



AFTA

**Monograph Series
Lessons Learned In Community Practice**



American Family Therapy Academy
Theory - Research - Practice

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AFTA

Founded in 1977, the American Family Therapy Academy is a non-profit organization of leading family therapy teachers, clinicians, program developers, researchers and social scientists, dedicated to advancing systemic thinking and practices for families in their ecological context.

Through diversity in its membership and through continuous dialogue and collaborative interchange, AFTA flourishes as a learning organization that adds value to its members and to those whom they serve.

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Lessons Learned In
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Introduction

Family Therapists Keep Building Communities in the Global Village

Ramón Rojano, M.D.,
Guest Editor

The development of the second issue of the *AFTA Monograph Series* started at the end of June, 2005, when I invited a group of family therapists to contribute to this project by answering, in a 60-day period, the following eight questions regarding their experience in community settings:

1. Describe the basic elements or your prototype (scope, financing, where, who, what).
2. Population served; issues addressed.
3. Routines, rituals and practices.
4. Partnerships established.
5. Summary of successes (Has it helped anyone? Who helped you do it?).
6. Summary of challenges (internal and external forces you struggle against).
7. What makes you keep doing it? How do you nurture yourself?
8. Lessons learned (What worked well? What did not work? What adjustments did you make over the years? If you had to start all over again what would you do differently? What have you learned?)

I was blessed with the fact that half of the therapists invited were able to respond within the given short time frame. It was fascinating to see how each one of them ended constructing the response in different formats, but in one way or another, all managed to provide us with very good lessons.

The first lesson I learned was that, against all odds, in many corners of the world, there are

gifted family therapists still managing to keep systemic theory not only afloat, but also vibrant. Building on their desire to grow professionally, community needs, and innovative support systems, these authors use whatever is available to make things happen. They take advantage of institutional support, grants, fees, donations, and even some volunteer time and money so they may see their dreams realized. This fascinating group of practitioners is living proof of the validity of the old southern saying, "Where there is a will, there is a way." The story behind these stories is that fundamental systemic thinking and family therapy ideas have truly survived the funding cutbacks and decreased popularity of the past decade. On the other hand, none of these authors are swearing unconditional allegiance to any particular practice tradition. Everyone has reconstructed and adapted theories to personal styles, environmental realities, and community needs. They all have brought "the people to the book," rather than the opposite. In summary, judging from the enthusiasm I received in response to my request for articles, the first lesson to be learned is that our field is alive and kicking.

At a busy health center in Connecticut, Jeri Hepworth continues to refine the medical family therapy model. But over the years, while helping families to deal with physical illnesses and navigate complicated healthcare systems, she came to realize that increasing cultural competency among medical residents and other mainstream providers was the only possible way of guaranteeing high quality services with an increasingly

diverse clientele. For some time now, she has shared with others her personal journey to move outside the “white world” looking for meaningful connections with all communities.

In the disenfranchised and crime-infested neighborhoods of Springfield, Massachusetts, Marcelo Pakman adjusts the practice of psychopharmacology to the lifestyles and realities of his clientele and has started practicing what he calls “systemic psychiatry.” As always, he is bold and engaging and shows us interesting and nontraditional ways of thinking.

In New York City, Peter Fraenkel keeps bringing family therapy to the shelters. Using his practical and humble drumbeat of careful research and family interviewing, he continues to assemble orchestras of students and volunteers. Together, they bring hope and wisdom as well as jobs and other supports to some of the most destitute homeless families that find renewal through these programs.

In Colombia, after many years of successful practicing and teaching in her home town of Medellin, Beatriz Maria Molina became the consultant for an inspirational group of professionals that have worked hard for many years materializing their dream of building a well structured family therapy institute. Concentrating on teamwork and community education, Nuestra Casa is now one of the most prestigious centers in the country, on its way to expanding its services in outreach for families displaced by Colombian violence.

In New York, Eleanor Nealy has managed to materialize her dream of creating a “LGBT free country.” Along with others, she has helped to develop a liberated and empowering territory in which people of different sexual orientations feel welcomed, accepted, happy, and self-actualized.

In Brazil, impacted by the overwhelming lack of mental health resources, Rosa Maria Macedo joins hands with an enthusiastic team of practitioners and makes culturally

relevant family therapy available to large groups of people.

In South Africa, after reading most of the authoritative and well-known family therapy books and articles, Madhubala Kasiram realized that almost none of them could work by themselves in the context of the massive suffering from the AIDS epidemic that has now left over one million children orphaned. She realized that South African therapists need to craft their own approach, combining established theory with ongoing cultural practices and strategies that harness the beliefs and imagination of these communities.

Howard Liddle shows us how he brought his research and grant development skills to Miami, where he has worked to produce a large program that, using the multi-systemic therapy model, now has multiple sites in the country. Surviving and coping within the national climate of mental health cutbacks, he has done all of us a favor by showing that family therapy responds to the demand for demonstrable effective therapeutic outcomes.

Reading these papers, I learned that rainmaking is still a viable art in this world and that the will to make things happen continues to be its primary tool. I also learned that it is about time to stop shedding tears for the old ways of practicing psychotherapy, and now is the time to create new approaches that match the realities at hand. The good news is that it is already happening, as you can see from this *Monograph's* remarkable collection. It is with great affection and delight that I invite you to let your eyes and spirits wander around the fascinating eight neighborhoods presented here. Enjoy the visit.

Is Caring for Our Communities Enough? Moving Beyond the Do-Gooder to Maybe Doing Good

Jeri Hepworth, Ph.D.

For those of us who are parents, it was easy when our children were in school, wasn't it? We met other families who were also interested in their children and making our communities a more enriching place. Some of us have taken our turn as room parents, as softball coaches, or as treasures of our churches or synagogues and have found our niches as mentors or contributors in our communities. I remember when with no expectations I went to the Girl Scout orientation session with our five-year-old daughter, and came home a leader. The next six years were far more enriching than I ever imagined. Lifetime connections with girls who are now young women, and other parents who still remain dear friends, were unanticipated perks. My husband, family therapist Robert Ryder, took the more systemic view, and served on the local Democratic Council and the school board, with many adventures as Chair. Those formal positions and the informal ones, which we hold by virtue of our professions, allow us to participate and reap the benefits of collective action within the communities that are also our homes.

