

COMMUNITY ALTERNATIVES FOR LOVE AND LIMITS (CALL): A
COMMUNITY-BASED FAMILY STRENGTHENING MULTI-FAMILY
INTERVENTION PROGRAM TO RESPOND TO ADOLESCENTS AT RISK

David Wilkerson
Phillip M. Ouellette

Abstract: *Family strengthening has become a source of growing interest, research, and program design in the fields of prevention and treatment for problems of youth delinquency, school failure, alcohol, tobacco and other drug abuse (ATOD). Despite many studies that illustrate positive outcomes of family strengthening programs and family-focused interventions, their use in communities has not advanced commensurate with their promise. This article offers a rationale for why programming efforts should continue to be directed towards family strengthening efforts as opposed to youth-focused only interventions. In addition, a community-based, family-strengthening alternative is described that addresses issues of youth delinquency while reducing barriers associated with availability, accessibility, and cost.*

Key Words: *empowerment, multi-family intervention, family strengthening, adolescents at risk.*

For problems of youth delinquency, school failure, alcohol, tobacco and other drug abuse (ATOD) family strengthening programs have become a source of growing interest, research, and program design in the fields of prevention and treatment. Who is going to love and care enough to make the long-term efforts needed for change? Family strengthening interventions offer important answers based on their demonstrated success in years of outcome studies (Kumpfer and Alvarado, 1998). But while family focused interventions such as family strengthening approaches have shown much promise, they are not as prevalent as the use of youth only focused interventions when working with at-risk youth with ATOD (Muck, Zempelich, Titus, and Fishman, 2001). There are several reasons for the limited use of family strengthening approaches including cost and accessibility of these services.

This article offers a rationale for why programming efforts should continue to be directed towards family strengthening efforts as opposed to youth-focused only interventions when dealing with serious problems of youth delinquency and problems of ATOD. What follows will describe the design of one community-based, family-strengthening program that addresses issues of youth delinquency and ATOD while reducing barriers associated with availability, accessibility, and cost.

David Wilkerson, MSW is in private practice in Indianapolis and a doctoral student at Indiana University School of Social Work, Indianapolis. Phillip M. Ouellette Ph.D. is associate professor at Indiana University School of Social Work, Indianapolis.

Copyright © 2005 *Advances in Social Work* Vol. 6 No. 2 (Fall 2005) 263-275.

FAMILY-FOCUSED VS. YOUTH-FOCUSED INTERVENTIONS

There is a substantial body of literature demonstrating family-focused interventions to be the most powerful and enduring interventions for adolescent presenting problems of alcohol, tobacco, and other drug use (ATOD) and youth delinquency (Dishion, & Kavanaugh, 2003, Kumpfer 1999). Family-focused interventions include those that are family strengthening. They build on the family influences that protect youth while mediating family influences, which place youth at risk. Years of studies have demonstrated decreases in child and adolescent problem behaviors when interventions aim at strengthening family protective factors such as positive parent-child attachment, and effective behavior management and reinforcement (Spoth, Kavanaugh, & Dishion, 2002). Studies have demonstrated adolescent presenting problems of ATOD and delinquent behavior decrease when interventions focus on strengthening parent nurturing behaviors and behavior management skills. (Spoth, Redmond, & Shin, 2001). Research has identified positive child outcomes from activities that focus on positive parental mental health, household routines, shared parent-child activities (Marsh, 2003). Effective family management by parents when the adolescent was 15 was found to lower the probability of youth violence at 18 years to 17% whereas the probability of violence increased to 41% when effective management was absent (Herrenkohl, Hill, Chung, Guo, Abbott, & Hawkins, 2003).

Family-focused intervention programs are increasingly studied because the youth-focused treatment approaches and programs that have been developed and implemented have been demonstrated to be ineffective for problems of youth delinquency and ATOD. These include intensive casework, remedial reading programs, training for employment, teaching social skills, participating in outdoor activities, individual psychotherapy, group psychotherapy, probation, institutionalization and residential treatment programs (Wilson & Herrnstein, 1985). A widely used youth only focused intervention, the Drug Abuse Resistance Education program (DARE), used by as many as half of the United States public and private schools, was demonstrated to be ineffective (Zickler, 2003).

