative to hospitalization. The Brandywine Project uses a multidisciplinary team, can provide 72-hour respite care, and involves the family and its social network.

- *Youth Rehabilitation Services (YRS):* YRS is undergoing a transition from an institutional model (training schools) to one that places the delinquent youngsters in the least restrictive environment by (a) purchasing home-based services from private providers, and (b) referring to a new group outpatient therapy program (7-30 hours per week), the Delaware Advocate Program.

Case Management

In 1986, the department initiated a 6-month pilot test of a unified, family-centered case management system across the different divisions. The purposes of this pilot were, first, to identify the advantages and disadvantages of providing and coordinating services without regard to divisional or categorical boundaries, and, second, specify the administrative, structural, or other obstacles to implementing this approach throughout the department.

The service problems that led to the decision to pilot a test of the unified case management approach include:

- Fragmentation, due to multiple conflicting service plans.

- Discontinuity, due to changing case management whenever a new service is provided.

- Waste, due to overlapping interventions.

- "Dumping," due to the tendency to relabel a child's problem so as to exclude him from a worker's caseload.

- Unnecessary and redundant assessments, due to the need to reevaluate the service plan whenever case management changes.

The department has identified a population of families with multiple problems, known to many agencies, that consume a disproportionate share of the department's resources. These cases usually have at least two case managers, and are often more difficult and complex than other cases.

A pilot project with 60 of these families was conducted, and it demonstrated that both case managers and families benefited from the unified case management approach. The success of the pilot program led to plans to implement Unified Case Management Programs throughout the State. These units will be assigned the long-term, multiproblem families that require services from more than one division.

The most important guideline for preparing to implement the family-centered model within a large service system is the understanding that the endeavor must include shifts in attitudes as well as services.

Problems In Implementation

As exciting and successful as the Family Preservation Project has been, there have, of course, been some problems encountered in the process of implementation. In hindsight, some aspects of the implementation might have been approached differently.

First, the time and effort needed to complete various tasks were underestimated. This resulted in a great deal of stress for some participants, occasional delays in completion of other assignments, and less attention to some aspects of the project than would otherwise have been given. Many other States have assigned a full-time director to their family preservation projects, which Delaware did not, even though their programs allowed for more narrowly focused responsibilities than those required by our project. In retrospect, that approach seems more realistic.

Second, the participation by department staff in the earliest phases of the project was inadequate. Much energy was focused on involving people outside the department, in order to build support and spread information. Their involvement was indeed crucial to the initiation of the project and should not have been decreased, but a wider range of department staff should have had a more intensive role earlier in the process.

Finally, too much time and energy were spent on early data collection. As with much research using case record data, significant problems were encountered in interpreting information developed by many different sources. Ultimately, the development of a consensus around the values of the project was more important to the outcome than the presentation of data about the specific dynamics of placement decisions.

Lessons Learned

The most important guideline for preparing to implement the family-centered model within a large service system is the understanding that the endeavor must include shifts in attitudes as well as services. Simply creating a position or a program is insufficient. A commitment from the top to address the entire context of the family-centered model, that is, the attitudes and beliefs of the persons and systems surrounding it, is essential.

In addition, the Delaware experience points up the following tips for planning and implementing change to a family focus in a large bureaucracy:

- *Organizational Seeding.* Although a project of this scale requires both top-down and bottom-up participation, the support and investment of top management is the critical first step. Key staff within the organization should be given thorough and regular briefings on the project with clear indications as to how the project will help them attain their own objectives.

- *Opportunistic Creativity.* One cannot predict opportunities for moving the family preservation agenda forward. By becoming thoroughly familiar with the theory, values, programs, and practices associated with family preservation, key persons can be prepared to respond to those opportunities presented in the normal course of events. For example, if funds are freed up due to unexpended contracts, a pilot of a family-focused model can be proposed.

- *Sustained Effort.* Accomplishing a shift to a family-focused service delivery system is a multiyear effort. One should assume that many, if not most, of the attempts to impact

the organization will fail, at least in the short term. Perseverance is perhaps the single most important element in the overall strategy.

- *Multi-level "Ownership" of the Change in Perspective:* The attempt to shift to a family-focused system can perhaps best be understood as a complex organizational development effort, requiring top management, middle management, supervisors, and line staff to commit to the model.

- *Sound, Well-Articulated Programs:* Research in family preservation and other outcome evaluations have documented the need for well-designed interventions that are adequately funded and integrated into the service delivery system. The great effort necessary to initiate family preservation programs can be easily squandered if the programs are poorly conceptualized and ignore the lessons learned through previous efforts.

- *Quality Training That Includes All Personnel:* Training is the key to the ability to deliver quality services and is an important part of helping all staff to invest in the change in perspective.

- *Fiscal Support:* To become institutionalized, family preservation and other family-focused services must become as entrenched in the budget base of the agency as foster care or incarceration.

- *Incremental Change:* Because organizational change in public bureaucracies is so difficult, the efforts to shift to a family focus may need to include both broad-based efforts, such as departmentwide staff training and program development, and more comprehensive, intensive initiatives targeted to smaller sub-units of the agency that spell out step by step the incremental processes and components of change.

Steps and Strategies at the County Level: The Montgomery County Experience in Maryland

Peter F. Luongo, Ph.D.

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Overview

What does it take to build a publicly funded, countywide, integrated, family-centered service system for adolescents? What is the most effective way for institutional systems (for example, public school, social services, and juvenile justice systems) to access community-based treatment for troubled adolescents and their families?

This article presents the development of a countywide, family-focused mental health and alcohol and other drug abuse service system for children and adolescents in Montgomery County, Maryland. The discussion highlights the evolutionary process and conscious choices made to organize a system of services to meet the needs of an identified target population. The paper further discusses the general principles used to implement a family-focused, community-based mental health system for adolescents and the relationship between administrative structure and clinical process.

The Montgomery County Experience

Montgomery County is a Maryland suburb of Washington, DC, with a population of approximately 730,000 and a public school system serving 100,000 students. Prior to 1986, all public mental health and addiction services were provided by the local health department. A core of adolescent services existed in one section of the health department that was administratively known as "Alternatives and Counseling Programs." This label was used to distinguish this section from the more traditionally organized section called "Mental Health." By 1985, the weight and stress of a mental health system providing traditional mental health services to an almost exclusively adult population forced the county to look seriously at alternatives to the way public mental health services were delivered. Throughout the very public discussion about the fate of mental health services in the county, the topic of child and adolescent services was virtually ignored. Advocacy groups for the chronically mentally ill dominated the agenda. This, paradoxically, was beneficial to child and adolescent services.

The spirited debate that ensued about the structure and function of mental health services gave birth to a radical solution to the mental health dilemma in a locality and State more accustomed to incremental adjustments in the status quo than to major innovations. The county chose to abandon the traditional public health structure and establish mental health services separate from the health department. In 1986, the Department of Addiction, Victim, and Mental Health Services (DAVMHS) was created to centralize the planning and implementation of a community-based system of addiction, victim, and mental health services for Montgomery County. This was, and still is, the first department devoted exclusively to mental health services in Maryland. It has approximately 90 staff working in child and adolescent services. In addition, many services are provided through contracts with the private sector.

At the time DAVMHS was organized, the family-based adolescent treatment programs of the Alternatives and Counseling section were the only organizational entities clearly

The first order of business was to clearly specify the target population of adolescents and their families that the system was to serve.

identified as family and adolescent focused. Included in this rather eclectic mix of programs was a program anomaly called Parents and Children Together (PACT). PACT began as a family crisis intervention and diversion program for status offenders in 1977. By 1986, the program had become a hybrid short-term family therapy agency. All the staff were trained family therapists. The Alternatives and Counseling Program, lumped together in DAVMHS as little more than an afterthought, became the foundation for reorganizing and refocusing mental health services in the county. With most of the public's attention devoted to the revitalization of services to the chronically mentally ill and the struggle with deinstitutionalization, the field was wide open for a serious attempt at making the system of services for children and adolescents work. No spotlight meant the freedom to rework the system in helpful anonymity.

The administrative and clinical outcomes of reorganizing child and adolescent mental health and addiction services have been impressive. Administratively and fiscally, DAVMHS has achieved a "single stream of funding" capacity, that is, all public funds for child and adolescent services, whether from local or State sources, come to the department for program development and operations. The PACT program was restructured as the central point of intake and case management services for community and institutional referrals. The result has been that in the course of 2 years, referrals to PACT have doubled from 750 a year to 1,500. At the same time, clinical staff devoted to child and adolescent services has more than doubled in 4 years, and six new programs, including three community-based residential alternatives, have been started. The expansion of joint programming with the public school system was an expected and welcomed outcome, as these two systems recognized the need to commingle resources. The past 3 years have seen the cooperative planning and implementation of an intermediate level (grades 7-8) day treatment program and an afterschool program for adolescents in a special education school. Further programs are in planning stages as a natural consequence of the process of collaboration.

The following section discusses the steps taken to organize this local system of service, the general principles gleaned from the experience, and some of the problems encountered in implementing a systemwide shift to a family-based system of care for children and adolescents.

Steps and Strategies at the County Level

Specifying the Target Population

The first order of business was to specify clearly the target population of adolescents and their families that the system was to serve. As a matter of policy from the beginning, the county placed a priority on children and adolescents already engaged with public sector services (for instance, social services, juvenile services, or special education) and targeted services to children from families of very low income or too limited financial means to secure services in the private sector. The reason was straightforward and simple. Troubled adolescents and their families already identified in these service systems were costing the community a considerable amount of money and were not getting access to all the services available. This approach provided the opportunity to form partnerships with natural allies—the other public human service providers in the community. This priority sparked immediate interest from the public agencies, which for too long had felt that "their" clients, were not getting adequate service. DAVMHS management and staff defined these clients as "our" clients, too, and began to cement a partnership with the other public agencies.

Restructuring

Simultaneous to the definition of the target population was the administrative placement of all children and adolescent programs into one division, that is, mental health, alcohol and other drug abuse, and juvenile-care-related services. The structure to begin this process was found in the old Alternatives and Counseling section. That structure was chosen as the foundation of growth because of its history (since 1971) of providing family-based treatment for adolescents. In its early years, the program was not seen as a mental health program and was left much to its own devices to develop as an alternative. In those years of benign administrative neglect, the program evolved a clinical model of strategic-structural family therapy and expanded the model into crisis-intervention services for status offenders. The PACT program was an evolutionary product of that system. It was a natural for the county to build on this solid clinical model for family interventions with public systems. Not having to start from scratch was an advantage. (See diagram 5, page 160.)

Designating Single Point of Entry

Once child and adolescent services were administratively organized into one division, the problem of access to services was addressed. There are several frequently heard complaints about child and adolescent mental health and addiction services:

- "I don't know who/where to call for help."
- "How do I know this is the right help?"
- "It seems that you have to know what you want before anyone will help."
- "I refer a family and they fall through the cracks."

The solution was to designate one program, PACT, as a single point of entry to the child and adolescent mental health and addictions system. PACT's function, as case managers, became assessment of the adolescent and family's need for service, referral of the family into the appropriate community-based treatment, and continued involvement throughout the receipt of treatment services to ensure that families didn't fall between the cracks. Three changes needed to occur in order for PACT to fulfill this mission.

Clarifying Referral Pathways

The first was that new referral pathways had to be established for public agencies to PACT. Preexisting pathways into the child and adolescent system were more informal and clinician-based rather than system-based. Formal Memoranda of Agreement (MOA's) were negotiated and executed with systems users. These agreements with the local juvenile services, social services, and public school systems specified referral and reporting procedures and shared clinical and communication responsibilities of the respective systems. The negotiations with these referral agencies often involved confronting history and breaking down barriers. A standard technique used in family therapy practice (ascribing noble intent) served as a useful tool whenever negotiations reached stalemate. And they did. Stalemates typically came when systems users saw PACT as usurping their professional judgment about what type of treatment was needed. This barrier was often overcome by pointing out how the systemic changes proposed by the MOA answered many of their expressed complaints about accessing children and adolescent services. "And after all, isn't this what we all want?" Given that approach, it is hard to walk away from the bargaining table.