But what happens when we look beyond whatever boundaries we determine as our own and think about participating in the communities in which we work, or the communities in which we determine there is need? Nearly 25 miles from my office and medical school, my "home" is a rural town in Connecticut. My work community is inner city Hartford, one of the 15 poorest cities in the country, within one of the most economically advantaged states in the US. As part of an interdisciplinary faculty in a Family

Medicine educational program, my colleagues and I have always considered our mission to be one of caring for patients and families in the community context. That language is part of our department's formal mission statement, part of our educational objectives and includes focused and creative curricula.

Of course we provide medical and psychosocial care to families. But we also are aware that our patients' concerns reflect the poverty and injustice of their lives. How can we play a part in recognizing and responding to those concerns? How can we be of assistance without determining what assistance should be provided? Where are the best places to put our efforts: direct service and research, participatory or communal action, political action, or board and organizational activity? These kinds of questions have been debated, and members of our department have been actively involved in community activities for more than two decades. We believe that we are making progress in this endeavor. Although we have not been entirely successful, we believe that we have moved beyond wanting to do good and have become contributing members of this community, partnering with our patients and the many governmental and justice organizations active in the city. As I think about our efforts, I can identify several factors that have enabled this ongoing process.

Administrative and Mission Support

Support for community work comes from the highest levels in our department. We take seriously the mission of the larger university and hospital to contribute to the

community. Within the residency training program, a full month of curriculum time is devoted to community medicine and active engagement in the community. Residents spend time together learning about community services, possible roles for physicians, and have an “immersion” experience which includes a couple days of eating in very local restaurants, sleeping in community centers, and meeting with multiple community leaders, innovative programs and people that those programs serve. We learn much more about how and where our patients live, eat, work, and play. Faculty at all levels are encouraged to model this engaged participation, and activities and collaborative efforts are highlighted in the department’s Annual Report. This creates an ethos of participation that reinforces any individual effort.

Sufficient Number of Key Players

It isn’t possible to think about my own efforts in the community in isolation from the work of my colleagues. My long-term colleagues, Linda Sinapi, M.S.W. and Robert Cushman, M.D., and I have worked together to identify community partners, create and lead curricula, and engage as board members and participants in several ongoing community efforts. As Department Chair, Rob Cushman’s encouragement and participation sets the tone for us all. As Director of Community Medicine, Linda Sinapi has led our efforts to create innovative educational and networking experiences for residents and students.

This inspiring leadership encourages several other faculty and staff members to engage in cooperative community activities, supporting one another and encouraging resident and student involvement. Many are volunteer providers or supervisors at student health clinics for homeless people or migrant workers. The research director leads a collaborative community based research project in which religious leaders and academics have created a weight loss and hypertension intervention that occurs in churches and faith

communities. The nurses and receptionists have participated in community health fairs and encouraged faculty and resident participation. Faculty and family medicine residents volunteer as medical backup for local high school sport events. Several faculty serve on community boards representing a large social justice agency, a charter magnet school, and the citywide program addressing the cycle of teenage pregnancy. As more of my immediate colleagues participate in various activities and organizations, the opportunity for additional contacts and opportunities grows. This is a mutually reinforcing and synergistic process.

Sufficient Focus of Attention

On the individual level, community involvement requires a priority of attention and time. The same focus of attention, time, and resources are required for larger system involvement. For many of the past twenty years, I have negotiated my time to spend approximately one half day per week in community work. Initially, this was possible because our department received a three-year federal training grant to support faculty time. After that, the work was so personally rewarding, that I have continued to make it a priority. In the first years, I expanded my traditional family therapy work, especially supervision, to unique settings. I supervised family therapists in a high school health clinic and in an agency that provided services to Hispanic families. I didn’t speak Spanish. Even if I had wanted to, I couldn’t have pretended to be an expert about the transmigration experiences of families.

This initial work moved me out of the comfort zone of my own office. And that learning, the newness, was part of the process that became so personally rewarding. The physicians in our office were also caring for people from Puerto Rico without significant knowledge of their context. This led to the development, with Linda Sinapi and a bi-cultural community leader, Edwin Ayala, to our annual immersion trip to Puerto Rico for second-year residents and some faculty and

staff. During these five days, we meet health and civic leaders and local people to learn something about the bi-cultural experiences of many. We don't travel as tourists, but stay and eat locally, experiencing on a small level what it's like to not know the language, rules, or context. We recognize that we can never know what it is like to fully experience this—since we are reminded of our educational and social class privileges. In six years, most faculty have participated in this opportunity, and the residents report it as one of the most expanding opportunities of their training. Development and implementation of this curriculum has only been possible because of the level of attention from the larger departmental system.

“Move the Big Rocks”

When a colleague moved to another university, he left me these handwritten words that I had admired. Much community work occurs because of who we begin to know and what opportunities emerge. This flexibility is necessary and creates opportunities that we never would have anticipated. A lesson learned is that we cannot know how we can be useful participants in advance. We need to learn the priorities and needs of the people and agencies, and collaboratively determine how to move forward.

This provides a tension however, because community work leads to new contacts, new opportunities and eventually requires that we make personal decisions about where we place our priorities. After observing and slightly participating in many community programs focusing on justice, I was impressed with an organization that addressed the task of breaking the cycle of teenage pregnancy, and I sought membership on the Board of Directors. Among activities in that role, I participate in meetings with school administrators, state and city health directors, and celebrations of adolescent peer educators. The big rock is not something I can move alone, but I appreciate that with many others, I'm putting my weight

and energy towards moving something that is important.

This final paragraph could be entitled “Personal Commitment,” but that is not a distinct factor. It is the umbrella concept that describes my view about community participation. As I think about my path of involvement, I realize that it is not my participation but my view that has changed. As I noted in the beginning, it is a no-brainer for most of us to find enriching ways to engage in the communities in which we live. For me, the biggest change has occurred in how I view the community in which I work. Even though it is not where I sleep, the community in which I work has become in my mind a community in which I also live. Once we feel a part of our communities, then we have no choice but to become functioning members.

Systemic Community Psychiatry

Marcelo Pakman, M.D.

On different occasions I have written about the integration of systemic approaches in community mental health. They have included experiences of constructive therapies in day treatment and outpatient settings (Pakman, 1999), a thorough analysis of the state of the mental health system in community settings (Pakman, 2003), and a risk reduction program for multi-problem families (Pakman, 2005). Having elaborated on attempts at impacting the delivery of mental health services with the introduction of systemic practices, I want to introduce a preliminary account of my work as a systemically oriented community psychiatrist, based on my experience since my arrival in the U.S.A. in 1989 at the beginning of the managed care era¹.