Youth-focused interventions have also shown to be damaging to adolescents at high risk for delinquency and ATOD. For example, interventions in groups which aggregate youth with high risk for delinquency were harmful and increased both ATOD behaviors and delinquency (Dishion, Poulin, & Burraston, B., 2001). Placement in a group home setting as opposed to a therapeutic foster home setting increased opportunity for delinquent behavior and resulted in more arrests (Chamberlain, Fisher, & Moore, 2002). The Cambridge-Somerville Youth Study examined the effects of massive social work interventions for delinquency prior to World War II for adolescents after thirty years. This study found that negative life outcomes were 10:1 for adolescents who were aggregated in a summer camp for two successive summers compared to the matched control group (Dishion, McCord, & Poulin, 1999).

Despite ineffectiveness and iatrogenic results, youth-focused only programs continue to be financially supported. For example, in one Mid-West community, the first author recently attended three different county's local drug free coordinating council

meetings, which included discussion of funding objectives for the prevention and/or reduction of ATOD problems with youth. In each county, all projects associated with prevention or intervention activities for children and teens were youth-focused only programs and interventions.

Various reasons have been cited for the continued predominance of youth-focused interventions despite their ineffectiveness. In a literature review on family strengthening research, Kumpfer (1999 p.5) notes, "Historically, earlier approaches to rehabilitation and therapy assumed that it was the youth who had the problem, not the family. Additionally, working with children and youth is also much easier than working with parents and other family members. Children and adolescents are generally more accessible through schools and community groups for participation in delinquency prevention activities than are entire families."

Barriers to the implementation of family-focused interventions including availability and accessibility of intervention services for families are seen to result from multiple factors. In the mental health field, the previous decade has seen the dominance of insurance companies and managed care directing nature and delivery of treatment services. The result has favored bio-psychiatric treatments with family-focused approaches being utilized in a limited fashion and only as an adjunctive treatment to medications. Pharmaceutical companies, with their exhaustive marketing and selling of psychiatric medication based on a bio-psychiatric ontology of mental disorder, have further eroded demand for family-focused intervention programs (Duncan and Miller, 2000). What has been observed from personal experience in working with families is that parents who can afford treatment services believe solutions to youth difficulties are only available through chemical treatments. With this perspective, parents, and practitioners tend to ignore the family's own expertise and abilities as an essential resource in finding solutions with youth experiencing serious behavioral difficulties.

DESIGNS FOR FAMILY-BASED INTERVENTION MODELS

During the past thirty years, many family-based models of intervention have been extensively developed to address the issue of troubled adolescents and their families (Minuchin, 1974; Haley, 1980; Fishman, 1988; Madanes, 1991; Selekman, 1993). Not all family strengthening programs and models of intervention, however, are designed or implemented in the same fashion. Each focuses on a particular aspect of family functioning when designing or implementing intervention strategies. Each also delivers help-giving practices, which utilize methods that range from a continuum of expert-based methods with only the professional determining what is needed, to empowerment-based methods where the client or family determines what is needed.

A conceptual cornerstone of most family-based intervention models is family systems theory (Nichols & Schwartz, 1998). Essentially, a family systems view of a problem youth is its focus on the manner in which the young person's functioning is related to parental, sibling, and extended-family functioning as well as to patterns of communication and interaction within and between various family members (Ozechowski & Liddle, 2000). More recently, family-based models of intervention that address severe problems of youth have expanded the boundaries of clinical intervention beyond the

family unit and include the family's social and ecological context as an important part of the overall process of intervention (Liddle, 1995; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998).