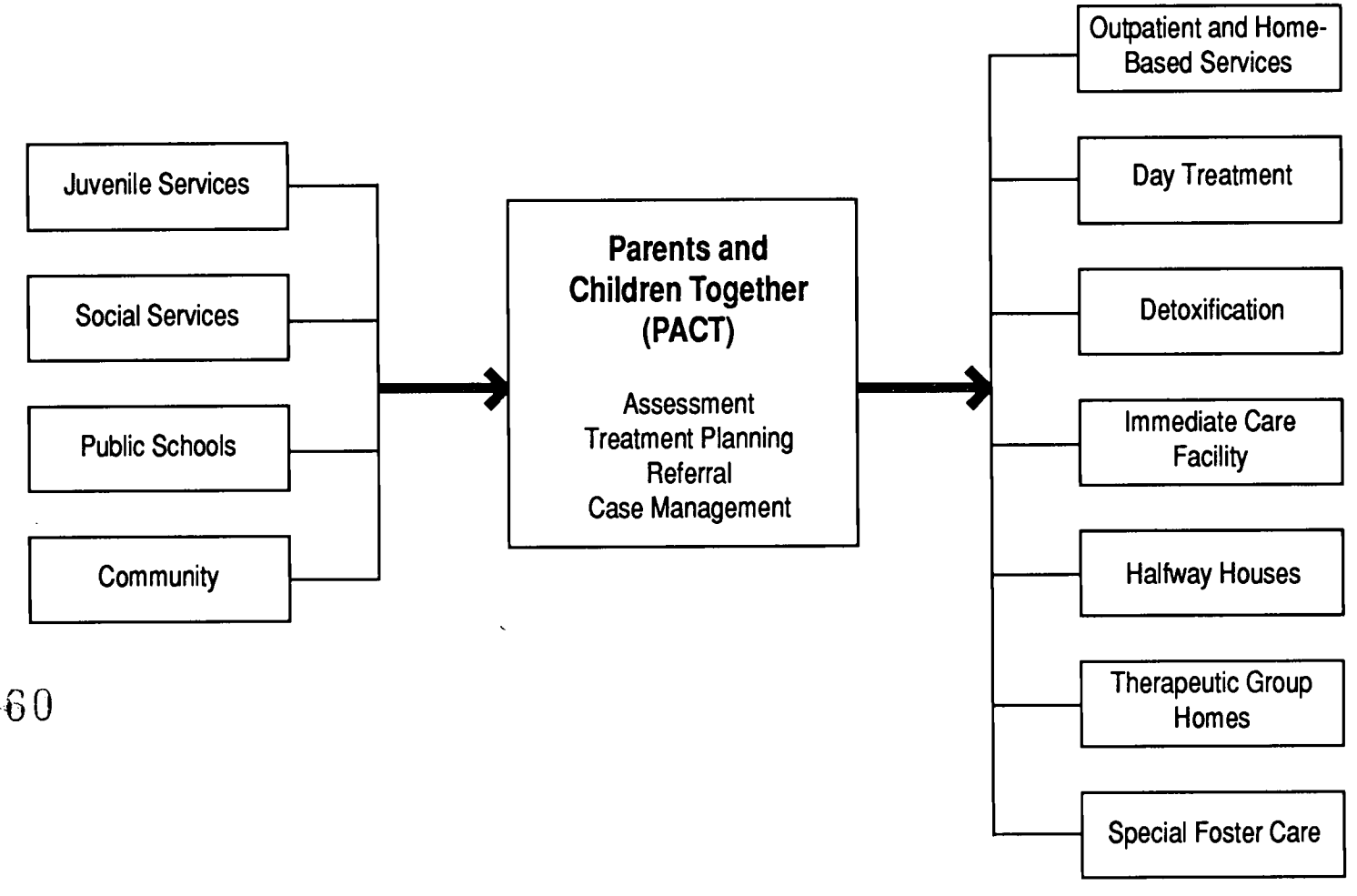
Controlling Use of Services

The second change that needed to occur was internal to DAVMHS. PACT case workers had to directly control access to publicly funded outpatient and residential treatment services. This was the only way to guarantee that priority populations got the service needed. Intake services for outpatient county treatment were handled at PACT, as were all screenings for residential treatment. When a PACT worker decided on a treatment placement, the DAVMHS treatment agency accepted the case.

The negotiations with referral agencies often involved confronting history and breaking down barriers.

Diagram 5

PACT — A Single Point of Entry to Adolescent Mental Health and Addiction Services in Montgomery County, Maryland



No further intake was needed. This required a renegotiation of PACT's authority and status among its sister agencies, and, not surprisingly, led to the surfacing of the same issues within the department as were raised by PACT's role external to the department.

Controlling Funding

Facilitating PACT's assumption of a central intake and case management role was the funding mechanism for county child and adolescent mental health and addiction services. Approximately 70 percent of the revenue for these programs is derived from county general revenue, with the remainder coming from the State. All revenue for children and adolescents was "single streamed" into DAVMHS. DAVMHS was assigned the responsibility for designing and implementing community-based programs for children, adolescents, and their families with mental health and addiction problems. Control of the funding stream made PACT's role feasible.

Summary

Building on Montgomery County's experience, five critical principles for implementing a countywide system of family-based child and adolescent services emerge as critical to success:

1. A clear and operational definition of the target populations.

2. A single stream of funding for community mental health and addictions services.

3. Negotiated and executed Memoranda of Agreements (MOA's) with systems users.

4. A central intake and case management authority having control over access to public services for children and adolescents and their families.

5. Though this has not been discussed here, a critical component of Montgomery County's success with adolescents is on-going inservice training in the family-based approach to treatment. Substantial dollars and time are allocated in the budget for training.

This administrative structure is conducive to family systems work. It provides for flexibility, yet at the same time requires specific definitions of responsibilities. Like family systems interventions, it acknowledges the interrelatedness of the actors in the system. Finally, it underscores the fact that adolescent services must involve as many of the systems of the child's life as possible.

Training Staff: Preparing Clinicians To Deliver Family-Centered Treatment

Marion Lindblad-Goldberg, Ph.D.

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Family-centered treatment can only be provided if clinicians possess the necessary skills and knowledge required to conduct it. Limited skill levels increase professional fatigue, morale problems, and staff turnover. When the State of Pennsylvania funded a major children and adolescent mental health initiative, Family-Based Mental Health Services, beginning in fiscal year 1987-88, moneys were also allocated for staff training and program evaluation. A 3-year curriculum of competency-based family intervention training was developed by the Philadelphia Child Guidance Clinic's Family Therapy Training Center, and was provided to master's and bachelor's level home-based services staff 2 days a month at four regional training sites. After providing a detailed description of the Pennsylvania training experience, this article discusses implications and recommendations for other States and/or agencies seeking to train staff in family-centered treatment.

The Pennsylvania Training Experience

Background

As a result of the Federal Children and Adolescent Service Systems Program (CASSP) initiative through the National Institute of Mental Health (NIMH), Pennsylvania's Bureau of Children and Youth Services, Office of Mental Health, funded a major children's mental health initiative, Family-Based Mental Health Services, at an annual cost of $2.03 million in fiscal year 1987-88. This initiative put into operation the CASSP philosophy of "family as primary caregiver" by providing startup moneys for family-based services to providers in ten counties statewide. Since that time, funding has been increased to allow for the implementation of ten additional programs, with another five to eight programs to be funded in fiscal year 1990-91. The initiative now includes a total of 25 programs participating. These county programs are located in both public and private agencies and institutions, in a variety of social and political contexts with diverse urban and rural client populations. In addition to program costs, moneys have been allocated through this initiative for staff training and program evaluation, both of which have been conducted through a subcontract with the Philadelphia Child Guidance Clinic. Sixty-five percent of the Pennsylvania Office of Mental Health's Home-Based Services Program patients were adolescents.

The 6-month intervention model selected uses a multisystemic approach to provide mental health services in the homes of families having seriously symptomatic children and adolescents at risk for out-of-home placements. The theoretical values underlying this initiative include family focus, integration of child service systems (mental health, child welfare, drug and alcohol, juvenile justice, and education), parental empowerment, and parent advocacy.

Mental health counseling and concrete support services are available on call, 24 hours per day, 7 days per week, and are delivered by a two-person team consisting of master's and bachelor's level clinicians. Small caseloads of six to eight families are recommended. Treatment is systemically oriented, in that both the family system and the local child service systems are the foci of change efforts. The

Both the training model and the program evaluation design must be congruent with the theoretical approach used in service delivery.

systemic orientation has been reflected throughout each program, from the intake process, which involves consultation with the major child-serving systems in each program's county, to the engagement of community systems on the family's behalf. The treatment goal of this model is to expand each participating family's competence by changing current patterns of interaction both within the family and between family and community systems, so that a family can make better use of its internal resources as well as the resources in its environment.

Training

Both the training model and the program evaluation design must be congruent with the theoretical approach used in service delivery. The training carried out by trainers from the Philadelphia Child Guidance Clinic's Family Therapy Training Center draws theoretically from ecosystemic, structural family theory and emphasizes clinical and conceptual skills necessary for effective family-centered intervention delivered in the home.

The competency-based training curriculum was developed by a team composed of parent advocates and child service system providers, including mental health professionals working in home-based, outpatient, and inpatient programs. While preparing the curriculum, "home visits"—that is, site visits—were made to the first 10 projects funded and a needs assessment of project staff was conducted. The curriculum has continued to be refined during the first 2 years of training project staff. Curriculum modules include "how to" implement a structural family treatment approach to families experiencing a variety of crises related to, or involving: alcohol and other drug abuse, physical and/or sexual abuse, violence, single parenthood, divorce, remarriage, ineffective parenting skills, multiple agency involvement, and so forth. Planning is in process for university graduate programs statewide to incorporate this curriculum as electives.

Training Format

The training occurs over a 3-year cycle and targets every level of agency staff, from the top administrators to the line staff. Training begins with two initial technical assistance/training days provided to regional, county, and agency program directors and county CASSP representatives. The focus of this initial training is to build supportive relationships with top-level administrators and to educate them on both a systemically oriented, family-centered treatment approach, as well as to have them directly experience the training approach that will be used by the county's home-based program staff. Following this initial training, each program's staff receive training at one of the four state regional training sites 2 days per months, for a total of 17 days per year and a total of 51 days during the 3-year cycle. The experiential component of clinical skills training is based on videotaped case presentations of the trainee's clinical work in the home.

While conducting experiential clinical skills training, a training day is organized so that supervisors meet as a group with the trainer before the staff training session, during lunch, and at the end of the training day. Thus, the trainer's primary alliance to the supervisors and respect for the supervisor/worker hierarchy is preserved.

A set of 72 clinical skill competencies and 27 knowledge area competencies form the basis of evaluations of clinician development over time and the measurement of the relationship between clinician competency and family outcome in the State evaluation plan. Evaluation feedback to date has indicated increased staff retention, clinical skills growth, and high morale due to the training initiative.

Use of Videotapes in Supervision

A very important component of the training is the use of videotaped training interviews with the client families in their homes. Each program is required to invest in the videotape equipment, and the therapists are carefully trained in their use through first using them with their own families. A two-person team goes into each home, and they alternate between using the camera and conducting the interview.

The taping with the families was, of course, voluntary; but once the families understood that the tapes would be taken back to the agency in order for the team to plan how best to help them, they usually accepted the taping. The tapes are then shown in the monthly training sessions in which several programs participate jointly.

Basic Questions for the States and Agencies Seeking Training

What are the philosophical and organizational issues to be examined by the State or agency before seeking training services?

The organization's theoretical orientation(s), procedures, hierarchy, and traditions are generally interwoven with the treatment services being provided. Many mental health services focus on the pathology of the identified patient and offer long-term treatment approaches and excessive use of inpatient facilities. One cannot conduct family intervention training within a context that does not support family intervention services. Family-centered treatment requires that States or agencies adopt a unifying theoretical model that is systemic, goal-oriented, brief in duration, and emphasizes using the resources of families and other social systems to solve problems specifically identified by the family. This approach includes making use of professional resources having differing theoretical orientations (for example, psychologists, whose orientation is to the individual, and social workers, whose orientation is to the social context), but doing so within the framework of the unifying theoretical model. Similarly, family intervention training requires a unifying theoretical model that is congruent with the service delivery model. This provides clearer intervention guidelines for therapists. More typically, there is not a unifying theoretical model for service delivery and/or training (as occurs in many State training projects), and trainees receive various learning modules from trainers each representing diverse theoretical orientations. Somehow, the trainee is expected to integrate this eclectic experience, which can be confusing for a new therapist.

Adopting a unified theoretical model based on ecosystemic, structural family theory has direct logistical, financial, and practical consequences for both service delivery and training in agencies:

- Intake, medical records, and treatment policies may have to be modified for whole families to be seen. Will there be space? Evening hours?
- What will be the agency's support for staff, time off for training, and equipment (e.g., one-way mirrors, adequately sized observation rooms and audio connections between these rooms and videotaping and playback equipment)?

Who is to be trained?

This question is crucial. First, we advocate training "from the top down," that is, building supportive relationships with organization decisionmakers and training them to understand the basics of a family-centered systemic orientation using the same training format their staff will receive. Second, and ideally, we recommend providing intensive clinical training to those supervisors whom the administration trusts will remain committed to staying with the agency and who will eventually become trainers themselves to other

We advocate training "from the top down," that is, building supportive relationships with organization decisionmakers and training them to understand the basics of a family-centered systemic orientation using the same training format their staff will receive. Family-centered treatment will be most effective if every level of personnel is trained (administrators through maintenance staff).

staff. Alternatively, sometimes it is more cost effective for agencies to hire a trainer to work with a heterogeneous group of supervisors and staff together. When this occurs, it is important to design the training day (as indicated in the Pennsylvania training experience) so that supervisors are empowered and recognized for their supervisory hierarchical position relative to the staff. A crucial principle to remember is that training supplements ongoing supervision and that the supervisor-supervisee relationship must be supported. In determining what staff to include for training, several factors should be kept in mind:

- Include staff who work closely together programmatically (for instance, M.A. and B.A. members of a team).
- Do not make the training groups too heterogeneous in terms of job function (for example, intake workers and senior-level clinicians).
- Family-centered treatment will be most effective if every level of personnel is trained (administrators through maintenance staff).

Administrators should recognize that skill acquisition is a process which occurs over time. If intensive family intervention training is provided, provision should always be made for follow-up post-training consultation to ensure continuing trainee growth.

Another important issue is how to incorporate into a family-centered model the resources of the "old guard"—that is, long-time institutional staff—who feel comfortable in what they already know and do not want to learn new methods. Addressing this concern requires considerable skill and sensitivity on the part of administrators and trainers.

What are the training curriculum needs?

The question of what to train for should be addressed by first conducting a needs assessment of staff's family intervention skills. It is advisable to have a representative staff group that can help the administration make this assessment work.

How long does training take?

Administrators should recognize that skill acquisition is a process that occurs over time. Our Pennsylvania 3-year cycle, totaling 51 days, has empirically demonstrated growth in clinical competence over this time period. Decisionmakers should be aware that random workshop and/or conference attendance does not necessary result in clinical skill growth. If intensive family intervention training is provided, provision should always be made for followup posttraining consultation to ensure continuing trainee growth.

Potential Barriers

This training program was ambitious and required agency directors and staff to do things in very different ways. Inevitably, there was some initial resistance and difficulties in implementing the original plan, most of which have been overcome.