In the current mental health system, credentials are destiny. As psychiatrists (physicians), our work in community mental health settings is necessarily restricted to providing psychiatric services, which has come to mean, so-called, “medication management.” Psychotherapy is generally provided by other professionals (social workers, psychologists, nurses, and educational specialists), to those same clients whose purported “chemical imbalances” (a term increasingly in use by mental health practitioners in the current “decade of the brain”). Still, well paid within the hierarchy of the mental health services system, psychiatrists saw their expertise increasingly constrained by a rather limited

biological view, and their practice restricted to serving as “neurotransmitter technicians.” The new generation of psychiatrists, trained only on this simplistic biological view of emotional problems, does not have adequate knowledge about psychotherapy; training and expertise in the social aspects of mental illness has all but disappeared for them.

Faced with this situation, mental health professionals like myself, who graduated in the politically heated environment of Latin America in the 1970s, with a view of psychiatrists as intellectuals at the crossroads of the social, the psychological and the biological, have had to put our systemic minds and skills to work. I have been working with poor populations in Massachusetts, whose healthcare needs are usually covered by basic government health insurance in outpatient and day treatment program settings. Minorities (predominantly Latinos and Blacks) are largely represented and clients usually present with complex, compounding health conditions.

Here we have a Decalogue of some of the lessons learned:

1. It is impossible to integrate the biological and the psychological in mental health if we try to put together a simplistic and individually based view of biology with an individually based, asystemic and decontextualized view of the mind and of psychotherapy.
2. As a psychiatrist, in order to go beyond the language of neurotransmitters and chemical imbalances, a common model of treatment is needed, along with a language

¹This is part of a book on the subject currently under negotiation with a publisher with the title of Systemic Community Psychiatry.

- more suited to move elegantly among those fields without stretching concepts beyond coherence. The premises of Batesonian systemic thinking and cybernetics, as well as postmodernist and post-structuralist literature, provide a solid basis for such a language and methodology.
3. The implementation of this common language and methodology is facilitated when we focus on what different mental health professionals do in practice, beyond their abstract theoretical allegiances (Schön, 1983, 1991). This is a way to go beyond the conundrum of how different professionals with different theoretical approaches can work with the same clients.
 4. The interventions of any professional join other cultural influences to become “objects-in-use” (Rein & Schön, 1994), open to reframing, redefinition and transformations under the impact of further interventions. This allows us to work on the way clients use therapeutic interventions in connection with psychopharmacological interventions.
 5. Psychotherapeutic interventions are always implemented by socio-somatic organisms, and all somatic interventions happen as social acts (medicating is a social act). During psychiatric visits, as they are implemented now, the usual theme of conversation is called “medication.” However, the meaning of this theme, its impact on the social and psychological goals of care, and its role in terms of the client’s interactions can all become legitimate subjects of therapeutic conversation.
 6. In the drama of individually based symptoms, the role of medication, as a life event, must be an integral part of the systemic view. A central focus for us is the role of symptom change in achieving therapy goals. Further, we focus on the politics of medication use in the mental health hierarchy and the position of the mental health program in the community.
 7. The participation of family and network members in consultations can be used as a complement to medication as a factor in life events without necessarily assuming a traditional family therapy approach, which we, as psychiatrists, have not been legitimized to do officially.
 8. An essential part of our systemic work is a careful negotiation with each client (and family) regarding what to expect from psychopharmacological interventions, and a discussion about the relationship that the medication has with the client and his/her family or social network (including other providers). We also discuss the client’s own evaluation of target symptoms. Constant use of evaluation and consideration of multiple perspectives and expectations is an essential.
 9. Systemic community psychiatry is the art of managing the micro-politics of socio-somatic situations. The client, the social network, the family, mental health system actors, and we (psychiatrist consultants?) are all part of that complex dynamic in which simple interventions can trigger cascades of positive amplifying events. In this light, we take medications (just as we might with nutrition, level of physical activity, lifestyle preferences, etc.) as a way of “calibrating” the nervous system in a way that is more or less conducive to the types of goals clients establish for themselves. I claim that an integration of biologically oriented psychiatry with the larger mental health system, along with use of systemic methodologies and language, also facilitates integration of mental health and primary care.
 10. We advise making systemic language “invisible” to conversations in meetings, to avoid conveying that we are trying to impose a “different” approach and to avoid

ideological struggles. Open confrontation should be used only occasionally when we consider there are unethical practices. Nevertheless, we have to relentlessly practice always taking a meta-stance instead of direct confrontation. I prefer language that sounds similar to traditional medical language to interact with colleagues and patients, since it enables colleagues and clients to take in the information they expect along with the systemic message I seek to impart. In community mental health settings, not connected with academia, it is, in my experience, more effective to “hide” within this invisible program the richness of practice that systemic thinking offers.

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Fresh Start for Families: A Collaboratively-Built Community-Based Program for Families that are Homeless¹

Peter Fraenkel, Ph.D.

Fresh Start for Families is a community-based program for families that are homeless² and living in shelters. The core of the program is a nine-week multiple family discussion group (MFDG) that mixes members' open discussions about challenges and coping approaches with specific activities designed to reverse demoralization, increase hope for a better immediate and long-term future, and revitalize families' resilience. Fresh Start is coordinated with a job-readiness, training, and placement program that parents can elect to join, as well as with the shelter's housing, childcare, social service, therapy, and recreation resources (see Figure 1). To date, Fresh Start has been implemented in two New York City shelters: a general family homelessness shelter in the South Bronx housing 212 families and a 52-family shelter for women survivors of domestic violence and their children, whose location is confidential. The families are mostly African-American, Afro-Caribbean, or Latino, mostly headed by single mothers, with children ranging in age from infancy through mid-twenties.

Fresh Start began in the winter of 1997, in response to the challenges faced by families that were homeless in which unemployed parents were suddenly being forced to move more quickly

into the workforce, due to reductions in welfare entitlements following President Clinton's signing of the 1996 Welfare to Work Act. Like many agencies working with poor adults and families, HELP USA, the nation's largest provider of services to the homeless, responded to this law by providing a job-readiness, training, and placement program, but was finding that parents were reluctant to attend or complete this program, or did not stay long in jobs once they obtained them. Tom Hameline, senior vice president of programs and a clinical psychologist trained as a family therapist at the Ackerman Institute, heard a range of concerns expressed by a number of these parents, as well as their employment specialists and case workers, many of which centered on challenges faced by families. Tom sought a consultation from Ackerman, and I was asked to work with him, and this began a long-term partnership to create systemically-based programs for poor families, which is now moving into working with housed families at risk for homelessness. Funding for the program has been through a mixture of federal monies (Housing and Urban Development) and private foundation grants, several of which have represented long-term, sustained support through yearly renewals.