One consequence of thinking ecologically has been its influence on present-day changes in the children's mental health field. For example, considerable efforts have been made in recent years to develop responsive community-based systems of care that emphasize individualized and culturally competent services developed in close partnerships with families and human service practitioners alike (Coe & Poe, 1993; Stroul & Friedman, 1996). This concept has captured the attention of national experts, advocates, and policy makers. The results led to human service practices that focus on the importance of establishing strong collaborative working relationships with those closest to the child needing service (Skrtic, Sailor, Gee, 1996). In addition to influencing the creation of strong client-professional partnerships, ecological perspectives have contributed to a greater appreciation for the concept of client empowerment (Rappaport, 1984; Wallerstein, 1992). Empowerment strongly suggests the need for a change in the way human needs and concerns are viewed, addressed, and operationalized. Not only is empowerment viewed as an important characteristic of a well developed system of care serving the needs of children, empowering families provides parents with the necessary social supports needed as they negotiate the vast network of social systems that often become involved in their children's lives as a result of their emotional and/or behavioral difficulties.

Despite the considerable efforts made at the policy level to influence a change in the delivery of mental health services to children, there have been modest gains in the area of developing effective service delivery systems for children with serious emotional disturbances and their families (Duchnowski, & Friedman, 1990; Knitzer, 1993). Significant impediment to gains in this area lies in the fact that interagency system development for children's mental health is considered a very difficult concept to operationalize at the community level for poorly funded community mental health service delivery systems, most especially in a funding environment that favors deficit-based, youth-focused only models of intervention. In addition, the system of care model largely depends on proactive and highly trained mental health professionals and administrators for its successful implementation. The concept assumes that at the operational level, professionals of different clinical backgrounds and orientation can effectively collaborate with one another for the sake of the family. In today's current funding environment and discipline-focused, this kind of inter-disciplinary and inter-agency collaboration is largely impossible.

Few family-focused models of intervention specifically guide the social work practitioner through the maze of multiple social systems that are typically involved when serious behavioral problems arise with at-risk youth. In an attempt to provide a clear roadmap for practitioners, Sells (1998) developed a 15-step, family-based intervention model that shows the promise of providing answers to the unique plight of the teenager presenting difficult behavioral challenges. The model recommends a highly structured process to effectively engage and collaborate with larger systems as well as getting the adolescent's behavior under control. This model has recently been adapted to a parent-

ing program that focuses on engaging parents towards reestablishing authority and nurturance (Sells, 2001). As with other family-focused models, the program requires the use of multiple, highly trained, group facilitators and utilizes both a youth-focused and family-focused training format. The program is practitioner driven and directed, and requires that close collaborative partnerships be developed with significant others for its effectiveness.

Although the research associated with family-based models show much promise, most family-based models of intervention contain generalized principles as its guide for implementation. Intervention and program manuals are a rarity. Those that do exist require that one follow a rigidly defined intervention protocol requiring the skills of highly trained mental health professionals. Because of their complexity and emphasis on generalized principles, practitioners utilizing existing family-focused intervention models are left up to their own devices to implement the general guidelines of a specific model intervention. In this context, family-based intervention services become a mystical process behind closed doors, are costly to implement, and not readily available to most families.

In an article on the effectiveness of family intervention, Pinsof and Wynne (1995) concluded, "in almost all of the family therapy research, it is impossible to know what actually occurred in family therapy" [p. 606]. Without the specification of key concepts, one does not even know whether or not the family practitioner treating the case is actually following the steps of an intervention model.

MOVING TOWARDS A COMMUNITY-BASED, FAMILY-FOCUSED ALTERNATIVE

For family strengthening programs to be successful, they must be readily available, accessible, and affordable to all families at different socio-economic levels and they must be designed to optimize the existing expertise of parents and families. For change to be durable and sustaining, family-focused interventions used in a family-strengthening program must provide a clear message that parents are ultimately the most important resource. Fogatch and Patterson (1989, p. 264) challenged the helping professions by stating, "It is only the parents who can produce long term changes in children". Consequently, efforts should be directed towards strengthening the family's existing resource, enhance community support systems to work with the family, and address motivational factors that promote change in the way we understand and deal with youth presenting serious behavioral challenges.

For help-giving to optimize the expertise and abilities of the family it must be empowerment based rather than professionally based. This suggests the role of the professional will also need to change if family-focused intervention programs are designed to highlight the importance of parents and families as a crucial and under-utilized resource for dealing with youth delinquency. A parent driven, problem solving format in this kind of program will ensure that solutions that evolve from the group are culturally and regionally significant, family-centered, and are realistically applicable (Dunst, & Trivette (1994). The literature provides several examples of how these important variables can be operationalized.