One of the initial areas of resistance was the use of home videotaping. A couple of programs took much longer to accept this new learning tool. But once they began to see how useful staff from other programs found the taped interviews to be, their resistance was lowered. As of now, all the programs are regularly taping their interviews for training purposes.

A second area of difficulty was the complex logistics involved in flying the training staff all over the State for the training sessions. Much more planning time and travel time was needed than had been anticipated, including making allowances for bad weather and other unforeseen circumstances.

Third, a couple of the programs had difficulty accepting the training and using it well, at least initially, because they were already committed to another model of doing home-based service—the Homebuilders model. This experience underscores the importance of ensuring that time is given in the beginning of any training program to careful discussion of the chosen treatment model and its implications and only accepting programs that are comfortable working within that model.

Finally, a significant and somewhat unexpected problem was the discovery that so many of the families referred to the program were "repeaters"—that is, one or another member of the family had already had some experience of placement outside the home. Sixty-one percent of the identified patients, 30 percent of their siblings, 17 percent of the mothers, and 7 percent of the fathers had experienced at least one out-of-home placement. When a family is already oriented to placement as a solution to a crisis, it is much harder for therapists to prevent placement, and success rates may be lower than when families have never experienced placement.

Administrators Seeking Training Services

In preparing a Request for Proposal (RFP) for family-based training services, it is extremely important for administrators to first articulate a philosophy and values with clearly stated objectives. The philosophy should emphasize the importance of family-centered programs involving five major components: a holistic frame of reference, an ecological perspective, a family systems perspective, the importance of developmental stages, and a permanency planning approach.

Other critical information found in the RFP would include providing criteria for evaluating the narrative description of the proposed training: (a) objectives, (b) teaching methods, (c) assessment of project objectives, and (d) the trainer's qualifications. It should also include a requirement in the budget to purchase videotape equipment and, if any of the models is an office-based approach, one-way mirrors.

Quality training can be provided by both individuals and organizations that specialize in training and have traveling faculty. In looking for someone who can do quality training, it is important to differentiate between individuals who provide supervision and those who have had experience as trainers. A qualified trainer is someone who has been a good family therapist, a good supervisor, and who has been training for at least 10 years. The qualified trainer is someone who can readily translate complex knowledge to both paraprofessional and senior professionals alike with humor, respect, clear communication skills, warmth, charisma, and who has excellent skills for dealing with group process. Probably the best way to select a trainer is to have your final candidates conduct, as part of the selection process, a short training session with some of the potential target groups. If that is not possible, then while evaluating a trainer's résumé, identify every agency where the trainer has provided similar training to your interests and contact those agencies for a recommendation.

The qualified trainer is someone who can readily translate complex knowledge to both paraprofessional and senior professionals alike with humor, respect, clear communication skills, warmth, charisma, and who has excellent skills for dealing with group process.

Keep in mind that a qualified trainer is a specialist who represents the highest level of clinical/teaching competence. Excellent trainers cost money. Cheaper training is not better training. True cost-effectiveness is realized when an expert trainer develops high-level skills in staff ranging from entry-level positions to more advanced positions. Development of skills also reduces staff turnover. In a paraprofessional training program we conducted in the late 1960's, trainees developed family intervention skills that exceeded those of the highest degreed staff.

In looking for quality trainers, seek out organizations like the Philadelphia Child Guidance Clinic's Family Therapy Training Center, which has a traveling faculty and has many years of experience training professionals, paraprofessionals, clinicians, supervisors, and administrators in public and private agencies and institutions. There are a number of these training centers growing up around the country (see Appendix I, page 193).

Summary

In summary, quality training increases skill levels, and fosters morale, staff retention, and effective service delivery. Establishing effective training in an agency, however, is a

process that begins with the agency setting up mechanisms for how the training will be supported in terms of the existing service delivery models, administrative and logistical support, setting clear goals for the training proposal, and selecting qualified trainers.

Part IV:
Guiding the Change:
A Checklist

Steps Toward Family-Centered Adolescent Treatment: A Program Self-Assessment Checklist

Theodora Ooms and Wendy Snyder

Introduction

While no adolescent treatment program completely ignores parents, few programs are totally organized around working with families—most programs function somewhere between the two extremes. Many program professionals would like their programs to work more closely with families than they do.

The contributors to this monograph have emphasized that family-centered treatment is not simply a new technique that can be learned by frontline clinicians. Family-centered treatment involves the program's philosophy, organization, financing, staffing, and many other policies and procedures. This checklist addresses all of these program factors. It serves as a summary review of much of the information presented in the monograph. We have designed it to be used as a diagnostic tool to help review and assess various program elements, staff attitudes, and practices. By using the checklist to assess your own program, you can determine:

- the profile of the teens and families being served — an indication of service needs;
- which aspects of the program are already family-centered;
- which could be more so;
- what policies and procedures constitute barriers to working with families;
- what can be improved and strengthened;
- and what needs to be radically changed.

This checklist is not an instrument for teaching or instituting family therapy. It focuses on identifying program practices and procedures involved in a family-centered approach. This approach may mean that members of the clinical staff need to develop some specific skills in interviewing families and/or that more family therapists need to be hired on staff or as trainers and consultants. Alcohol and drug abuse counselors and mental health professionals can learn to work more effectively with families without becoming family therapists themselves (which requires formal training). However, in order for them to do so, many of the program supports and components identified in this checklist need to be in place.

We have designed this checklist to help those working in inpatient, residential, outpatient, and day treatment settings and in the public and private sectors.

Self-Study Process

Why do we suggest a process of self-study? We hope that you as an alcohol, drug abuse, and mental health (ADM) professional or administrator will find that the checklist raises your awareness and stimulates ideas for changing some of your own clinical or program practices, policies, and procedures when providing treatment to troubled teens and their families. If you are a program administrator, you may then wish to initiate the desired changes throughout the program. However, as those who understand systems and organizations well know, organizational change is much more likely to be effective and long lasting if the people who have to implement change are involved in planning it. Thus we

recommend that you undertake the following steps in moving towards a more family-centered approach in your treatment program:

1. *Develop a staffwide consensus that such change is desirable.* Schedule staff discussions and set up presentations from, or site visits to, other programs that are working successfully with families. It is very important that all the key administrators and board members are involved at this stage and are themselves convinced of, or at least open to, the goal of becoming more family-centered. Suggest they read relevant sections of this monograph.

2. *Institute a self-study process.* Set up a study group or ad hoc committee that can plan a process of self-study using this checklist as a guide. All the key program units or departments that are involved should be represented (including, for example, intake, records, billing departments).

3. *Decide on the scope, timetable, and audience of the self-study.* Clarify at the outset the boundaries of the study. Are you looking at one department within a large program or at the whole program? How long should the study take? By when do you need the report and recommendations? The study may be conducted formally or informally. It may be accomplished in a matter of a few weeks or be more detailed and take a longer time. The information may be collected from staff discussions at meetings, conducting interviews, or distributing written questionnaires to staff, patients, and their families. Such studies can be done entirely in-house or may involve outside consultants.

4. *Make balanced and realistic recommendations for change.* The study should be careful to identify and report on the program's strengths as well as weaknesses in working with families. Recommendations for change should be realistic and take into account practical feasibility and available resources. One way of doing this is to identify under each heading a set of longrun goals and then suggest a series of immediate changes that will quickly and noticeably move the program in the desired direction.

5. *Outline plans for implementing the recommended changes.* Specify which person and/or department has responsibility for carrying out the changes and what the timetable is. Identify what financial resources are available. Changes and program improvement nearly always cost additional money initially, though farther down the road family-centered treatment may save costs by avoiding institutional placements and by sustaining the improvement gained through treatment. Identify needed expertise within and outside the program. (See Appendix I for a list of organizational resources, page 193.) Some of these organizations' members provide training, consultation, and technical assistance on implementing a family-centered approach.)

Self-Assessment Checklist

This checklist is organized under various headings representing key program components and features. While they are artificially separated here, the exercise of working through the checklist should show how each is closely interrelated with the others. Changes should be consistent across all areas.

The questions listed under the major headings are only a beginning. We suggest that you review them all and decide which ones are relevant to your program. You will probably want to rephrase some and add others to meet your specific situation. At the end of each list of questions we suggest some overall assessment questions and issues that you may want to return to after you have gathered all the basic information. (For example, the question about how well the program relates to minority

families is easier to answer when you have reviewed the questions under the staffing section about how many staff are members of the same minority group or about what special inservice training has focused on the special issues of that minority group.)

While many of the specific ideas in this checklist are drawn from the chapters in the monograph, it also builds on the Family Impact Seminar's and others' work in developing checklists in other program areas that are moving towards increased family involvement—for example, in teen-parent programs, schools and hospitals, etc. (See Henderson, Marburger, & Ooms, 1984; Ooms, et al., in press. Also see Association for the Care of Children's Health, in press.)

Profile of the Teenage Clients' Family Backgrounds

The place to begin a program self-study is to review what is known about the family characteristics, circumstances, and living environment of the population currently served by your program. Program data may be available to answer some or all of these questions. If not, rely on knowledgeable guesstimates based on clinical experience.

- What is the family structure breakdown of your current client population (percentage divorced, separated, remarried, never married)?
- What percentage is living with parents? Other relatives? In foster care or other nonfamilial care?
- What is the racial/ethnic composition of the families?
- If there is a significant number of any minority, what does the staff know about adolescence in this minority culture and the attitudes of this culture toward getting ADM treatment?
- What is the socioeconomic profile of the families? What are some of the mechanisms and barriers for families in gaining access to and paying for treatment?
- What ages/life-cycle stages are the teens' parents? (Are these young families or middle-aged families?)
- What stresses are the families likely to be dealing with in addition to their teenager? (For example, unemployment, neighborhood crime and violence, or rural isolation.)
- Have there been any recent changes in the types of families that are served by the program? (An influx of immigrants?)
- Are there any other special characteristics? (For example, high proportion of highly mobile families, military families, etc.)

Overall Assessment Issues and Questions

Once you have collected the answers to these questions, ask yourselves, especially if yours is a publicly funded program: Given what is known, does the client families' profile mirror the composition of the population the program is designed to serve? If not, why not? Is the program serving the type of family most in need? How well is the program meeting the special needs of this population? How well does it meet the needs of ethnic/racial minorities? What additional information is needed? What could the program do better?

Develop recommendations for change; identify long-term goals and shortrun steps toward them.

Program Philosophy and Attitudes

The program philosophy — that is, its underlying assumptions about the role of

families in mental health and alcoholism and drug treatment — permeates almost every area of the program's operations. This philosophy, which is often not made explicit, is usually an amalgam of the assumptions underlying the Federal or State programs and the beliefs of the program administrator and of influential staff. The philosophy may vary somewhat among units and staff members. However, any attempts at organizational change will need to confront these inexplicit assumptions and will reveal many of the inconsistencies among them.

Ask some of these questions to elicit how the philosophy is expressed:

- Overall, on average, how are parents and other family members viewed in relation to the adolescent's problems? (They may be viewed in different ways by different staff or units.)
  - As victims of the teenager's problem or as contributors to it?
  - As a resource to help the teen or as a hindrance?
  - As a resource to the program staff or as a hindrance?
  - As consultants/partners in treatment?
  - As having their own treatment needs?

- How is this philosophy expressed?
  - What is written about the family's participation in any program descriptions or advertising?
  - What is told to the adolescent and family at intake?
  - What is told to referral sources or expressed in any community outreach programs?
  - What is told to new employees?

Overall Assessment Questions and Issues

How is the current philosophy about the family's role carried out in the program operations? Is it explicit or implicit? Consistent or inconsistent? What needs to be done, if anything, to reflect a more family-centered philosophy? If the stated philosophy is family-centered, how well does the program carry out this philosophy in its operations?

Develop recommendations for change; identify long-term and shortrun goals.

Confidentiality and Consent

Family-centered treatment of adolescents raises troublesome issues concerning professional confidentiality and consent to treatment. Some of the questions to ask about this issue are:

- What are the State's laws regarding parent consent for a minor's ADM treatment (and for related issues that may arise such as reproductive health care, venereal disease treatment, HIV testing, etc.). Are the laws made known to all relevant program staff?

- What is program policy about parent consent for a minor's outpatient or inpatient treatment? (This may differ from State law.) About an adolescent's right to consent to treatment? What is said about these policies in program literature?

- How are conflicts between parents and adolescents about consent/confidentiality handled?

- What are the teens and parents told about protecting their confidentiality and about when and if information about each other will be divulged by the program professional?

- What are the program's policies about the confidentiality of records? What access does the teen have to these records? The parent? Who signs for release of information to other agencies or professionals?

- Does the program differentiate in practice on these issues between teenage clients who are minors and those who are adults?

- If audiotaping, videotaping, or a one-way mirror is used, when and how are families informed and asked for permission to use these procedures? How is their confidentiality protected with respect to their use? What kinds of forms are used?

Overall Assessment Issues and Questions

Are the program's policies on these issues known and understood by staff? How are they carried out in practice? Are they consistent with a family-centered approach, or do they make it difficult to implement such an approach?

Treatment Procedures and Processes

The different steps involved when a teenage client and family receive treatment are presented in sequential stages below, but in practice these stages may overlap. For example, in some programs "treatment" begins after the process of intake and diagnosis, while in other programs treatment is considered to begin with the first phone or inperson contact. Diagnosis and treatment planning are often continuing processes. At each of these stages, it is important to review how the family is involved.

Referral

- What information about the family is required from the referral sources?

- What is the referral source asked to tell the teenager and parents about the involvement that will be required of the parent(s) in your program?

Intake

- What information is asked for about the family in the first phone contact? On the intake/interview form?

- What determines who is considered to belong in this family, and who is significant in the life of this teenager?