Fresh Start was created and continues to be refined and replicated through the use of the collaborative family program development (CFPD) approach (Fraenkel, 2003, 2005). The guiding premise of the CFPD approach is that families, rather than mental health professionals, are the experts on their challenges, their means of coping, and on what they most need in a program. Any program that will consistently engage

¹ This program and research are supported by grants from the Louis and Anne Abrons Foundation, the Altria Doors of Hope Program, the Frances L. and Edwin L. Cummings Memorial Fund, the Ruth Perl Kahn Research Fund, the Dorothea L. Leonhardt Foundation, and HELP USA.

² In keeping with narrative therapy concerns about totalizing labels, we generally avoid the term "homeless families." However, at times sentence structure makes it awkward to use the phrase "families that are homeless" and we utilize the shorter phrase.

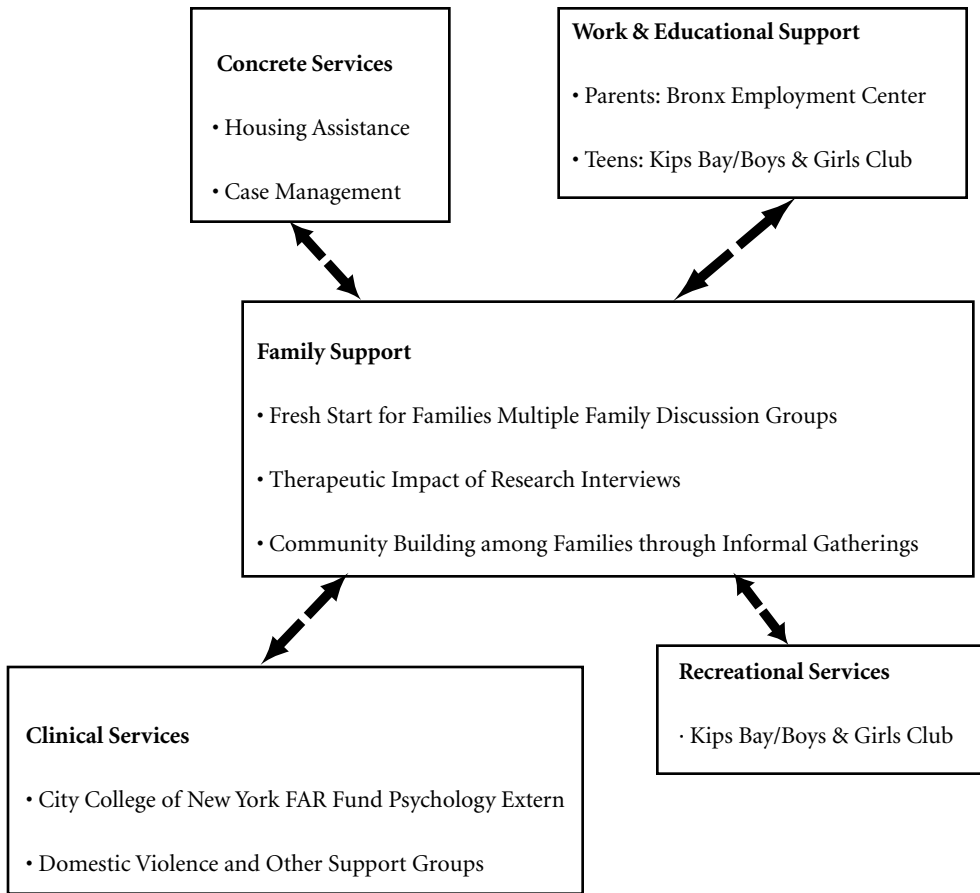


Figure 1

families—especially those with histories of marginalization and oppression based on race, class, ethnicity, education, and other dimensions of difference—must be built with them as esteemed experts who are offered as much influence in shaping the program as they have time to provide. The ten steps of this approach as they pertained to the creation of Fresh Start are briefly outlined below.

Step 1: Initiating the Project, Forming the Collaborative Professional Relationships, and Engaging Cultural Consultants

Following our initial meetings, Tom and I met with the Bronx regional director of shelter services, the director of the larger family shelter (where we began the program), and the director

of social services. All expressed enthusiasm for the idea of a family support program, as did the social services, childcare, recreation, and security staff, employment and housing specialists, and childcare workers when the idea was presented to them in a subsequent meeting. One senior social service staff member was assigned to work with us in coordinating family interviews and subsequent groups, and was given release time from some of her other responsibilities.

In these initial meetings, we shared professional and personal feelings about the plight of economically marginalized, homeless families, frustrations with attempts to provide service, and fantasies of ideal programs to address the issues. As we each spoke about

our experiences and roles with families that are homeless, the diversity in types of expertise and specific concerns emerged, providing us all with a sense of being part of a team—important in alleviating the sense of having to “go it alone” with all the issues presented in the lives of these families. These early meetings—peppered with passionate statements about the larger issues of injustice and social/economic inequity that contribute to homelessness, as well as descriptions of the smaller, daily impediments to aiding these families—were important in building the cohesion and sense of joint purpose that has sustained this project for many years despite numerous obstacles.

Patricia Grey, M.S.W., the shelter director, an Afro-Caribbean-American senior social worker with years of experience working in the shelter system, agreed to serve as a cultural consultant as we shaped the research and program. In addition, at various junctures I have engaged other senior colleagues of color in family research, program development, and therapy as cultural consultants, including Carmen Rodriguez, Ph.D., Kenneth Hardy, Ph.D., Paulette Hines, Ph.D., and Vanessa Glover, M.S.W., the director of the domestic violence shelter. (I also had the opportunity to ask Nancy Boyd-Franklin, Ph.D., to evaluate the program in her role as a discussant during a presentation at a Multicultural Institute conference.) Engaging senior colleagues as cultural consultants was especially important given that both Tom and I are white middle-class males who have never been homeless.