Availability, accessibility and cost were looked at with several studies which could be characterized as using family strengthening, empowerment models; they promoted active involvement by parents for the purposes of deciding about and learning new skills to reduce parenting stress and increase effectiveness. The new skills, which were developed, were family strengthening. That is these were skills which included effective limit setting and reinforcement that have been shown to provide protective factors for youth (Spoth, et. al. 2002). The studies compared community and school-based group parenting skills training programs with clinic-based individual parent training. One study found logistical barriers to attendance were reduced and utilization was increased when parents attended community and school-based group parenting skills training programs (Cunningham, Bremner, & Secord-Gilbert, 1993). A second study by the primary authors looked at parent behavioral skills training with preschoolers at risk for disruptive behavior disorders. They compared community-based treatment using parent behavioral skills training groups delivered by a facilitator to parent skills training delivered by a professional through individual family sessions in a clinic. Parents were less likely to enroll and participate in the clinic setting citing their child was not a problem (Cunningham, Bremner, & Boyle, 1995). Additionally, factors including cultural, linguistic, economic, educational and family barriers such as poorer family functioning were not found to predict either attendance or outcome for the group-based behavioral skills training program delivered in a community setting as opposed to a clinic setting with individual family sessions. Parents attending the community-based groups reported greater improvements in behavior problems at home and better maintenance of their gains at 6-month follow-up.

The studies also looked at cost, a factor that limits availability and accessibility. For the study of parent skills training for children with disruptive behavior disorders which was delivered in a large setting group, the group training was six times more cost effective than clinic-based individual family treatment (Cunningham, et al., 1995).

Several studies provide insight into the issue of family strengthening through empowerment by optimizing the existing expertise and abilities of families. The importance of this empowerment approach for increasing parent self-efficacy was noted in a study of three help-giving approaches for parents of preschool children. The help giving approaches included an expert based and professionally centered approach which was compared to a direct guidance approach where the client assists in delivering an expert determined intervention and an empowerment approach where skill acquisition was the central intervention to empower parents to solve their problems (Dunst, Trivette, Boyd & Brookfield, 1994). Empowerment approaches were found to produce significant increases in parent self-efficacy and effectiveness ratings of the help-givers.

Changing the role of the professional so that help-giving encourages families to take on a more significant role in the decision-making process rather than a professionally-centered approach where major decisions about treatment are determined by the professional, is supported in the professional literature. For example, the literature finds extensive validation for the effectiveness of nonprofessional psychological therapies (Christensen & Jacobson, 1994). In the specific area of children and adolescent treatment a meta-analysis of 108 studies failed to find superior outcomes for professional

therapists when compared to graduate students and paraprofessionals (Weisz, Weiss, Alicke, & Klotz 1987). The empirical support for the use of nonprofessionals was also found in a study of a parent-training group for children with disruptive behavioral disorders who were in residential treatment (Cunningham, C. E., David, J.R., Bremner, R., Rzaia, T., and Dunn, K., 1993). Parents were placed in leadership roles where they took on the role of experts, only viewing video excerpts of parenting errors from which they formulated their own solutions while a second group of parents only viewed video excerpts of corrected parenting methods in an information only and didactic delivery of program objectives. Parents who formulated their own solutions attended more sessions, arrived late significantly less often, were less likely to complain the program didn't work, were more likely to complete homework, and had higher satisfaction ratings than parents who only participated as an audience for the delivery of didactic information in the program.

THE BASICS OF THE COMMUNITY ALTERNATIVES FOR LOVE AND LIMITS (CALL) PROGRAM

Parents of challenging teens are often frustrated and confused. Stressful interactions between them and their teen have increased over time. Many parents have responded to this dilemma by reducing their involvement, management, and monitoring to minimal levels. One alternative to youth-focused only intervention is the Community Alternatives for Love and Limits (CALL) program.