- What are the teenager and his/her parents told about how the family will be involved, and what services and information they can expect, etc.?

- Who is asked to come to the first interview? If the family is asked to come, is it specified who in the family should come? (One or both parents? Grandparent? Everyone living in the household?)

- If the teenager is seen alone for the first interview, what is he/she told about contacts with his/her family?

- How is an absent father/mother involved?

Assessment/Diagnosis

- What kind of information is generally gathered about the family in the assessment/ diagnosis phase of service? Does it take place over the course of several initial interviews or in the form of a questionnaire?

- Does the person who conducts clinical intake/diagnosis also provide treatment?

- How much of the following types of information is routinely gathered?
  - The significant family members in the teenager's life — both immediate family and extended family
  - Each family member's assessment of the teenager's problem
  - The current physical health and emotional/social functioning of members of the family
  - The role of the important family members in the teenager's life, identifying positive and negative influences
  - The specific behavior of different family members with respect to the teenager's problem behavior
  - The family's social network and degree of social support. Which organizations or individuals are important to them (including church)?
  - Family's relationship to the teenager's school or other relevant agencies
  - Recent family events or crises

- Family's relationship to older generation (family of origin) and its involvement with the teenager
- Sources of family stress (other illnesses, workplace, unemployment, divorce battles, etc.)
- Sources of family strength and areas of healthy functioning
- Family problems that need to be addressed or referred elsewhere
- Family members' willingness to participate in treatment
- Other relatives who might be involved if parents are unavailable at any time
- How past problems have been dealt with by the family

- To which sources do clinical staff turn to get this information about the family? The teenager? Family members themselves? Referral sources? Schools and referring agencies?

- Do staff ever conduct home visits in order to meet with certain family members who do not or cannot come to the program, or to assess more fully the family's functioning and living environment?

- Do staff ever make school visits to meet with the teenager's teachers or other school personnel? Do they conduct interviews with family, teen, and school staff together?

- What role do family members and the teenager play in the assessment of the problems and in the decision to involve the adolescent in treatment?

- How do staff generally conceptualize the adolescent's problem? In terms of a DSM diagnosis? A developmental stage difficulty? A problem of dysfunctional family alliances? Or a broader systems intrusion (for example, conflict between school and teen/family)?

Treatment Planning and Implementation

- What role do the parents play in deciding upon treatment goals, reviewing treatment options, and developing a treatment plan? What role does the teen play?
- Does the treatment plan spell out specific treatment goals, tasks, and responsibilities for the teen and members of his/her family? Are the tasks and responsibilities of program staff also specified?

- Are the goals and plans specifically outlined in a written contract?

- How are the teen's parents informed about treatment progress? How are they involved in any changes in treatment (e.g., changes in medication, class assignment, etc.)?

- How many program staff members are directly involved with the adolescent? Is one person assigned to coordinate the work of these different professionals and to be the key liaison with the family? Are there times when everyone who works with the teenager meets together, and are the parents and teen ever invited to these meetings?

- If the program is inpatient/residential, what plans are made for the parents to remain involved? What is the visiting plan? What kind of telephone communication is encouraged? Are these plans worked out with the parent and teen?

- In a crisis, how is the family involved? For example, when there is a suicide threat, is the family asked to help avoid hospitalization by maintaining a 24-hour watch until the danger is passed ?

- What special activities are the parents required, expected, or encouraged to attend? Are they ever invited in to observe any of the group/educational activities?

- What ongoing efforts are made to help the family work collaboratively with other

significant professionals in the teen's life — e.g., school staff, probation officers, etc.?

- When the parents seem resistant or are otherwise unavailable, what efforts are made to involve other members of the teen's family or community support network in the treatment as a supplement or substitute for the parents?

Termination/ Discharge and Referral

- How are the parents involved in assessing treatment progress, deciding about whether to terminate treatment, or making referral to any other program? How is the teenager involved?

- What are the parents and teenager told about any future contacts with the program? Are they offered the option of initiating followup contacts?

- What are they told about information that may be passed on to other professionals about the results of the treatment?

Followup

- Who does the program contact for followup information — the teenager, the parents, or both?

Overall Assessment Issues and Questions

To what extent are these various treatment procedures and practices consistent with a family-centered treatment philosophy?

Administrative and Organizational Issues

Staffing

- What kinds of professional background or experience do the program staff have in working directly with families?

- To what extent does the staff's racial/ethnic background mirror that of the client population?

- Which members of staff have the most contact with the teenager's parents? Do these people also have contact with the teenager?

- When program staff account for their clinical hours, what credits can they claim for working with the family? Are there incentives or disincentives for the time spent with the family? For time spent on home visits, school visits, etc.?

- Is the staff reimbursed for transportation to make home/school/agency visits?

- What kinds of supervision do the clinical staff have for work with the family? What kinds of support are provided to deal with staff burnout? (Working with difficult family situations can be even more taxing than work with difficult adolescents.)

- How is the staff's work with the families evaluated? What weight is given to work with family members in the staff's performance evaluations?

Staff Training and Consultation

- What regular opportunities, if any, do you provide to the clinical staff for inservice training? How are the topics chosen? Have any ever focused on working with families? Have they ever focused on issues of working with cultural and racial minorities?

- If there has been training or staff development in working with families, what was the nature of these sessions? Did you use clinical case material through videotapes or live supervision? Were the sessions helpful or not? What could have been improved?

- How could more inservice training be financed?

- What regular opportunities, if any, are provided for clinical consultation, especially with difficult family situations? Does the program ever employ family therapy

consultants to work with the staff? How is consultation financed?

- If the program serves racial/ethnic minorities, have consultants from their communities ever been used?

- Has the program developed good contacts with other agencies or programs (for instance, adult ADM programs, social services, employment programs, etc.) in the community that program staff can use to refer families to for help with family problems not directly related to their adolescent?

Program Evaluation/Records and Data Collection (See Piercy, et al., 1989)

- What kinds of program/management data are collected?

- Do the format of client records and the filing system allow for the participation of family members to be recorded and followed?

Family-Friendly Facilities

- Is the waiting room convenient, friendly, and attractive for family members, especially those with other young children?

- Are there any toys or a separate playroom available for the younger children while the family waits for appointments?

- Are the interview rooms/staff offices large enough to interview several members of a family at one time? Do they offer privacy from outsiders?

- If the cost of transportation to the program is a major barrier in a family's participation are funds available to assist it with transportation?

- For inpatient/residential programs, are inexpensive accommodations available in the community for the families who live at a distance?

Consumers in Program Advisory and Policy Roles

- How, if at all, does the program tap into the experience, knowledge, and expertise of its clients as consumers to monitor and improve operations?

- Does the program ever invite parents/family members who have been served by the program to join special committees, boards, or other structures set up to provide advice on program design, management, and policy?

- Are former clients ever asked to be involved as volunteers in fundraising efforts?

- Are ex-adolescent patients/clients ever used in these or other ways?

- Are parent/consumers ever asked to participate in public education, media, and outreach programs? Are they ever asked to participate in governmental hearings or other events such as conferences?

Overall Assessment Issues and Questions

Which areas of administrative policy and procedures presently provide the strongest support for family-centered clinical treatment? Which areas most need to be changed? What are the expected rewards and benefits of working more with families? What are the anticipated problems and resistances?

How strong is the commitment of administrators and staff to a family-centered approach? Can it withstand the public pressures to change to a policy of institutionalization that often follows upon the suicide of a teenage client or other publicized violent behavior in a family?

Develop recommendations for change; identify longrun goals and shortrun steps to implement them.

References

Association for the Care of Children's Health. (In press). *Caring for children and families: Guidelines for hospitals.*
A comprehensive guide to assist hospitals in providing family-centered, psychosocial, developmentally oriented pediatric care. Checklists follow each of the 15 chapters. Available from ACCH, 7910 Woodmont Avenue, Suite 300, Bethesda, MD 20814.

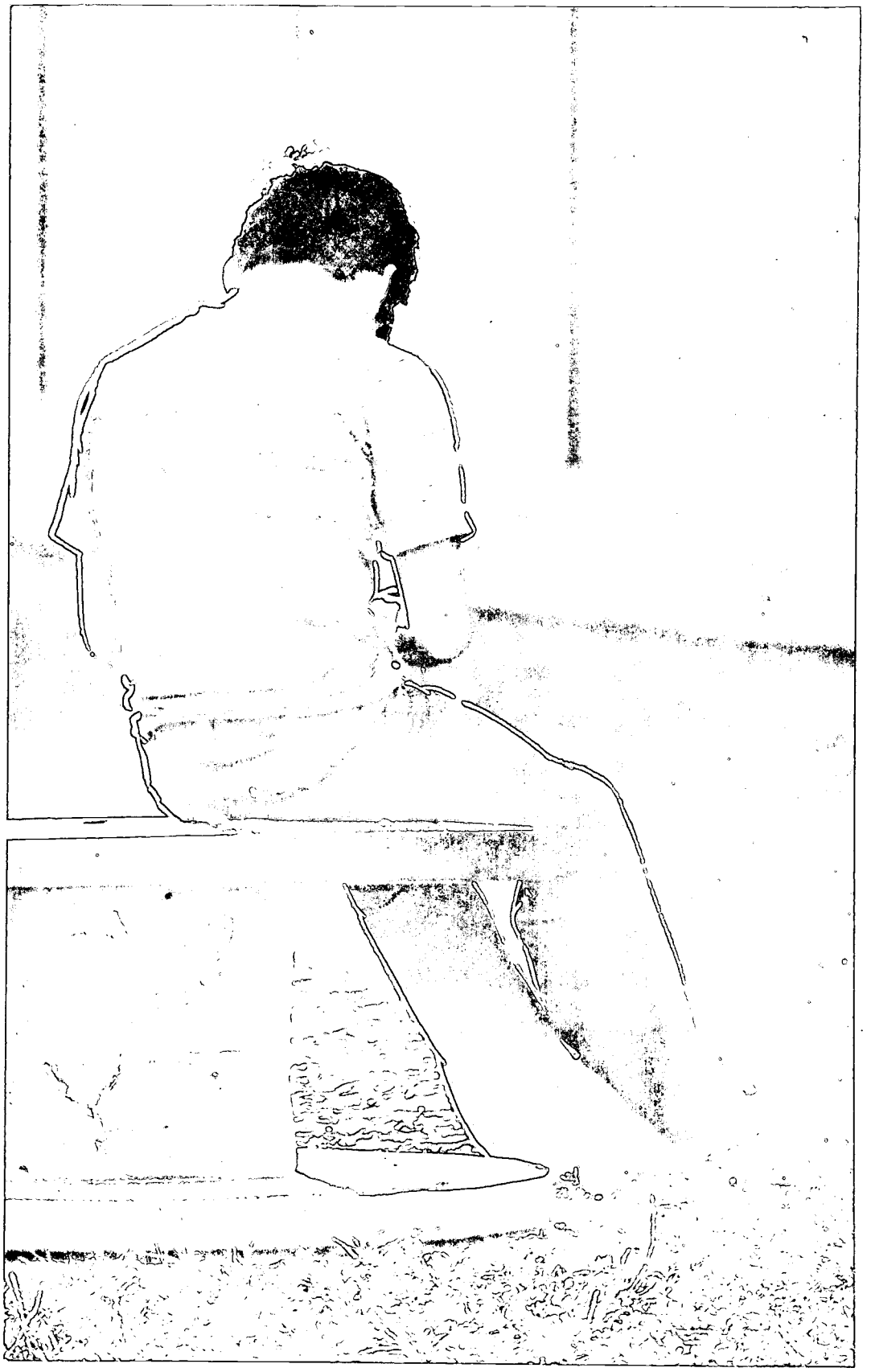
Henderson, A. T., Marburger, C. L., & Ooms, T. J. (1986). *Beyond the bake sale: An educator's guide to working with parents.* Columbia, MD: National Committee for Citizens in Education.

Ooms, T. J., Leitch, L., Hanson, S., & Smollar, J. (In press). *Guide to family involvement in adolescent parent programs.* Booklet prepared for the Adolescent Family Life Office, Office of Population Affairs, Department of Health and Human Services.

Piercy, F., Lasswell, M., & Brock, G. (Eds.). (1989). *AAMFT forms book.* Washington, DC: American Association for Marriage and Family Therapy.
A collection of sample forms used throughout the treatment process by family therapists. Includes intake, assessment, consent, evaluation, and other forms.

Part V:
Annotated Bibliography

For those who are interested in finding out more about family-centered treatment for adolescents with alcohol and other drug abuse or mental health problems or about family therapy in general, this annotated bibliography is a broad, but not exhaustive, listing of easily accessible and mostly recent journal articles and books. The sources listed cover a range of topics, from general theory to specific treatment approaches for adolescents.



Annotated Bibliography

Abelsohn, D. (1983). Dealing with the abdication dynamic in the post-divorce family: A context for adolescent crisis. *Family Process, 22,* 359-383.
Presents a family systems approach to be utilized with separated and divorced families with adolescent children. Discusses how to improve parental functioning following a separation or divorce. Examples from a case study are provided.

Alexander, J. F. (1988). Phases of family therapy process: A framework for clinicians and researchers. In L. C. Wynne (Ed.), *The state of the art in family therapy research: Controversies and recommendations* (pp. 175-186). New York: Family Process Press.
In his chapter, Alexander discusses the fundamental phases of family therapy. Useful for those clinicians and researchers who are interested in understanding the processes involved in family therapy.

Anderson, C. M., Reiss, D. J., & Hogarty, G. E. (1986). *Schizophrenia and the family: A practitioner's guide to psychoeducation and management*. New York: Guilford Press.
Presents a psychoeducational approach for working with schizophrenic clients. Describes each phase of the treatment program. Discusses particular interventions and techniques to be utilized during these phases. Offers suggestions on how to utilize this approach in various mental health settings. Case examples are provided.