Step 2: Intensive Interviewing of Family Members

Families are interviewed extensively for up to four hours, with breaks, snacks, dinner, and a small monetary stipend. Although we were initially anxious that families would fatigue midway through the interview, we found repeatedly that they seemed instead to become even more energized as the interview went

on: they smiled more, told more elaborated anecdotes, and family members interacted more freely with one another. They often confused the interview with the support program itself. Families explained that this interview was the first time anyone had taken an interest in their story and asked them not only about their difficulties, but how they had coped. Most of the interviews they had experienced in social service settings had focused on what they weren't doing or didn't have—jobs, homes, savings—and seemed implicitly (and sometimes, explicitly) to blame them for these circumstances. They also appreciated being asked to contribute ideas to the program. As one woman stated, “Most programs just tell us things we already know. But you listened. Sometimes, people just have to listen to us.”

Step 3: Intensive Interviewing of Agency Professionals

In addition to the previously described preliminary meetings of professionals which are focused on team-building, we interview front-line professionals in depth to hear their observations and beliefs about families' challenges and coping methods; professionals' own challenges and coping methods in attempting to do their jobs with overwhelming caseloads and little time or resources; and the professionals' recommendations for the program. We conduct these professional interviews only after first interviewing several families, because we want our experience of their lives to be shaped first by the families. In many instances, group interviews with staff professionals have led them to new, and more empathic, understandings of family member behavior that workers previously attributed to “bad attitudes,” “laziness,” and “uncooperativeness.”

Step 4: Phrase-By-Phrase Qualitative Coding

Families' video- or audio-taped interviews are qualitatively coded sentence by sentence by me and a multiracial team of graduate students in order to identify

themes of challenge, coping, and program recommendations. Although time-consuming (it takes about 2 hours to code 5 minutes of tape), we believe the unique voice and wisdom of each family can only be captured by slowing down our listening process.

Step 5: Creating Program Formats and Contents and Writing an Initial Manual

Families' suggestions for the program, as well as shelter workers' recommendations, guide everything from when, how long, and how often during the course of the week the groups meet; whether to have parents and kids together always or separate for some of the time; what to do when members don't attend; and what activities to include. Although there are differences among the three versions of Fresh Start, and differences across the 9 weeks of the MFDG, all versions proceed through the following sequence: dinner, greetings and announcements, work (or school) progress reports that highlight even small positive changes and sources of pride, families' presentations of what they did with home activities suggested at the end of the previous week's group, discussion of challenges and sharing of coping approaches, and presentation of the next week's home activities. Home activities include an exercise in externalizing homelessness; discussing each family members' "dream jobs;" creating a one-year timeline of the family's goals; a collage or mobile of challenges and coping approaches, using magazine photos, index cards, and drawings; using arts and crafts supplies to create a mask that depicts (metaphorically speaking) the "face" a battered woman shows the world to hide her fear; and families writing letters of appreciation to themselves from five years in the future that make meaning of the present and emphasize their resilience.

We also created a Card Sort activity that provides a direct link between the research and the program, as well as adding some structure to the discussion of challenges and coping. Each

challenge mentioned in a family interview is written on a card, and in the group, families are asked to sort the total set of cards into three categories in terms of relevance to them: (1) Not at All a Challenge, (2) Somewhat of a Challenge, (3) Definitely a Challenge. Family members are then asked to begin by picking one card from Category 1 that they'd like to share with the group. Of course, what one family finds not challenging another family might find some what or definitely a challenge, and this provides opportunities for one family to help another.

The program is specified in a manual, so that it can be disseminated and conducted by front-line workers who may not have much experience conducting group or family therapy or community programs.

Step 6: Piloting of the Group with Meeting-By-Meeting Evaluations by Participants

At the end of each group meeting, members fill out a short questionnaire to evaluate that meeting. They are asked to write a sentence in answer to the question, "What was the most important thing that happened or was said today?" They also rate the degree of helpfulness of the meeting, and note anything they did not like about the meeting. We make a commitment to rectify anything they did not like by the next meeting, or at least present it to the group for discussion at the next meeting.

Step 7: Revising the Program and Manual

Each new family interview and each new group provides opportunities to alter the program and manual. Thus, the manual is not a rigid, unchanging document, but reflects the ongoing collaboration between families and program developers.

Step 8: Intensive Interviewing of Families for Each Subsequent Group Cycle

One difference between the CFPD approach and typical needs assessments is that, even though we have by now interviewed 250

families, conducted 35 cycles of the nine-week program, and written manuals for three versions of it (families with young children, families with teens, families that have survived domestic violence), each new family joining the program is first interviewed, and the experiences and ideas shared are incorporated into program materials. Thus, program development is ongoing, and all families have the opportunity to experience themselves as experts. Ongoing in-depth interviewing of families also allows us to keep abreast of changes in city, state, and federal laws and policies that affect poor families and our program, as families often experience the ramifications of these changes before they become widely known to social service providers or the news media.

Step 9: Evaluating Effectiveness in Comparison or Randomized Designs

Following the interview, we give each family a packet of self-report measures that assess degree of well-being on the individual, family, and family-in-community levels. With parents' permission, we also obtain progress reports from the employment program. Following completion of the program, and when possible, at six-month and one-year follow-up points, we re-administer these research instruments.

So far, we have conducted evaluation of Fresh Start without a formal control group—an appropriate design for the first stage in developing an intervention. However, this spring we embark on the first randomized evaluation that will compare Fresh Start to the existing programs provided in the shelter that do not offer a specific family format or focus (a teen recreation group and a group for parents that provides opportunities to discuss problems in shelter life). These existing programs, along with parenting and money management classes, are typical offerings in family shelters.

Step 10: Disseminating and Adapting the Program to Other Settings

We began Fresh Start at the general family shelter, and then developed a version

for families that survived domestic violence, and then returned to the general shelter to develop a new program for families with teens. We have sent manuals to various agencies in the U.S. (including those working with families displaced by Hurricane Katrina) as well as abroad. We have also developed a training program for front-line professionals.

Has the Program Helped Anyone?

As noted, we are engaging in both qualitative and quantitative evaluations to determine detailed answers to this question. Data analyses conducted so far are quite supportive, including:

- Significant decreases (for adults) in demoralization, as measured by the PERI Demoralization Index (Dohrenwend, Shrout, Egri & Mendelsohn, 1980) and psychological symptoms, as measured by the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, n.d.), and for kids, decreases on level of child behavior problems as measured by the Child Behavior Checklist (CBCL; Achenbach, 1991).³
- Consistently high ratings of the helpfulness of group meetings by family members (average rating of 4.57 on a 5-point helpfulness scale).
- Higher rates of engagement in the job-readiness program and in employment than for adults who did not participate in the program.
- Higher rates of engagement in Fresh Start than in other programs offered at the shelter (on parenting, programs for teens).