The CALL program was developed to demonstrate the effectiveness of a community-based family strengthening multi-family intervention program to respond to adolescents at risk. CALL uses behavioral skills training to facilitate parental empowerment while supporting parental leadership as a primary resource for change. It intervenes with multiple families in a group format in order to develop a supportive network for parents. The program's strategies for empowering parents as well as its strategies for increasing accessibility, availability, and affordability, were modeled from numerous factors cited in the literature.

Epistemology: The program's epistemological underpinnings regarding the nature of at risk youth behaviors are based on the work of the Oregon Social Learning Center. A review of over 20 years of research by Patterson and his colleagues conducted through the Oregon Social Learning Center (OSLC) on antisocial youth cites the strong association between irritable and ineffective parenting methods and antisocial behavior in children (Patterson, Reid, & Eddy, 2002).

The OSLC had centered much of their effort on the development of their Coercion Model to explain how within the context of family influence antisocial behavior is reinforced and maintained. The trajectory of this influence is an unfolding series of developmental stages, which move from factors such as hard to take child temperament, maternal depression and family stress to a coercive process in the parent-child relationship whereby the parent's and child's use of aggression, intimidation and non-compliant behaviors are mutually negatively reinforced. When the child is negatively reinforced for the use of these behaviors in school with peers and teachers this coercive

process is strengthened, as are poor outcomes such as school failure and peer failure. The combination of school and peer failure progresses to the child's association with deviant peer groups, and in combination with coercive family interactions, reduced parental monitoring and supervision. ATOD and delinquency are seen to be later outcomes to this coercive process.

Target Population: The CALL program is designed for implementation with a middle school population of adolescents and their families. This is a crucial time for parental decision-making regarding the protective family influence of monitoring and supervision. The chronological age of the youth falls between twelve and fifteen. The adolescents represent an at-risk population, and decision makers within the community including school officials, other involved community agencies and parent groups determine selection criteria.

Accessibility, availability and affordability: The CALL program is delivered in a community-based setting rather than a clinic or hospital. Neighborhood schools are chosen because they are obviously familiar to families and easier to locate and attend as opposed to a clinic. Also, school-based programs do not have the stigma that is attached to mental health settings. Offering childcare further enhances availability. Evening programs are also seen to be a necessary ingredient so working parents can more readily attend. The program design allows for as many as 15 families to participate with only one group facilitator. In comparison to the limited professional resources and waiting lists associated with clinic-based services, significant savings can accrue.

Curriculum: CALL includes seven two-hour sessions. Each session introduces a theme, which is acted upon through behavioral family or parenting skill interventions. These behavioral skill building interventions enhance or develop parent leadership while building protective family factors. The program focuses on four protective factors found important by research: supportive parent-child relationships, positive discipline methods, monitoring and supervision, and communication to problem solve and negotiate conflict (Kumpfer, & Alvarado, 1998).

Description of group activities: The programs activities start by motivating parents to consider regaining family leadership to increase their involvement, management and monitoring. The stumbling blocks for motivation, e.g. issues of resistance, negative emotion, frustration, and giving up are managed in this program by helping parents find hope through an experience of empowerment. In this program, empowerment starts with the development of a belief by each parent that working with other parents can enhance their own abilities to become leaders for family change. This belief and the sense of empowerment that may result are seen to be important factors for gaining group participant's commitment to make the effort to change.

To experience empowerment, parents must begin to form supportive alliances with one another. A sense of empowerment is then enhanced through help-giving activities, which are family-centered. These empowering help-giving strategies start with the manner in which group activities are structured. The group is divided into several teams of four to five parents or three to four parents and their adolescents. Adolescents

do not participate in all group meetings and when they do participate they are paired either their own parent or another parent in the group. The teams then work together to decide upon, problem solve, model and practice the use of behavioral skills which are crucial for developing the protective factors of families.