Aponte, H. J. (1980). Family therapy and the community. In M. S. Gibbs, J. R. Lachenmeyer, & J. Segal (Eds.), *Community psychology: Theoretical and empirical approaches*. New York: Gardner Press.
Discusses the family within the larger context of its environment. Examines the power and impact of such agencies as schools, courts, and mental health centers. Illustrates use of structural therapy techniques with inner-city families. Includes interventions with individuals, the family, and the school community.

Berger, M., & Jurkovic, G. (1984). *Practicing family therapy in diverse settings*. San Francisco: Jossey-Bass.
Explores the application of family therapy in a variety of settings, including a public mental health center, a hospital psychiatric unit, social service agencies, employee assistance programs, private practice, and others. Useful to those who want to understand how a family systems approach can fit into different programs and settings.

Bowen, M. (1978). Theory in the practice of psychotherapy. In M. Bowen (Ed.), *Family therapy in clinical practice* (pp. 337-387). New York: Jason Aronson.
Bowen elucidates his theory of how families operate. Explores concepts of differentiation of self, undifferentiated family ego mass, triangles, nuclear family emotional system, marital conflict, family projection process, emotional cutoff, multigenerational transmission process, and a variety of other concepts. Useful to those who are interested in understanding family dynamics.

Boyd-Franklin, N. (1989). *Black families in therapy*. New York: The Guilford Press.
While not specifically focusing on adolescents, Boyd-Franklin's book provides a multitude of information applicable to black adolescents and their families. Presents how specific cultural aspects impact the treatment of black families. The author discusses a multisystems approach to treating black families.

Bry, B. H. (1988). *Family-based approaches to reducing adolescent substance use: Theories, techniques, and findings.* NIDA Research Series: Adolescent Drug Abuse: Analyses of Treatment Research, 77, 39-68.
Provides a broad overview of systems theory and behavioral theory. Describes and reviews systems and behavioral techniques and interventions found to be effective in changing problem behavior in adolescents.

Carter, E., & McGoldrick, M. (Eds.). (1980). *The family life cycle: Framework of family therapy.* New York: Gardner Press.
Presents overview of the American family from a systems and developmental perspective. Conceptualizes problems as difficulties in negotiating tasks at various stages of family life. Chapters of particular relevance are "The Family With Adolescents" and "Launching Children and Moving On."

Combrinck-Graham, L. (1985). Hospitalization as a therapeutic intervention in the family. In R. L. Ziffer (Ed.), *Adjunctive techniques in family therapy* (pp. 99-124). New York: Grune & Stratton.
Presents a family-centered approach to psychiatric treatment in hospital settings. Especially useful to those clinicians whose clients are at risk for hospitalization. Discusses specific interventions and techniques. Case examples are provided.

Daniels, J. (1990). Adolescent separation-individuation and family transitions. *Adolescence, 25*(97), 105-116.
Provides an overview of developmental theory, while specifically reviewing the separation-individuation stage of development. How various marital transition factors such as separation, divorce, single-parent families, and remarried families impact adolescent separation-individuation are discussed. The author recommends alternative interventions for use in family therapy to enhance adolescent separation-individuation in nontraditional families.

Davis, D. (1980). Alcoholics Anonymous and family therapy. *Journal of Marital and Family Therapy, 6*, 65-73.
Explores similarities and differences between family therapy and self-help approach to the treatment of alcoholism, and discusses how each can add to, rather than detract from, the other. Presents illustrative case scenarios.

Donner, R., & Fine, G . (1987). *A guide for developing self-help/advocacy groups for parents of children with serious emotional problems.* Washington, DC: CASSP Technical Assistance Center, Georgetown University.
Presents brief background and rationale for self-help movement for parents of children with serious emotional problems and practical guidelines for those interested in forming a group. Includes references and resources.

Falloon, I . (Ed.). (1988). *Handbook of behavioral family therapy.* New York: Guilford Press.
Presents an overview of behavioral family therapy and explores general issues including assessment and handling resistance. Discusses specific applications, including parent training, alcoholism, and schizophrenia, among others. Also presents a comparison of behavioral and systemic family therapy. Includes a chapter by James Alexander on his Functional Family Therapy model, described in Part II.

Fisch, R., Weakland, J., & Segal, L. (1982). *The tactics of change.* San Francisco: Jossey-Bass.
Explains the Mental Research Institute's (MRI) concepts of problem formation and resolution. Discusses the basic elements of brief therapy, and illustrates its use with case studies. Of special interest is the chapter "Case Study, The Adversive Adolescent."

Fishman, C. (1988). *Treating troubled adolescents: A family therapy approach.* New York: Basic Books.

Presents a systems model for assessment, setting priorities, and designing therapeutic techniques for adolescents with such presenting problems as suicide attempts, drug abuse, delinquency, violence, running away, and incest. Demonstrates structural therapy with case studies.

Fishman, H. C., Stanton, M. D., & Roseman, B. L. (1982). Treating families of adolescent drug abusers. In M. Stanton, T. Todd, & Associates (Eds.), *The family therapy of drug abuse and addiction* (pp. 335-357). New York: The Guilford Press.

Compares adolescent alcohol and other drug (AODA) abusers to adult AODA abusers. Provides goals for therapy and suggests therapeutic techniques to be used with families of adolescent AODA abusers.

Frankel, L. (1987). Structural family therapy for adolescent substance abusers and their families. In *Treatment services for adolescent substance abusers*, National Institute on Drug Abuse, DHHS Publication No. (ADM)87-1342. Washington, DC: U.S. Government Printing Office.

Discusses basic family dynamics and the background of family therapy application to the adolescent AODA abuser, and presents fundamental aspects of structural family therapy and specifics of structural work with this population. Describes specific interventions and presents a session-by-session summary of a case study.

Friedman, A. (1987). Family factors and the family role in treatment for adolescent drug abuse. In *Treatment services for adolescent substance abusers*, National Institute on Drug Abuse, DHHS Publication No. (ADM) 87-1342 . Washington, DC: U.S. Government Printing Office.

Presents research findings regarding family factors and family dynamics in families of drug-abusing adolescents, discusses the family's role in treatment of the adolescent, and describes traditional and alternative family therapy approaches.

Friesen, B., & Koroloff, N. (1990). Family-centered services: Implications for mental health administration and research. *Journal of Mental Health Administration, 17*, (1)13-23.

Examines the shifts in policy and administrative practice that are needed in order to move toward a family-centered system of care, identifies barriers to a family-centered system of care, and describes new roles for parents and their implications for administrators and researchers.

Glynn, T. (1984). Adolescent drug use and the family environment: A review. *Journal of Drug Issues, 14* (2), 271-295.

Reviews and summarizes the findings of research on the characteristics of families of adolescent drug abusers. Discusses limitations of the research and suggests future directions. While considerable research has been conducted since this article was written, it is an excellent review of the work conducted through 1984 and provides a framework for thinking about family factors as they affect drug use by teens.

Goldenberg, I., & Goldenberg, H. (1980). *Family therapy: An overview*. Monterey, CA: Brooks/Cole.

Presents broad introduction of family therapy, especially useful for the clinician unfamiliar with systems theory. Describes the development of family therapy and the theoretical models of such founders as Nathan Ackerman, Murray Bowen, Virginia Satir, Salvador Minuchin, Jay Haley, and Richard Stuart.

Goldman, S. (1988). *Series on community-based services for children and adolescents who are severely emotionally disturbed. Volume II: Crisis services*. Washington, DC: CASSP Technical Assistance Center,

Georgetown University Child Development Center.
Discusses the background and principles underlying the concept of a "system" of care for children and adolescents who are severely emotionally disturbed and focuses specifically on crisis services. Based on a study of community-based services funded by the National Institute of Mental Health, reviews the history, philosophy, goals, and characteristics of crisis services and describes a number of programs in specific detail. "Profiles" numerous existing programs in order to provide specific examples of a variety of programs.

Group for the Advancement of Psychiatry. (1985). *The family, the patient and the psychiatric hospital: Toward a new model.* New York: Brunner/Mazel.
Provides alternative approaches to the hospitalization of clients. Includes the family system as a crucial part of the treatment. Discusses how hospitalization may be utilized as the beginning of change in the family as opposed to a final attempt to facilitate change. Presents family interventions and how to use them through the hospitalization process.

Gurman, A., & Kniskern, D. (1981). *Handbook of family therapy.* New York: Brunner/Mazel.
Seminal work reviewing the major approaches to family therapy, including psychoanalytic and object relations, intergenerational, systems, and behavioral. Each approach is described by a founder or "master" who discusses background, the healthy family, family pathology or dysfunction, assessment, goal setting, treatment applicability, the structure of the therapy process, techniques, curative factors, effectiveness, and training. Reviews the existing research on family therapy.

Gutstein, S. E., Rudd, M.D., Graham, J. C., & Rayha, L. L. (1988). Systemic crisis intervention as a response to adolescent crises: An outcome study. *Family Process, 27*, 201-211.
Presents a study illustrating how to resolve adolescent crises and restructure family systems through a home-based program, Systemic Crisis Intervention (SCIP). The subjects, method, and results of this study are presented.

Haley, J. (1980). *Leaving home.* New York: McGraw-Hill.
Presents a view of adolescence in a family context. Examines implications of labeling youngsters and using mechanisms of social control of adolescents. Describes stages of therapy with a troubled adolescent and his/her family, presents case studies, and examines "special cases."

Haley, J. (1976). *Problem-solving therapy.* San Francisco: Jossey-Bass.
Discusses presenting problems as symptoms of dysfunctional family organization. Explains specific skills and techniques of strategic therapy. Illustrates with case studies. Furnishes specific guidelines for conducting the first family session—especially useful for the beginning family therapist.

Haley, J. (1975). Why a mental health clinic should avoid family therapy. *Journal of Marriage and Family Counseling, 1*, 3-13.
Describes the difficulties inherent in trying to add family therapy as an additional treatment procedure in a traditionally individual-oriented mental health clinic. Explains likely consequences, including disorientation of staff and problems with administrative procedures. Advocates for a change in the theory of causation, diagnosis, and therapeutic technique and training in order to integrate family therapy effectively.

Imber-Black, E., Roberts, J., & Whiting, R. (Eds.). (1988). *Rituals in families and family therapy.* New York: W. W. Norton.
Defines family and therapeutic rituals, describes ritual themes, and presents guidelines for designing therapeutic rituals as basis for change within the family. Describes application

for presenting problems involving adolescents in "Rituals for Couples, Children, and Adolescents."

Karpel, M. A., & Strauss, E. S. (1983). *Family evaluation.* New York: Gardner Press.
Provides a wealth of information applicable to the evaluation of adolescents and their families. Discusses various family theory concepts. Provides specific guidelines and techniques for setting up and carrying out family evaluations.

Kidwell, J., Fischer, J. L., Dunham, R. M., & Baranowski, M. (1983). Parents and adolescents: Push and pull of change. In H. I. McCubbin & C. R. Figley (Eds.), *Stress and the family* (pp. 74-89). New York: Brunner/ Mazel.
Presents an overview of systems and developmental theories. Discusses specific stressors associated with the normal developmental changes in adolescents and in their parents. Provides a systems perspective for coping with the stressors and the changes that occur within the family system.

Lewis, R., Piercy, F., Sprenkle, D., & Trepper, T. (1990). Family-based interventions for helping drug-abusing adolescents. *Journal of Adolescent Research, 5* (1), 82-95.
Describes the efficacy of two family-based interventions for drug-abusing adolescents, the Purdue Brief Family Therapy model and the Training in Parenting Skills Program. Based on a research project funded by the National Institute on Drug Abuse.

Liddle, H., Breunlin, D., & Schwartz, R. (Eds.). (1988). *Handbook of family therapy training and supervision.* New York: Guilford Press.
Discusses family therapy models, such as structural, Milan, Bowenian, strategic, and Mental Research Institute (MRI). Provides conceptual overview and guidelines for training and supervision. For the clinician or administrator who is interested in understanding the unique characteristics of family systems therapy supervision.

Madanes, Cloé. (1990). *Sex, love, and violence: Strategies for transformation.* New York: W. W. Norton.
Presents a model for empowering families to create new expressions of love out of their previous violence. Discusses treatment of the adolescent sexual offender. Illustrates the use of reframing, enactment, metaphors, and directives for behavior change in case studies. For the clinician interested in family therapy as treatment model for incest and other sexual offenses, adolescent suicidal behavior, and physical abuse.

McGaha, J. E., & Fournier, D. G. (1988). Juvenile justice and the family: A systems approach to family assessment. *Marriage and Family Review, 12* (1/2), 155-172.
Provides an overview of the juvenile justice system. Presents a systemic approach for working with juvenile delinquents and their families. Describes research utilizing a variety of instruments to assess a family's level of risk.

McGoldrick, M., Pearce, J., & Giordano, J. (Eds.). (1982). *Ethnicity and family therapy.* New York: Guilford Press.
Presents family behavior in larger context of cultural environment. Explores ethnic influences on behavioral and social patterns and on belief systems. Intended to increase therapists' sensitivity to differences and adaptability in designing goals and strategies.

Minuchin, P. (1985). Families and individual development: Provocations from the field of family therapy. *Child Development, 56,* 289-302.
Explores family systems theory and family therapy clinical experiences as a resource for developmental psychology. Gives particular attention to those aspects that challenge traditional formulations in the developmental field. Considers the implications of the systems paradigm for conceptions of the individual and discusses trends in the developmental field that move toward systems formulations.

187

Minuchin, S. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.
Explains how problems develop within families and how they can be resolved. Presents his model of structural therapy; illustrates with case studies how to "map" problems, define therapeutic goals, and plan structural strategies for challenging a family to change dysfunctional patterns.