Challenges

Here are a few of the challenges we've faced and how we've coped.

Lack of Time: All staff members of the project have many other commitments. But by keeping regular time for the program and research, it's

³ The PERI Demoralization Index, SCL-90-R, and CBCL are all widely used measures of psychological and behavioral difficulties. Scale references are available from the author on request.

embedded in our schedules, and becomes part of our weekly routines. Yet we always feel we could spend much more time on the project.

Pressure on Families to Move Out: Over the years, the pressure for families to be placed in permanent housing has been increased by the city government, leading families to be increasingly reluctant to commit to the program—even though their average length of stay has actually stayed the same! We've adapted by creating shorter versions of the program, such as a four-hour version held once on a weekend. We are currently creating a shorter interview.

Changes in Welfare and Housing Policies: One of our most important outcome measures is whether parents obtain employment. Yet two years ago, the city changed its policies so that if parents obtained a job before placement in subsidized housing, they were immediately disqualified from receiving such housing. We've sided with the parents, encouraging them to complete all the steps up to getting a job (completing job-readiness and training) and to wait until obtaining housing before getting a job (Fraenkel, Hameline & Kowal, 2005).

Why Do We Keep Doing It?

This work has been the most moving in my life, a feeling shared by my students and many other professionals who have worked with us. The families we have met truly are an inspiration—although we arrive at the shelter each week already exhausted, we leave reinvigorated. And we keep doing it because we promised Diane, one of the first women to participate in the groups. In a six-month follow-up interview, she said, “Don't give up on the people, because you'll have another group like us. What made the difference was that you all didn't treat us like we were clients, and you were workers. You treated us like we were friends, and that's what made the difference.”

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Nuestra Casa [Our Home]: From the Family to the Community

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The creation of Nuestra Casa [Our Home] Family Care Center arose from our interdisciplinary group's research and clinical work with the families attending Hogar CREA [Center for the Re-Education of Addicts], a therapeutic residential community for the treatment of addictions in Barranquilla, Colombia. Hogar CREA is an international movement that started in Puerto Rico in 1966. In 1984, when the movement was brought to us in Colombia, it sparked a very positive community reaction. Substance abuse had been on the rise, and many wanted to help. Our group of mental health professionals began exploring ways to increase our family consultation skills while addressing the problems experienced by families of Barranquilla and surrounding towns.

Ramón Rojano, a Colombian psychiatrist, introduced family therapy to our team in 1985, which became the basis for all our work. For the next 19 years, the family therapy team continued to meet on its own, bringing in trained family therapists from Argentina and other places, improving our expertise in family work. During the last decade, our team also forged an alliance with the larger family therapy community in the city of Medellín, a practitioner community that pioneered the development of family therapy in Colombia beginning in the late 1970's. Thus, provided with ongoing training seminars, consultation and individual supervision, we began to envision creating a nongovernmental organization dedicated exclusively to provide family services.

Nuestra Casa Foundation became a reality in 1997, when it began officially to deliver services. Nuestra Casa's mission is stated as follows: "to work towards the development and strengthening of families through preventive, educational, therapeutic, and legal programs serving families, with a community approach." Today, the agency operates out of its own "home," a large house with rooms for various types of group activities and several individual counseling offices. It has its own administrative staff and a multidisciplinary clinical staff of social workers, psychologists, family therapists, educators, and attorneys. Almost all of us work part-time, partly on a fee-for-service basis, and partly *pro bono*. Service contracts, educational seminars, direct fees from clients and donations financially support the center. Services are provided at low or no cost, thus opening the doors to many who could not afford counseling fees from private practitioners. Administratively, Nuestra Casa has an infrastructure that flows through a Board of Directors and Founders Committee, into working teams feeding into a program coordinator level.

Services are provided not only to individuals and families, but also to schools, educational institutions, businesses, and the community at large. Nuestra Casa addresses a great variety of issues, including intra-family violence and addiction, stressful family

life cycle transitions, family disintegration, separation, conflicts and breakups, and other types of relational and emotional problems. The primary goal is to strengthen families, providing them with tools to enhance communication and cohesiveness. Additionally, families are trained to identify for themselves specific situations that require therapeutic intervention. The following interventions are offered:

1. Preventive educational services provided through seminars, workshops, forums, and conferences.
2. A special “couples’ school” that offers education and ongoing support.
3. Individual therapy for adults, adolescents, and children.
4. Traditional systemic and postmodern family and couples therapy.
5. Legal family counseling including educational, preventive, and mediation services.

These activities were shaped taking into account cultural differences in our communities, always allowing for inclusion and contribution from various client groups. Educational workshops tailored to specific constituencies also proved to be an effective type of community action. In seeking to attain greater impact, the Center decided to include some family therapy concepts in educational presentations. Great emphasis has also been put on fostering the integration and development of Nuestra Casa’s team, which operates as its own family. Important activities include Group Integration, Bingo, and the Christmas Novena and Skirts Party, a traditional celebration from the Caribbean coast of Colombia. Many internal celebrations help to increase our group’s cohesiveness, such as birthdays, Mother’s Day, and the Center’s anniversary. We also make time for spiritual activities, including the celebration of religious holidays and retreats. The spirit of our team shows clearly when we sing our own original hymn, “Prayer for the Family.” In addition, we have worked to make our interventions more culturally competent by adapting them

to the paradigm of the Colombian coastal community—los Costeños—within the Colombian cultural mosaic. Evaluation and inclusion of the extended family allows staff and family to harness the solidarity of relatives and friends and the tendency to practical problem-solving, which is inherent to Costeño culture.

Nuestra Casa’s success has been built on several specific strategies. They include: dedicating significant time to building and enriching a powerful multidisciplinary team; developing strong inter-institutional agreements; maintaining working partnerships with businesses, public and private institutions; maintaining strong linkages with the community; and building a very strong volunteer workforce. We have contracts with the Instituto Colombiano de Bienestar Familiar [Colombian Family Welfare Institute] and the United Nations Preventive Project for Strengthening of the Family. Institutional and community bonds are strong enough now to support a large roster of clinical activities, and draw a significant number of attendees. For its conferences and forums, the agency is able to mobilize large numbers of individuals at a time, ranging from 100 to 700 participants.