Parent teams increase motivation, hope and empower leadership while developing support. An initial strategy calls for each of the parent teams to view videotape sequences, which depict parenting errors and then troubleshoot alternative skills or strategies, which they believe may lead to better outcomes. Each team elects its own leader who records and summarizes team solutions, makes sure their team stays on task, and makes sure all members get a chance to participate. For example, parents view a typical conflict where a parent sets a limit and conflict escalates with the result being several common negative outcomes, e.g. parent blows up or parent gives up. Following both large group and team group discussion, parents' ideas evolve about the consequences for continued use of ineffective behavioral practices. Discussion may consider the long term consequences for each of the protective factors like limit setting, attachment, monitoring and communicating or only one particular factor. Ideas about more effective skills or strategies needed to solve the problems depicted in the videotape are then explored along with their anticipated effect on the protective factors if used over time.

This type of structuring of problem solving activity offers parents an opportunity to become the expert. It creates an atmosphere for parent networking and enhances parental support. Parents get to know one another and learn to appreciate mutual strengths.

Problem-solving activities are linked with other empowerment strategies, which help parents, and families begin to decide about and practice the use of behavioral strategies in their own home. One such strategy is for the parents to decide about situations, which they would like to see the facilitator model using their teams preferred strategies. It is important to identify that the facilitator does not determine the situations or the strategies to be modeled. In some sessions a video example of a professionally "corrected" or expert-determined use of strategies may also be shown as a follow-up so that parents can compare their model result with that of the experts. When working with a large group of parents, the group's solutions will invariably look very much like the experts solutions. An empowering consequence is the enhancement of parent self-efficacy.

Parents also work together in teams or dyads to practice with one another a specific skill and implementation of the skill in their own home. Groups, which teens attend, allow for other variations on this method. Attitude change is enhanced when parents identify and discuss ineffective strategies, create better strategies and practice with the group the skills they have decided will make a difference for their family. The natural resistance, which is endemic to expert-based delivery of help giving, is eliminated.

In sum, the CALL program is designed as a family focused, family-driven, community-school based, and affordable alternative to current service delivery for delinquency and ATOD which is predominately youth-focused in delivery. Family strengthening

activities are employed to increase the protective factors of families. This is accomplished through behavioral skills training which employs group process to empower parents as leaders and a primary resource for family change.

DIRECTIONS FOR FUTURE RESEARCH

Family strengthening is an area of family-focused treatment that has been shown to be increasingly promising compared to youth focused only programs for decreasing negative outcomes associated with delinquency and ATOD. Help-giving practices in family strengthening programs whose intervention methods utilize empowering and client-centered strategies have been demonstrated to be effective for increasing parent self-efficacy. More investigation is needed, however, on the delivery of strategies that empower families and to what extent do these strategies contribute to the protective factors of family influence on social health problems of adolescent delinquency and ATOD. Other questions for investigation include whether the effectiveness of empowerment strategies is delimited by the age of the adolescent, the degree of risk the adolescent is experiencing and by parent factors such as mental health, substance abuse, and other family stressors. Does a community based setting facilitate the delivery of an empowerment-based family-strengthening program? Does the fact that the program is promoted and conducted from an empowerment base rather than a deficit base facilitate recruitment? What impact does empowerment strategies have on the integration of skills needed for family strengthening. Are empowerment strategies more effective for the integration of specific skills for family strengthening?

CONCLUSIONS

If in fact empowerment based models for family strengthening intervention have better effects for social health problems of adolescent delinquency and ATOD than deficit based help giving intervention strategies the traditions of social work practice would be enhanced. Greater efforts to develop strategies in partnership with families and community stakeholders would be needed. The current preeminence of bio-psychiatric methods in the mental health field approach to these problems would also demand greater scrutiny, questioning, and action.

References

- Chamberlain, P., Fisher, P. A. & Moore, K. Multidimensional Treatment Foster Care: Applications of the OSCL Intervention Model to High-Risk Youth and Their Families in Reid, J. B., Patterson, G.R., & Snyder, J. (Ed.) (2002). *Antisocial Behavior in Children and Adolescents: A Developmental Analysis and Model for Intervention*. Washington DC, American Psychological Association.
- Christensen, A. & Jacobson, N.S. (1994). Who (Or What) Can Do Psychotherapy: The status and challenge of nonprofessional therapies. *Psychological Science*, 5 (1), 8-14.
- Coe, R.F., Poe, S.L. (1993) *Partnership for Care: Systems of Care for Children With Serious Emotional Disturbances and Their Families*. Washington, DC: Washington Business Group on Health.