Minuchin, S., & Fishman, H. (1981). *Family therapy techniques.* Cambridge, MA: Harvard University Press.
Explains and illustrates the fundamentals of structural therapy techniques—joining, reframing, enactment, restructuring, unbalancing, and changing boundaries. Discusses how challenging the presenting symptom, the family structure, and family reality creates change.

Minuchin, S., Roseman, B. L., & Baker, L. (1978). *Psychosomatic families: Anorexia nervosa in context.* Cambridge, MA: Harvard University Press.
Defines psychosomatic illness and provides an overview of a multitude of models for specifically diagnosing and treating anorectic families. Presents a treatment model for working with psychosomatic illness. Case exampes are provided.

Mirkin, M., & Koman, S. (Eds.). (1985). *Handbook of adolescents and family therapy.* Boston: Allyn and Bacon.
A number of authors from a variety of mental health disciplines contributed to this volume, which includes sections on theoretical background, issues in practice in various settings, and treatment issues. Discusses multiple-family groups in both inpatient and outpatient settings, systems interventions in schools, and home-based therapy. Presents treatment approaches to specific adolescent problems, including drug abuse, runaway, anorexia/bulimia, psychosis, and suicide. Includes a chapter on the adolescent and cultural transition. Also includes an annotated bibliography of 24 selected works.

National Institute on Alcohol and Alcoholism. (1984). *Prevention plus: Involving schools, parents, and the community in alcohol and drug education.* DHHS Publication No. (ADM)84-1256. Washington, DC: U.S. Government Printing Office.
Provides information on teen alcohol use and abuse in a question-and-answer format, discusses classroom education, teacher training for alcohol abuse prevention, the role of school alcohol and drug policies, parent education, and community approaches. Describes several model programs and provides many resource references.

Nichols, M. (1984). *Family therapy: Concepts and methods.* New York: Gardner Press.
Discusses the historical, contemporary, and theoretical contexts of family therapy. Describes various approaches, including psychoanalytic and group family therapy, as well as experiential, behavioral, extended family systems, communication, strategic, and structural. Presents a comparative analysis of the approaches that examines factors in the selection of a theoretical position.

Nowinski, J. (1990). *Substance abuse in adolescents and young adults: A guide to treatment.* New York: W. W. Norton.
Combines the individual psychological and family systems perspectives on adolescent abuse of alcohol and other drugs. Discusses the patterns and causes of adolescent drug abuse, developmental implications, and the diagnosis and treatment process. Includes a chapter on family recovery and one on working with families.

Ooms, T., Beck, D., & Herendeen, L. (1990). *Keeping troubled families together: Promising programs and statewide reform.* Background briefing report. Washington, DC: Family Impact Seminar, American

Association for Marriage and Family Therapy, June.
Describes the roots of the family preservation movement and the philosophy and technology of family preservation. Presents models of relevant programs and explores how family preservation works. Explains State experiences and practices and the role of the Federal Government in family preservation. Includes a list of selected references and organizational resources.

Ooms, T., & Herendeen, L. (1989). *Integrated approaches to youth's health problems: Federal, state, and community roles.* Background briefing report. Washington, DC: Family Impact Seminar, American Association for Marriage and Family Therapy, July.
Explores issues in the coordination of health services to youth and presents new integrated approaches for delivering health care to adolescents that are being tried at Federal and State levels. Describes efforts under the auspices of three main sectors of the Public Health Service: Alcohol and other drug abuse, mental health, and primary health.

Peterson, G., & Leigh, G. (In press). The family and social competence in adolescence. In T. Gullota (Ed.), *Advances in adolescent development.* Beverly Hills: Sage.
Discusses the development of social competence as a task of adolescent development and explores the role of the family. Provides up-to-date research findings and discusses implications for intervention.

Piercy, F., & Sprenkle, D. (1986). *Family therapy sourcebook.* New York: Guilford Press.
Explains major schools of family therapy, including information about the treatment models themselves, theoretical background, interventions, key persons in the development of the models, and relevant research issues and books and other resources. Discusses specific applications of family therapy. Includes chapters on family therapy's unique approach to training and supervision, research in family therapy, and ethical, legal, and professional issues.

Quinn, W. H., Kuehl, B. P., & Joanning, H. (1988). Families of adolescent drug abusers: Systemic interventions to attain drug-free behavior. *American Journal of Alcohol Abuse, 14*(1), 65-87.
Presents systemic interventions to be used during the early stages of adolescent alcohol and other drug abuse treatment. Discusses how and when to use these interventions in family therapy. Provides vignettes as examples to illustrate both the contextual and family goals of these interventions.

Quinn, W. H., Kuehl, B. P., Thomas, F. N., & Joanning, H. (1988). Families of adolescent drug abusers: Systemic interventions to attain drug-free behavior. *American Journal of Drug and Alcohol Abuse, 14* (1), 65-87.
Presents basic rationale for viewing the family as the unit of treatment. Describes and explains specific interventions aimed at attaining drug-free behavior in the adolescent including the therapeutic use of urinalysis. Illustrated by vignettes that include transcripts from therapy segments.

Saba, G., Karrer, B., & Hardy, K. (Eds.). (1989). Minorities and family therapy. *Journal of Psychotherapy and the Family, 6* (1/2), 1-236.
Explores issues relevant to family therapy with families of various cultural backgrounds. Examines the concept of culture and implications of the interaction of the family's culture and the therapist's culture. Presents assumptions and guidelines to assist the practitioner. Specifically addresses issues in the treatment of black families, Native American families, and Chinese-American immigrant families, and describes contextual family therapy of addictions with Latinos.

Satir, V. (1967). *Conjoint family therapy.* Palo Alto, CA: Science and Behavior Books.
Illustrates Satir's communications model of family therapy. Explains family life and family therapy theories with dialog from family sessions.

Selvini Palazzoli, M. (1985). *Self-starvation: From the intrapsychic to the transpersonal approach to anorexia nervosa.* Northvale, NJ: Jason Aronson.
Presents a historical perspective of anorexia nervosa. Discusses the social and family background of her clients to describe the typical interactional patterns. Includes the use of rituals in treating the families. For the clinician with a basic understanding of family systems theory.

Selvini Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. (1978). *Paradox and counterparadox.* Northvale, NJ: Jason Aronson.
Presents the concepts of the Milan or systemic family therapy. Explains such techniques as paradoxical prescription, positive connotation, and family rituals. Illustrates use of this model with schizophrenics and their families.

Steinglass, P. (1987). *The alcoholic family.* New York: Basic Books.
Presents basic family systems views of alcoholism, "core issues," and a behavioral and developmental overview of alcoholism and the family. Discusses family systems treatment of alcoholism. Not specific to adolescents, but a seminal work of the family therapy of alcoholism.

Stroul, B. (1988). *Series on community-based services for children and adolescents who are severely emotionally disturbed, Vol. 1: Home-based services.* Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.
Discusses the background and principles underlying the concept of a "system" of care for children and adolescents who are severely emotionally disturbed. Based on a study of community-based services funded by the National Institute of Mental Health, reviews the history, philosophy, goals, and characteristics of home-based services and describes a number of programs in specific detail. "Profiles" numerous existing programs in order to provide specific examples of a variety of programs.

Szapocznik, J., & Kurtines, W. (1989). *Breakthroughs in family therapy with drug-abusing and problem youth.* New York: Springer.
Presents basic concepts of Brief Strategic Family Therapy, a systematic approach to family assessment and diagnosis, and specific treatment interventions. Includes chapters on engagement of the family in therapy and on one-person family therapy, and provides case studies for illustration. Also presents a brief overview of the research on diagnosis, engagement, and treatment of this population.

Szapocznik, J., Perez-Vidal, A., Brick, A. L., Foote, F. H., Santisteban, D., & Hervis, 0. (1988). Engaging adolescent drug abusers and their families in treatment: A strategic-structural systems approach. *Journal of Consulting and Clinical Psychology, 56*(4), 552-557.
Reports a study on strategies for engaging adolescent drug abusers and their families in therapy. Discusses a highly successful structural-strategic intervention for soliciting family involvement in treatment of the adolescent.

Todd, T., & Selekman, M. (Eds.). (1991). *Family therapy approaches with adolescent substance abusers.* Englewood Cliffs, NJ: Prentice Hall.
Examines the crucial issues in the treatment of adolescent alcohol and other drug abuse and presents and evaluates a variety of family systems models of treatment. Designed to promote dialog between the specialty fields of family therapy and drug abuse and present

"cutting edge" thoughts on treatment of this population. Contributing authors are professionals from a variety of mental health disciplines.

Tolan, P. (1990). Family therapy, substance abuse, and adolescents: moving from isolated cultures to related components. *Journal of Family Psychology, 3*, 454-465.
Reviews several books representative of three "cultures" interested in family therapy with drug-abusing adolescents: developmentally oriented research on drug abuse, family therapy applied to drug abuse, and the addiction/self-help approach. Discusses the current dearth of "cross-cultural" integration and makes suggestions for movement toward an integrated model.

Tolan, P. (Ed.). Multisystemic structural-strategic interventions for child and adolescent behavior problems. *Journal of Psychotherapy and the Family, 6* (3/4).
Entire volume dedicated to structural-strategic family therapy with such child/adolescent problems as bulimia, school misbehavior, intrafamilial child sexual abuse, and others. Also includes more general articles on structural-strategic work.

Treadway, D. (1989). Hanging on for dear life: Family treatment of adolescent substance abusers. In D. Treadway (Ed.), *Before it's too late* (pp. 134-162). New York: W. W. Norton.
Presents a six-stage treatment model for working with families of adolescent alcohol and other drug abusers. The author discusses (1) how to engage the whole system; (2) how to asses the adolescent's behavior; (3) how to empower the parents; (4) how the crisis of change develops; (5) how to restrain the family from changing too quickly; and (6) how to assist the adolescent in separating and individuating.

Vosler-Hunter, R. (1989). *Changing roles, changing relationships: Parent-professional collaboration on behalf of children with serious emotional disabilities*. Portland, OR: Families as Allies Project, Research and Training Center on Family Support and Children's Mental Health, Portland State University.
Explores the history and context of parent-professional collaboration and describes the elements of collaboration and strategies for "making it happen." Provides checklists for professionals, parents, service providers, States, and professional training programs. Includes a reference list of resources and publications. (Available from: Publications, Research and Training Center, Regional Research Institute for Human Services, Portland State University, P.O. Box 751, Portland, OR, 97207-0751).

Walsh, F. (1982). *Normal family processes*. New York: Guilford Press.
Presents research on and conceptualizations of normal family processes. Discusses variables, such as temporal, structural, and cultural variations in families, that influence normal family functioning and dysfunction. Various approaches and interventions that have proved effective are recommended.

Walters, M., Carter, B., Papp, P., Silverstein, 0. (1988). *The invisible web: Gender patterns in family relations*. New York: Guilford Press.
Describes the feminist perspective, and presents the history and development of the Women's Project in Family Therapy. Explores from a feminist view the three parent-child relationships involving females (mother-daughter, father-daughter, and mother-son). Discusses other specific family issues, and elucidates the role of gender in family life, family problems, and family therapy. Stimulates questions and a reexamination of longstanding assumptions underlying the traditional systemic view of the family.

Watzlawick, P., Weakland, C., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution*. New York: W. W. Norton.

Presents the Mental Research Institute (MRI) model of brief therapy. Examines how logical solutions to problems fail, and seemingly illogical actions can produce positive changes. Illustrates concepts of second order change, paradoxical interventions, and reframing.

Whitaker, C., & Bumberry, W. (1988). *Dancing with the family: A symbolic-experiential approach.* New York: Brunner/Mazel.

Presents Whitaker's work with one family over 3 days. Includes his comments, explanations of his interventions, and his answers to questions posed by Bumberry. Discusses integrity and the professional role of the therapist, and presents an indepth description of symbolic-experiential therapy.

White, C. (1983). Anorexia nervosa: Transgenerational system perspective. (1983). *Family Process, 22*(3), 255-272.

Explores relationship between vulnerability to anorexia and rigid systems of family rules. Presents treatment model that challenges beliefs such as role prescriptions for daughter, loyalty, and "insightfulness." Illustrates the use of techniques such as genograms, circular questioning, challenging the belief system, and predicting relapse.

Appendix I: Organizational Resources for the Treatment of Adolescents With Alcohol, Drug Abuse, and Mental Health Problems

The following organizations provide information, publications, research, technical assistance, consultation, and related services in the fields of mental health and alcohol and drug abuse that may be useful to those providing family-centered treatment to adolescents and to the consumers of treatment, including family members. A few of these organizations have a special focus on adolescents.

Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT)

CSAT (formerly the Office for Treatment Improvement) was established within the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, in October 1989 to lead and administer the new Federal drug abuse treatment initiative. The Office provides Federal financial assistance and program expertise to State and local alcohol, drug abuse, and mental health administrators and clinicians to improve the quality and availability of alcohol, drug abuse, and mental health services.

Contact: Janice Berger, Public Health Adviser, CSAT, Rockwall II, 7th floor, 5600 Fishers Lane, Rockville, MD 20857. (301) 443-6533.

American Academy of Child and Adolescent Psychiatry (AACAP)

The AACAP is a professional membership organization representing child and adolescent psychiatrists and other mental health professionals. AACAP members actively research, diagnose, and treat psychiatric disorders affecting children, adolescents, and their families. The academy develops materials and programs of professional and public education on all psychiatric disorders affecting children. The Academy publishes its bi-monthly *Journal of the American Academy of Child and Adolescent Psychiatry* for professionals, a quarterly newsletter, and a series of topical information sheets geared towards the lay audience.

Contact: Virginia Anthony, Executive Director, American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue NW, Washington, DC 20016. (202) 966-7300.