Throughout the years, Nuestra Casa has wrestled with several challenges: Maintaining financial viability has been a constant issue. Poor socioeconomic conditions make it difficult for our clients to afford even the reduced fees that we charge per session. Traditional beliefs and prejudices create skepticism in some families, restraining them from pursuing personal and family transformation through counseling or participation. The community as a whole is not sufficiently familiar with the concept of seeking professional help for family problems. To achieve better visibility and strengthen our economic support base, Nuestra Casa still has a lot of work to do in public relations and marketing. Use of the media for community education campaigns is not yet at the level we would desire. Although Nuestra Casa was created to serve all socioeconomic groups,

the poorest families still do not benefit sufficiently. The team is seeking more resources to enable us to add services, e.g., a satellite office in one of the very financially deprived neighborhoods of Barranquilla. As our program is managed with a very lean administrative infrastructure, it is difficult at times to effectively manage our inter-institutional contracts. Finally, a research division we envisioned has not yet been organized.

We have been asked, "If you could start over again, what would you do differently?" Based on what we have learned through our experience thus far and on our ultimate goals, we would have preferred a location with easier access to low-income families. We also would have preferred to engage in a more consolidated search for national and international funding to subsidize our work with families who lack resources. Over time, many adjustments and improvements were made both at the operational and programmatic levels. To make our services more flexible and available to individuals and families, Nuestra Casa extended its hours of operation and increased the number of therapists.

Our therapeutic model benefited from refinements included later: cotherapy, reflective teams, and solution-focused interventions. A family therapist runs the risk of establishing a vertical relationship with clients and using the power given to him/her to define and dominate needs and solutions. One of the crucial contributions of family therapy to our institution has been the move toward a bidirectional and cooperative relationship with client families. As Harlene Anderson explains, the therapist, the person and the family are equal partners in the conversation: the first is an expert in understandings and possibilities, and the second is an expert on himself and the situation (Anderson, 1997). Therapists should adapt themselves to families, not the opposite. Inter-institutional work should be broadened to examination of policies, practices, and financing that affect family welfare. Difficulties

in life are best understood through a systemic lens, which gives participants a sense of responsibility for their own destiny. Michael White has commented that this way of working is also a source of support and inspiration for the therapist. We have found that working in community is an antidote for professional fatigue.

After many years of intensive training, teamwork, and community practice, we at Nuestra Casa have learned important lessons. The most valuable have been: to think and treat the family as a system in its structure and language; to believe in the family's potential to change; to empower consultation through listening to and privileging a client's needs; and to empower families by seeing them as authors of their own change. Nuestra Casa planted the seed of systemic family therapy as the basis of the mission, watered it with community work, fertilized it through links with social institutions, and energized it through the team's commitment to collaboration. Out of this project, two principles have emerged: appreciation of the relational world in which we live, and a deeper understanding that personal difficulties are best resolved through a network that connects the individual, the family, and the community.

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Photo Gallery



Jeri Hepworth with colleagues as they learn more about the Puerto Rican community.



*Ramon Rojano with members of his Middle Class Express team
Standing from the left to the right:
James Johnson Jr., Elba Cruz-Schulman,
Renee Hamilton-Jones, Iris Nieves-Cross
and Ramon Rojano.
Seating: Renee Smith*



Madhubala Ishver Kasiram, Ph.D.

Rosa Macedo's Group(NUFAC).

From the left to the right seated: Rosa Maria Macedo - Ph.D. Coordinator, Mathilde Neder - Ph.D., Ceneide Cerveny - Ph.D. Standing: Marianne Feijó - Ms., Maria Luiza Piszeszman - Ph.D. Marilene Grandesso - Ph.D., Claudia Brusacagin - Ph.D., Monica Galano - Ph.D.



A photo of a Fresh Start graduation ceremony at HELP Morris shelter in the South Bronx, featuring staff from Ackerman Institute, City College of New York Doctoral Program in Clinical Psychology, and HELP USA. Families are not included so as to preserve confidentiality.

Standing in the middle: Peter Fraenkel, 5th from right to left



Marcelo Pakman, MD



Members of Nuestra Casa Team standing in front of the agency. Standing from the left to the right: Cielo de Cure, Daisy Barros, Beatriz Molina, Carmen de Salazar, Silvia de Navarro, Maria de Theran, Katia de Rosales y Maria Teresa de Sabbagh



We are Not Alone: Making Connections in the Lesbian, Gay, Bisexual, and Transgender Communities

Eleanor C. Nealy, M.Div., M.S.S.W., L.M.S.W.

My home base is the Lesbian, Gay, Bisexual & Transgender (LGBT) Community Center (the Center) of New York City. Our long-time mission statement says that, in keeping with the Center's commitment to fostering empowerment, Center programs offer LGBT persons opportunities to discover who they are in an atmosphere of self-acceptance and support, to come together and build community to end stigma and prejudice, and to celebrate lesbian, gay, bisexual, and transgender culture and identities.

Since its inception in 1983, the Center has served as the hub of activity and a resource for support for the diverse LGBT communities of New York City and beyond. Today, 6,000 persons come through our doors each week to access over 300 different LGBT groups and organizations; a comprehensive adult and youth counseling and social services program; educational services including a lending library, an LGBT archives, a full service adult cyber center and a youth computer lab; more than 250 recreational, cultural, professional, spiritual, and civic activities and forums monthly; and 90 self-help support group meetings weekly.

Center CARE (emphasizing Counseling, Advocacy, Recovery, and Education), the adult counseling program, offers a wide range of individual and couples counseling regarding substance abuse, mental health, bereavement, HIV/AIDS, coming out, and gender identity concerns. At any given time, 12-15 different support groups are offered. The goal of these services is to build self-esteem by bringing LGBT people out of isolation and helping them to connect to proactive, healthy, and affirmative community services and activities.

Sixty-five percent of Center adult clients are men and 35% percent are women, with 20% of these identifying as transgender. A quarter of Center clients are African American, another 25% are Latino/a, 4% are Asian/Pacific Islander, 1% are Native American, and 45% are White. Nearly one-third are living with HIV/AIDS. Fifteen percent are homeless and roughly 25% are unemployed. Some 40% present with co-occurring mental health and substance abuse diagnoses.