- Cunningham, C.E., Bremner, R., and Boyle, M. (1995). Large group community based parenting programs for families of preschoolers at risk for disruptive behavior disorders: Utilization, cost effectiveness and outcome. *Child Psychology and Psychiatry*, 36, 1141-1159.
- Cunningham, C.E., Bremner, R. and Secord-Gilbert, M. (1993). Increasing the availability, accessibility and cost-efficacy of services for families of ADHD children: A school based systems oriented parenting course. *Canadian Journal of School Psychology*, 9, 1-15.
- Cunningham, C. E., David, J.R., Bremner, R., Rzasa, T. & Dunn, K. (1993). Coping modeling problem solving versus mastery modeling: Effects on adherence, in-session process, and skill acquisition in a residential parent training program. *Journal of Consulting and Clinical Psychology*, 61, 871-877.
- Dishion, T.J. & Kavanaugh, (2003). *Intervening in adolescent problem behavior*. New York: Guilford Press.
- Dishion, T.J., McCord, J., & Poulin, F. (1999). When interventions harm: Peer groups and problem behavior. *American Psychologist*, 54, 1-10.
- Dishion, T.J., Poulin, F., & Burraston, B., (2001). Peer group dynamics associated with iatrogenic effects in group interventions with high-risk young adolescents. In D.W. Nangle & C.A. Erdley (Eds.). *The role of friendship in psychological adjustment. New directions for child and adolescent development*, No. 91. (pp. 79-92). San Francisco, CA.: Jossey-Bass.
- Dishion, T., Kavanagh, K., Schneiger, A., Nelson, S., & Kaufman, N. (2002). Preventing early adolescent substance use: A family-centered strategy for the public middle school. *Prevention Science*, 3(3), 191-201.
- Duchnowski, AJ, Friedman, R. M. (1990) Children's mental health: Challenges for the nineties. *Journal of Mental Health Administration*, 17, 3-12.
- Duncan, B. L. & Miller, S. D. (2000). *The heroic client: doing client-centered, outcome-informed therapy*. San Francisco, CA, Jossey-Bass.
- Dunst, C. J. & Trivette, C.M.,(1994). What is Effective Helping? in Dunst, C.J., Trivette, C. M. & Deal, A.G. (Ed.) (1994) *Supporting and strengthening families; Methods, strategies and practices*, Cambridge, MA: Brookline Books.
- Dunst, C.J., Trivette, C. M., Boyd, K. & Brookfield, J. (1994). Help-giving practices and the self-efficacy appraisals of parents. In Dunst, C.J., Trivette, C. M. & Deal, A.G. (Ed.) *Supporting and strengthening families; Methods, strategies and practices*, Cambridge, MA: Brookline Books.
- Fishman, H.C. (1988) *Treating troubled adolescents*. New York: Basic Books.
- Forgatch, M. & Patterson, G. (1989). *Parents and adolescents living together, Part 2: Family problem solving*. Eugene, OR: Castalia Publishing.
- Haley, J. (1980) *Leaving home: The therapy of disturbed young people*. New York: McGraw-Hill Book Company.
- Henggeler, S. W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D., & Cunningham, P.B. (1998) *Multisystemic treatment of antisocial behavior in children and adolescents*, New York: Guilford Press.
- Herrenkohl, T. I., Hill, K.G., Chung, I.-J., Guo, J., Abbott, R.D. & Hawkins, J.D. (2003). Protective factors against serious violent behavior in adolescence: A prospective study of aggressive children. *Social Work*, 27 (3), 179-191.
- Knitzer, J. (1993). Children's mental health policy: Challenging the future. *Emotional and Behavioral Disorders*, 1, 8-16.
- Kumpfer, K. L. (1999) *Strengthening America's families: Exemplary parenting and family strate-*