American Association for Marriage and Family Therapy (AAMFT)

The AAMFT is the professional association for the field of marriage and family therapy. Its purpose is to promote the practice and the profession of marriage and family therapy through promulgating professional and ethical practice standards, accreditation, and advocacy. Clinical members have completed specific graduate training and had extensive supervised clinical experience. Members engage in clinical practice in private and public settings, conduct research and therapist training, and provide training and consultation to educational, health care, and social service systems and corporations. AAMFT's "Register" provides a listing of accredited members and approved supervisors by city and State.

AAMFT publications include brochures explaining the field of marriage and family therapy, when to refer for family therapy, and a series of newsletters for the public on specific topics. AAMFT also provides a series of videotapes of clinical work by leading family therapists in the field. The "Forms Book" includes samples of forms related to intake, release of information, progress, supervision, and other purposes used by family therapists in public and private clinical practice settings. The association publishes the quarterly *Journal of Marital and Family Therapy*, which has the widest circulation of the more than 50 scholarly family therapy journals published around the world.

AAMFT's Research and Education Foundation is a nonprofit organization whose purpose is to promote family well-being through advancing the contribution that marriage and family therapy, family research, and family policy can make to family life. It promotes research in the field through a program of awards and fellowships and conducts activities that encourage communication among researchers, program professionals, and policymakers. **The Family Impact Seminar** is the policy unit of the Foundation (see below).

Contact: Mark Ginsberg, Executive Director, American Association for Marriage and Family Therapy, 1100 17th Street NW, 10th floor, Washington, DC 20036. (202) 452-0109.

Beach Center on Families and Disability

Family Enhancement Project

The Beach Center, affiliated with the University of Kansas, is a rehabilitation research and training center with core funding provided by the National Institute on Disability and Rehabilitation Research. Research training and dissemination projects span the life cycle and concentrate on finding ways to support families of persons with developmental disabilities, emotional disabilities, and technology support needs. **The Family Enhancement Project** is developing and evaluating a new home-based program for families with adolescents with serious emotional disturbances. The center publishes a thrice-yearly newsletter for families, as well as a publications catalog.

Contact: Ann P. Turnbull and H. Rutherford Turnbull, Codirectors, Beach Center on Families and Disability, 3111 Haworth Hall, University of Kansas, Lawrence, KS 66045. (913) 864-7600.

Child and Adolescent Service System Program Technical Assistance Center (CASSP/ TA Center)

The CASSP/TA Center is a division of the Georgetown University Child Development Center and part of the National Network for Children With Special Needs. The center's special areas of emphasis include the development of systems of care for children and their families, community-based service approaches, cultural competence services for special populations of high-risk youth, and financing of these special services. Activities include providing consultation on achieving systems change and on all aspects of developing and providing services to children and families, and collaborating with Federal and State human service agencies and national child advocacy organizations concerned with improving services for children and adolescents who are seriously disturbed.

Contact: Sybil Goldman or Ellen Kagen, CASSP/TA Center, Georgetown University Child Development Center, 2233 Wisconsin Avenue NW, Washington, DC 20007. (202) 338-1831.

Family Impact Seminar (FIS)

Research and Education Foundation, AAMFT

The Family Impact Seminar is a nonpartisan policy research organization founded in 1976 to promote a family perspective in policy. In 1988, in collaboration with the Consortium of Family Organizations, FIS began a series of monthly seminars in Washington, DC, for invited congressional and executive branch staff on family policy issues. The focus of each seminar generally relates to current legislative proposals and implementation issues. Among the topics covered to date include: maternal drug abuse, adolescent alcohol and other drug abuse, financing and integration of adolescent health care, children with special health care needs, and teen pregnancy. Accompanying each seminar is a background briefing report, prepared by FIS staff, summarizing the key research, policy responses and options, references, resources, and meeting highlights. These reports and other publications are available upon request. FIS staff are currently providing technical assistance to organizations to establish similar seminars in selected State capitals in 1991.

Contact: Theodora Ooms or Susan Golonka, Family Impact Seminar, Research and Education Foundation, American Association for Marriage and Family Therapy, 1100 17th Street NW, 10th floor, Washington, DC 20036. (202) 567-5113 or 5114.

Federation for Children With Special Needs

The federation is a national network of a number of parent-run and/or parent-focused organizations concerned with children and adolescents with specific chronic illnesses and disabilities. The headquarters office operates several programs that aim to provide information and technical assistance to parent organizations and individual parents. Among these are the Parent Training and Information Project (PTI), Technical Assistance for Parents Programs (TAPP), and Collaboration Among Parents and Health Professionals (CAPP).

Contact: Betty Anderson or Barbara Popper, Federation for Children With Special Needs, 95 Berkeley Street, Suite 104, Boston, MA 02166. (617) 482-2915.

Federation of Families for Children's Mental Health

The federation is a national parent-run organization focusing on the needs of children and youth with emotional, behavioral, and mental disorders and their families. The organization grew out of a series of meetings held after the first Families as Allies conference sponsored by the Portland State Regional Training Center in 1986. The federation was formally incorporated in 1989. Many of the board members and others involved in the organization are members of active parent groups and State organizations.

The federation's mission is to provide national leadership and advocacy for full citizenship and support and access to community-based services for all children and youth with these disorders and their families. It also aims to provide information and advocacy about the full range of research, prevention, and treatment services needed by these children and their families. The federation publishes a newsletter, *Claiming Children.* The first issue, spring 1990, has a list of names and addresses of representatives in each State. President: Barbara Huff, c/o Keys for Networking, Inc., 700 S.W. Jackson, Suite 100 A, Topeka, KS 66603. (913) 233-8732.

Contact: For membership information and the newsletter, write to 1021 Prince Street, Alexandria, VA 22314. (703) 684-7710.

Mental Health Law Project (MHLP)

The MHLP is a national, nonprofit, public interest organization working to bring people with mental disabilities under the full protection of our Nation's laws and assure them access to needed services. The MHLP uses a coordinated approach—combining precedent-setting litigation, Federal policy reform, and support for local advocates—to establish the legal rights of children and adults with mental disabilities and generate resources to meet their needs.

The MHLP's various programs work toward two broad goals: integration of people with mental disabilities into the mainstream of American life and humane and appropriate care and treatment for children and adults in residential facilities. The Early Intervention Advocacy Network is one of these programs. The MHLP also produces numerous publications relating to services and entitlements, legal rights, and general advocacy.

Contact: Beth Carter or Margaret Lorber, Early Intervention Advocacy Network, Mental Health Law Project, 2021 L Street NW, Suite 800, Washington, DC 20036. (202) 467-5730.

Mental Health Policy Resource Center

Established in 1988, the Mental Health Policy Research Center seeks to advance mental health policymaking by sharing ideas and information. The center functions as a clearinghouse for a wide range of mental-health-related publications, including policy analysis and current research. Its activities include original and secondary research; publications; seminars; meetings and workshops; library and referral services; and computer communications via an interactive online data base.

Contact: Lucia Davidson or Sharon Kaufer, Mental Health Policy Resource Center, 1730 Rhode Island Avenue NW, Suite 308, Washington, DC 20036. (202) 775-8826.

National Adolescent Treatment Consortium (NATC)

The NATC was formally established in 1985 to respond to the needs of chemically dependent adolescents and to address the issues facing the agencies that provide services to this population. Among the services provided by NATC are: educational seminars for treatment providers, support for public education concerning adolescent chemical dependency treatment and resources, the establishment of guidelines for training and certification of providers, advocacy for model legal statutes, and the facilitation of expansion of third-party payment systems.

Contact: Charles W. Torjesen, Executive Director, NATC, University at Penn, Des Moines, IA 50316. (515) 263-5747.

National Alliance for the Mentally Ill, Child and Adolescent Network (NAMI-CAN)

NAMI-CAN is a grassroots self-help support and advocacy organization of parents and friends of seriously emotionally disturbed children and is affiliated with its parent organization, the National Alliance for the Mentally Ill. In addition to sponsoring local member support groups, it focuses on public education and advocacy for improved understanding of children's mental illness and increased funds for services and research.

Contact: National Alliance for the Mentally Ill, 2101 Wilson Boulevard, Suite 302, Arlington, VA 22201. (703) 524-7600.

National Center for Youth With Disabilities

The National Center for Youth With Disabilities works to expand the knowledge and involvement of individuals, agencies, and programs providing services to youth with chronic illness/disabling conditions and to demonstrated service system models that enhance the ability of adolescents and young adults to grow, develop, work, and participate in community life to their fullest capacity.

The center seeks to make possible pooling and sharing of resources that help advance thought and practice in a rapidly developing field. The center is committed to an interdisciplinary perspective and to fostering collaboration between and among professionals, parents, and youth. The programs of the center include the National Resource Library; workshops and conferences at State and national levels that support the design and implementation of State and community programs for youth and their families; and publication of monographs, bibliographies, and newsletters on vital issues regarding adolescence and disability.

Contact: Nancy Okinow, Executive Director, National Center for Youth With Disabilities, Adolescent Health Program, University of Minnesota, Box 721—UMHC, Harvard Street at East River Road, Minneapolis, MN 55455. 1-800-333-NCYD.

National Center for Youth Law (NCYL)

Adolescent Health Care Project.

The National Center for Youth Law is a non-profit organization devoted to improving the lives of poor children in the United States. It is part of a national system of legal services for the poor, providing expertise in areas of the law affecting poor children and adolescents primarily in the areas of foster care, juvenile justice, housing discrimination, public benefits, and health. Its primary role is to assist legal services attorneys nationwide by providing advice and technical assistance, acting as cocounsel in selected cases, conducting training sessions, and disseminating publications. It publishes *Youth Law News* six times a year.

The Adolescent Health Care Project provides consultation and training, legal advocacy, and prepares publications related to adolescents' access to health care. The project is especially interested in the complex ethical and legal issues that arise for professionals providing services to youth in the sensitive areas of mental health, reproductive health, sexually transmitted diseases (including AIDS), and alcohol and other drug abuse diagnosis and treatment.

Contact: Abigail English or Lilian Tereszkiewicz, Adolescent Health Care Project, National Center for Youth Law, 114 Sansome Street, Suite 900, San Francisco, CA 94104. (415) 543-3307.

National Families in Action (NFIA)

NFIA, founded in 1977, is a parent-run organization whose purpose is to create and lead a nationwide, volunteer, grassroots movement in which ordinary citizens organize to prevent drug abuse in their families and in their communities. Its purpose is to educate society about the dangers of drug abuse by disseminating accurate and timely information. The organization houses and operates an information clearinghouse, the National Drug Information Center, that publishes a quarterly newsletter, *Drug Abuse Updates*, which reports regularly on new research and the activities of Federal and State agencies and answers requests for information and for treatment referrals. Its information is designed to assist hundreds of local and State parent organizations that conduct advocacy activities at the local, State, and Federal level to change

the community environment that serves to foster adolescent and adult drug abuse.

Contact: Sue Rusche, Executive Director, National Families in Action, 2296 Henderson Mill Road, Suite 204, Atlanta, GA 30345. (404) 934-6364.

National Mental Health Association (NMHA)

The NMHA is the Nation's only non-government, citizens' voluntary organization concerned with all aspects of mental illness and mental health. NMHA is a primary source of referral and education information. NMHA provides training and technical assistance to local and State NMHA affiliates for patient and family support groups, services and housing programs, monitoring community-based mental health services, and school mental health education programs. Other NMHA programs address prevention, research advocacy, and stimulate public support, legislative advocacy, and public awareness.

NMHA actively focuses on improving mental health services and access to treatment for children and adolescents, most recently in the Invisible Children Project, which focused on identifying the numbers of children with emotional problems placed out of their homes in public systems.

Contact: Linda Greenham, Coordinator, Mental Health Information Center, NMHA, 1021 Prince Street, Alexandria, VA 22314-2971. (703) 684-7722.

National Parent Network on Disability

The National Parent Network on Disability is a new coalition of many parent organizations in the States and communities and individual parents that was established in early 1990 in the Nation's capital to provide a presence and national voice for parents of persons with disabilities. It is a successor organization to the National Network of Parent Centers, Inc. It is concerned with handicapped children and individuals of all ages, including young adults.

Contact: Patti McGill Smith, Director, National Parent Network on Disability, 1600 Prince Street, Suite 115, Alexandria, VA 22314. (703) 684-6763.

Research and Training Center on Family Support and Children's Mental Health
Portland, Oregon

The Research and Training Center, initiated in 1984, conducts research, consultation, and training of mental health professionals and parents related to improving mental health services, policy implementation, and parent-professional collaboration. It receives funding from the National Institute on Disability and Rehabilitation Research (Department of Education), in collaboration with the National Institute of Mental Health (Department of Health and Human Services).

The center operates the National Clearinghouse on Family Support and Children's Mental Health and publishes a wide range of resource materials and a quarterly newsletter, *Focal Point*. The center has sponsored several conferences and training meetings under the title Families as Allies, designed to promote parent-professional collaboration.

Contact: Barbara Friesen, Director, Research and Training Center on Family Support and Children's Mental Health, Regional Research Institute, Portland State University, P.O. Box 751, Portland, OR 97207. (503) 725-4040.

Research and Training Center for Children's Mental Health

Tampa, Florida

The Research and Training Center for Children's Mental Health at the Florida Mental Health Institute was initiated in 1984 to address the need for improved services for children with serious emotional disturbances and their families. The center receives funding from the National Institute on Disability and Rehabilitation Research and the National Institute of Mental Health.

The center seeks to improve services by increasing the knowledge base for the development of an effective service delivery system. The center conducts research, synthesizes and disseminates existing knowledge, provides training and consultation, and serves as a resource for policymakers, researchers, parents, and advocates. The center also conducts a project to enhance collaboration between child welfare and child mental health agencies to promote family preservation services. It publishes a quarterly newsletter, *FOCUS*.

Contact: Robert Freidman, Director, Research and Training Center for Children's Mental Health, Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Boulevard, Tampa, FL 33612-3899. (813) 974-4565.

Self-Help Organizations

Alcoholics Anonymous (AA) is the oldest and best known of the several self-help organizations existing in communities across the Nation that provide support through peer group meetings to alcoholics, drug abusers, and their relatives and close friends. Since many individuals abuse both drugs and alcohol and/or have relatives who do so, there is considerable crossover in membership between the groups, and some individuals may attend more then one group.

AA is a voluntary, worldwide fellowship of men and women who help each other maintain sobriety and who offer to share their recovery experience freely with others who may have a drinking problem. The only requirement for membership is a desire to stop drinking. AA is a program of total abstinence. Members simply stay away from one drink, one day at a time. Sobriety is maintained through sharing experience, strength, and hope at group meetings and through the 12-step program for recovery from alcoholism. AA groups disseminate organization literature, may sponsor social activities, and help connect individuals with personal "sponsors." Membership is strictly anonymous, and the organizations do not solicit funding from outside organizations but support their minimal expenses primarily from individual member donations.

In some communities, adolescent alcoholics attend AA groups. In others, separate AA groups are established specifically for teenagers.

Al-Anon Family Groups. In response to the realization that spouses, close family members and friends of alcoholics are very much affected by and involved in the alcoholic's behavior, **Al-Anon** groups were formed for these persons based on the same principles as AA. In recent years, additional groups have spun off and flourish in some communities. These include **Al-Anon,** for spouses, adult children, and other relatives, and **AlaTeen,** for teenage children of alcoholics. **Families Anonymous** groups exist in some communities specifically for parents of teenage alcoholics and drug users. A new organization has sprung up most recently called **Adult Children of Alcoholics (ACOA).**

Members of these support groups are those whose lives have been affected by alcoholism

of a family member or close friend and who share with each other their experience, strength, and hope in order to solve their common problems. They generally believe that alcoholism is a family illness and that changed attitudes on their part can aid and sustain the alcoholic's recovery and free themselves from the effects of alcoholism on their own lives. These family groups also practice the 12-step program.

Narcotics Anonymous are local support groups for drug addicts whose meetings are organized along principles similar to the AA groups, although they are not as commonly available. **NarAnon** are groups for relatives of drug addicts.

Contact: AA numbers listed in local telephone directories provide information about area meetings dates, times, and places. The national headquarters, which provides information about the organization and publications, is AA. General Service Office, Box 459, Grand Central Station, New York, NY 10163.

Information about Al-Anon and related group meetings is also listed in the telephone directories or is available from local AA groups. Al-Anon Family Group Headquarters, Inc., P.O. Box 862, Midtown Station, New York, NY 10018-0862. (212) 302-7240.

Toughlove International

Toughlove is a self-help organization for parents of teenagers with disruptive, defiant, or drug-abusing behaviors. It sponsors, and provides technical assistance to, hundreds of local parent-run groups all over the world. It is a combination of philosophy and action that, together, can help families and neighborhoods to change. It is a crisis-intervention program that uses structured group meetings to support parents and spouses in demanding responsible cooperation from out-of-control family members. Although its goals are similar to Families Anonymous and other AA-type programs, namely to help parents and relatives of teenage drug abusers, Toughlove is not guided by the 12-step program.

Toughlove International is the nonprofit organization that coordinates and provides services and support to the network of Toughlove groups. The service center maintains a hot-line referral system to more than 500 local groups; publishes a newsletter; publishes and distributes books, manuals, and videotapes; trains area representatives; and helps local groups get started. The organization has several groups in Hispanic communities, and its materials are translated into Spanish.

Contact: Teresa Quinn, Toughlove International, P.O. Box 1069, Doylestown, PA 18901. 1-800-333-1069.

Appendix II: Author Biographies

James Alexander, Ph.D., is a professor of psychology and past director of clinical training at the University of Utah. He is a past president of the family division of the American Psychological Association and has been a consultant to the National Institute on Drug Abuse (NIDA), the National Institute of Mental Health (NIMH), and numerous mental health programs and juvenile courts. Dr. Alexander has more than 20 years' experience in working with acting-out adolescents and their families. With his colleagues at the University of Utah, he developed the Functional Family Therapy model for working with this population. Dr. Alexander has published extensively in the field, including coauthoring the book *Functional Family Therapy*.

Carol Anderson, M.S.W., Ph.D., is professor of psychiatry and administrator of Western Psychiatric Institute and Clinic, University of Pittsburgh. Dr. Anderson is a family therapist who established the first family psychoeducation model as part of a larger NIMH-sponsored research project investigating the impact of various interventions with schizophrenic patients. She is the coauthor of several texts, including *Schizophrenia in the Family*, *Mastering Resistance*, and *Women in Families*. She is past president of the American Family Therapy Association.

Nancy Boyd-Franklin, Ph.D., is a clinical associate professor in the Department of Psychiatry at the University of Medicine and Dentistry of New Jersey-New Jersey Medical School in Newark. She is also a teacher and supervisor of family therapy in the Community Mental Health Center in Newark. She is the author of *Black Families in Therapy: A Multisystems Approach* and is a nationally known lecturer and author of many chapters, articles, and papers on this subject.

Lee Combrinck-Graham, M.D., is a child and adolescent psychiatrist. She is associate professor of clinical psychiatry at the University of Illinois at Chicago. She has held a number of positions involving training and service in child and adolescent mental health, including director of the inpatient program at the Philadelphia Child Guidance Clinic. From 1986-1990, she was the director of the Institute for Juvenile Research in Chicago. Dr. Combrinck-Graham is the editor of the volume, *Children in Family Contexts*, and author of *Giant Steps: Therapeutic Innovations in Child Mental Health*. She is a member of the American Association for Marriage and Family Therapy's board of directors.

Glenda Fine is a parent and a longtime advocate for improved mental health and related services for children and their families. She is director of the Parents Involved Network (PIN) Project at the Mental Health Association of Southeastern Pennsylvania in Philadelphia, a pioneering self-help and advocacy organization that assists families of children and adolescents who have serious emotional problems. She recently coauthored a chapter on parent advocacy in *Advocacy on Behalf of Children With Serious Emotional Problems* for the Research and Training Center for Children's Mental Health of the University of South Florida. She is on the board of directors of the Federation of Families for Children's Mental Health. Ms. Fine has appeared on radio and television and in the print media to call attention to the lack of children's mental health services and has presented at national, State, and local conferences on these issues.

John Hutchins is an instructor and a graduate student in the English Department at the University of Maryland, College Park. He is the former assistant managing editor of the

Family Therapy News and is the author of *Marriage and Family Therapy: Helping Today's Family*, a public information booklet published by the American Association for Marriage and Family Therapy.

Betty MacKune Karrer, M.A., holds a master's degree in psychology from the University of Mexico and a second master's degree in psychology from Roosevelt University in Chicago. She is the director of the Family Systems Program, a training unit within the Institute for Juvenile Research (IJR), University of Illinois. She is particularly known for her expertise on culture and gender frameworks of family therapy. She has published on minorities acculturation and life-cycle issues in family therapy, as well as videotape supervision and the stages of family therapy. Presently, Ms. Karrer is involved in writing a theoretical book on family therapy in collaboration with Doug Breunlin and Richard Schwartz.

Howard Liddle, Ph.D., is professor of counseling psychology and senior research associate in the Center for Human Development at Temple University. He currently directs two federally funded studies designed to test his family systems model for adolescent problems. These are the Adolescents and Families Project and the Adolescents, Families, and Schools Project, a new intervention study. Dr. Liddle conducts workshops nationally and internationally on his treatment approach. Dr. Liddle is the founding editor of the *Journal of Family Psychology* of the American Psychological Association, and he is a steady contributor to the professional literature, with two books and more than 60 articles. He serves on the editorial boards of seven scientific journals and is chairman of AAMFT's Research Committee.

Marion Lindblad-Goldberg, Ph.D., is director, Family Therapy Training Center, Philadelphia Child Guidance Clinic, and associate clinical professor of psychology, Department of Psychiatry, University of Pennsylvania Medical School. She currently develops and implements family-centered training programs for individuals, agencies, institutions, States, and foreign countries. She has developed one of the leading national training models for home-based services. Dr. Lindblad-Goldberg has published and lectured extensively in the field of marital and family therapy. Her areas of research include successful minority single-parent family functioning and evaluation of home-based services.

Peter F. Luongo, Ph.D., is a social worker who holds a doctorate from the University of Maryland at Baltimore School of Social Work. He is currently a faculty member of the Johns Hopkins University and the director of the Montgomery County, Maryland, Division of Addiction and Youth Treatment Services. Dr. Luongo has designed and implemented public sector mental health and addictions services for adolescents and adults. Two programs have recently received national recognition from the National Association of Counties as model community-based services.

Frances Lynch is currently working on her doctorate in public health economics at the Johns Hopkins University, where she is a National Institute of Mental Health trainee. Ms. Lynch holds a master of science in public health policy. Over the past 4 years, she has participated in several health economic research projects, including the financial evaluation of the Robert Wood Johnson Foundation Program for the Chronically Mentally Ill. For the past 2 years, Ms. Lynch has been a research assistant at the Center for the Organization and Financing of Care for the Severely Mentally Ill at Johns Hopkins, and, among other projects, she has been working on research on the financing of mental health services to children and adolescents.

Patrick McCarthy, Ph.D., is the director of the Division of Youth Rehabilitative Services, Department of Services for Children, Youth

and Families, for the State of Delaware. He initiated and sought funding for the Family Preservation Project (FPP), an ambitious multi-year project designed to reorient the entire 200-person agency to a family systems approach. Dr. McCarthy received his doctorate in social work planning and administration from Bryn Mawr and his family therapy training at the Philadelphia Child Guidance Clinic under Salvador Minuchin. He has administered an outpatient drug and alcohol program and an alternative school for emotionally disturbed children, and has taught at Bryn Mawr and the University of Southern California. He is the author of a chapter on evaluating home-based services in *Family Preservation*, a manual published by the Child Welfare League.

Theodora J. Ooms, M.S.W., is director of the Family Impact Seminar (FIS), which, in 1988, became the policy unit of the AAMFT Research and Education Foundation. FIS's major current activity is sponsoring a regular monthly series of family policy seminars in Washington, DC, for congressional and administration staff. Ms. Ooms had 12 years of clinical experience as a social worker and family therapist at the Yale Child Study Center and the Philadelphia Child Guidance Clinic. She is the editor of *Teenage Pregnancy in a Family Context: Implications for Policy*, coeditor of a forthcoming volume on young unwed fathers, and has published numerous articles and reports on family policy issues.

Douglas J. Reiss, Ph.D., is coordinator of the Family Treatment of Schizophrenia in the Schizophrenia Research Program at Western Psychiatric Institute and Clinic, University of Pittsburgh. He is coinvestigator of a research grant entitled, "Environmental and Personal Treatment of Schizophrenia," and supervisor of the Psychosocial Treatment of Schizophrenia Research. He is coauthor of the text, *Schizophrenia in the Family.*

Sue Rusche is cofounder and executive director of National Families in Action, a parent-run organization that conducts a nationwide grassroots movement to prevent drug abuse. She has served as a consultant to many government agencies, including the U.S. Office for Substance Abuse Prevention, ACTION, and the Centers for Disease Control. Ms. Rusche is the editor of *Drug Abuse Update*, a publication of the NFIA's National Drug Information Center. From 1984-1989, she wrote a syndicated newspaper column, "Straight Talk on Drugs," carried by more than 100 papers nationwide.

Matthew D. Selekman, M.S.W., currently serves as the family therapy supervisor at the Des Plaines Valley Community Center in Summit, Illinois. He is an adjunct faculty for the Marriage and Family Therapy Program, Northern Illinois University, and a lecturer in the School of Social Service Administration, the University of Chicago. Mr. Selekman maintains a private practice in Des Plaines, Illinois, where he specializes in family therapy with alcohol and drug abusers. He has conducted numerous workshops throughout the United States, Canada, and Europe. He is an advisory editor for several family therapy journals. Mr. Selekman received his master's degree in social work from the University of Chicago.

Wendy Snyder, R.N., M.P.H., M.S., is a registered nurse who received a master's degree in public health from Johns Hopkins University and a master's degree in marriage and family therapy from Virginia Tech. She is in private practice in Washington, D.C. and Vienna, Virginia and conducts anger management groups for the city of Alexandria, Virginia. Ms. Snyder has held both clinical and administrative positions in the alcohol and other drug abuse treatment field and in managed mental health care. She also acts as a private consultant and as such recently authored an annotated bibliography on self-help for the National Sudden Infant Death Syndrome Clearinghouse.

Thomas C. Todd, Ph.D., received his doctorate from New York University and his A.B. from Princeton University. His current duties include: dean and president, Forest Health Systems Center for Higher Education; chief psychologist, Forest Hospital, Des Plaines, Illinois; faculty, Family Studies Center, the Family Institute of Chicago; and a private practice in Evanston, Illinois. Dr. Todd is also a member of the Commission on Supervision, American Association for Marriage and Family Therapy (AAMFT), and serves on the editorial boards of several family therapy journals. He is a site visitor for the Commission on Accreditation, AAMFT, and is a member of the Grant Review Committee for the National Institute of Drug Abuse.

John J. Zarski, M.A., Ph.D., is currently director of the Clinic for Child Study and Family Therapy and coordinator of the Marriage and Family Therapy Training Program at the University of Akron, Akron, Ohio. He has presented numerous workshops on home-based family intervention. His present interests include the use of inhome supervision of home-based therapists and the use of multiple family group therapy as an adjunct to home-based intervention.

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