- gies for delinquency prevention*. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.
- Kumpfer, K. L. & Alvarado, R. (1998) *Effective family strengthening interventions*. U.S. Department of Justice, Office of Juvenile Justice Bulletin.
- Liddle, H.A. (1995) Conceptual and clinical dimensions of a multidimensional, multisystems engagement strategy in family-based adolescent treatment. *Psychotherapy: Theory, Research, and Practice*, 32, 39-58.
- Madanes, C. (1991) *Strategic family therapy*. San Francisco: Jossey-Bass.
- Marsh, J.C. (2003). Arguments for family strengths research. *Social Work*, 48 (2), 147-148.
- Minuchin, S. (1974) *Families and family therapy*. Cambridge, MA: Harvard University Press.
- Muck, R., Zempolich, K. A., Titue, J., Fishman, M..(2001) An overview of the effectiveness of adolescent substance abuse treatment models. *Youth and Society*, 33(2), 143-168.
- Nichols, M.P., & Schwartz, R.C. (1998) *Family therapy: Concepts and methods* (4th ed.). Needham Heights, MA: Allyn & Bacon.
- Ozechowski, T., Liddle, H.A. (2000) Family-based therapy for adolescent drug abuse: Knowns and unknowns. *Clinical Child and Family Psychology Review*, 3(4), 269-298.
- Patterson, G. R., Reid, J.B. & Eddy, J. M. (2002). A brief history of the Oregon model: Adolescent behavior in children and adolescents. In Reid, J. B., Patterson, G.R., & Snyder, J. (Eds.) *Antisocial behavior in children and adolescents: A developmental analysis and model for intervention*. Washington DC, American Psychological Association.
- Pinsof, W.M., & Wynne, L.C. (1995) The efficacy of marital and family therapy: An empirical overview, conclusions and recommendations. *Journal of marital and Family therapy*, 21(4), 585-610.
- Rappaport, J. (1984) Studies in empowerment: Introduction to the issues. In: J. Rappaport, C. Swift, & R. Hess (Eds.) *Studies in empowerment: Steps toward understanding and action*. New York: Haworth Press.
- Selekman, M.D. (1993) *Pathways to change: Brief therapy solutions with difficult adolescents*. New York: Guilford Press.
- Sells, S. P., (1998) *Treating the tough adolescent: A family-based, step-by-step guide*. New York: The Guilford Press.
- Sells, S.P. (2001) *Parenting your out-of-control teenager: 7 steps to reestablish authority and reclaim love*. New York: St Martin's Press.
- Spoth, R.L., Kavanaugh, K. A. & Dishion, T. J. (2002). Family-centered preventative intervention science: Toward benefits to larger populations of children, youth and families. *Prevention science*, 3(3) 146-152.
- Spoth, R.L., Redmond, C. & Shin, C. (2001). Randomized trial of brief family interventions for general populations: Adolescent substance use outcomes 4 years following baseline. *Journal of consulting and clinical psychology*, 69, 627-642.
- Stroul, B, Friedman, R. M. (1996) The system of care concept and philosophy. In: Stroul, B. (Ed.) *Children's mental health: Creating systems of care in a changing society*. Baltimore, MD: Paul H Brookes.
- Skrtic, T; Sailor, W; Gee, K, (1996) Voice, Collaboration, and Inclusion: Democratic themes in educational and social reform initiatives. *Remedial and special education*. 17(3), 142-157.
- Wallerstein, N. (1992) Powerlessness, empowerment and health: Implications for health promotion programs. *American journal of health promotion*, 6(3), 197-205.
- Weisz, J.R., Weiss, B., Alicke, M.D.& Klotz, M.L. (1987) Effectiveness of psychotherapy with

children and adolescents; A meta-analysis for clinicians. *Journal of consulting and clinical psychology, 55*, 542-549.

Wilson, J. Q. & Herrnstein, R.J. (1985) *Crime and human nature*. New York: Simon and Schuster.

Zickler, P. (2003). Few middle schools use proven preventative programs. *National Institute On Drug Abuse Notes, 17* (6).

Author's Note:

Address Correspondence to: Philip Ouellette Ph.D., associate professor, Indiana University School of Social Work, 902 West New York Street, Indianapolis, IN 46202-5156. e-mail: pouellet@iupui.edu.