The Center's Youth Enrichment Services (YES) program works each month with 350 lesbian, gay, bisexual, transgender, and questioning youth, aged 13-22 years. As an HIV and substance abuse prevention program, YES seeks to build self-esteem, create a community of inclusion, and develop youth leadership through a variety of media literacy and arts activities, peer education, recreation, support groups, and community events. Eighty-five percent of YES participants are youth of color and some 50% live in New York City zip codes with the highest poverty levels.

A unique aspect of the Center's counseling services is that they all occur in the context of the larger LGBT Center, a community-based and community-building institution. Clients' first point of contact is not organized as a traditional mental health clinic setting. Instead, clients begin their participation as members of a LGBT liberation and empowerment organization. As with earlier settlement houses, the focus is on delivery of collaborative services in the context of community building and social change. In marked contrast with earlier settlement house models (in which members of the dominant culture tried to "enlighten" and acculturate, as well as serve, members of

marginalized immigrant groups), Center staff are largely LGBT-identified and thus, members of the same communities they serve. Center counseling staff is deliberately comprised of peers and professionals who represent as much as possible, the cultural diversity of New York City's LGBT communities.

In keeping with this collaborative perspective, all members of the LGBT community are “immigrants to their own country,” who need to learn their own history and culture. They deserve a range of services delivered in an LGBT-affirmative environment with an awareness of LGBT-specific needs and concerns. The collaborations between staff and clients enable participants to become full and active members of the New York area LGBT community.

Swenson (as cited in Lee, 1994) notes a connection between an absence of constructive community relationships and individual fragmentation, purposelessness, addiction, and violence. She goes on to say that, for oppressed groups in particular, the community is a critical mediating structure between empowerment, liberation and, conversely, oppression. The Center's community building approach is not simply about the treatment of individual clients and families, or even of interpersonal conflicts; rather it is about building a community of empowered citizens and activists. From this perspective, community building must emphasize both partnership and the importance of difference and “must incorporate conflict and tensions, not simply cohesion and consensus building” (Fabricant & Fisher, 2002, pp. 288-289). One of the chief challenges in our work at the center revolves around how to continually embody the wide-ranging diversity of New York City's LGBT communities.

From its onset, the Center has been an engine of social change and transformation. Its policy and advocacy efforts include an extensive voter registration and mobilization

program; pre- & post-election forums; Causes in Common, a coalition of LGBT rights and reproductive rights activists; the Gender Identity Project, which works for the full equality and inclusion of transgender and transsexual persons and others who are gender-different; anti-death penalty organizing; and gay marriage activism.

The Center gave birth to ACT UP, an early HIV/AIDS activist organization and GLAAD (Gay & Lesbian Activists Against Defamation). It was also instrumental in the passage of New York City bills prohibiting discrimination on the basis of sexual orientation and gender identity and expression, and the New York State SONDA legislation prohibiting discrimination on the basis of sexual orientation. On a regular basis, city, state, and federal officials visit the Center to talk with LGBT constituents and hear their concerns. These social change efforts embody the ways that the final stage of community building results in a broader communal sense of identity and more political and economic clout (Fabricant & Fisher, 2002).

Several models guide our clinical work with adolescents and adults. The first is one of harm reduction that employs Prochaska, DiClemente and Norcross' (1992) stages of change as a tool for conceptualizing and intervening with individuals, couples, and families. The second model incorporates a strengths-based perspective that reframes what traditionally are defined as diagnoses and pathologies as survival strategies, and focuses on resiliencies rather than deficits. As Hirota, Brown and Martin (1998) note, this approach strengthens individual and community assets, and builds the collective capacity to address social problems. A third model we utilize explores client and community struggles from a systems perspective, with a focus on the person/family-in-environment. Drawing on this model, we address the impact of cultural, structural, and economic factors that can facilitate or limit personal and communal health and well-being. A fourth model grounds

our work in the intersections of oppression and recovery; we recognize that all LGBT persons experience the effects of internalized homophobia and transphobia. Consequently, we at the Center believe that all LGBT persons need to engage in a deliberate process of critical consciousness raising that enhances recovery, empowerment, and activism for individuals, families, and whole communities.

An example of two clients' experiences will serve to illustrate this process of self-in-communal development. Some years ago, 15-year-old José began attending after-school activities in the Center's youth program. He was fearful, shy, and awkward with peers and staff. Over time, we learned about the impact of his father's alcoholism and physical abuse, as well as the profound homophobic, religious rhetoric in his family. Gradually, José began to become more active in our program. In time, we were able to reach out to his mother and provide support and resources for their family's journey through the coming out process. By the time José was 19, he was serving as a peer counselor in our summer camp program. He was enrolled in college and active in the school's LGBT student group. Today, José is a proud gay Latino young man who serves as a teacher in the New York City public school system, helping other young students find their voices and develop their leadership skills.

More recently, a 40-year-old Caucasian lesbian living within the New York City shelter system reached out to the Center for help. Through individual and couples counseling, support groups, and twelve-step meetings, Sandy was able to move into sobriety. Our peer-based services provided a support network while she and her partner worked to re-build their lives. Recovery-themed retreats and peer leadership development trainings helped Sandy to build self-confidence, understand effects of the intersections of gender, class, and sexual orientation oppression on her life, and learn skills for advocating for herself and other LGBT persons in recovery. Today she works

as a peer educator, facilitating recovery groups for lesbian and bisexual women in New York City shelters and is a leader in a community-based group advocating for the needs of LGBT persons and others living in poverty.

José's and Sandy's stories speak to the critical role of community practice with LGBT persons and their partners and families. It is not enough to simply provide individual counseling or family therapy. Such services must be embedded in a community context that enables participants to recover from the effects of both actual and internalized oppression. These experiences of connection to community and culture lead participants into the work of advocacy and empowerment for themselves and their peers. They illustrate the words of lesbian activist Gloria Anzaldúa who wrote, "We have come to realize that we are not alone in our struggles nor separate nor autonomous but that we—white black straight queer female male—are connected and interdependent" (Anzaldúa, 1982, p. iv).

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Constructing Empowerment and Resilience Contexts—Systemic Interventions in Communities

Rosa Maria Stefanini de Macedo, Ph.D.

*“The utopian is not the unrealizable. The utopia is not the idealism....
But is to denounce the inhumanity of the structures and to announce their humanity.
That is the reason why utopia is also an historic compromise.”*

Paulo Freire, 1987

One of the major problems in Brazil is unfair income distribution. Statistical data shows that the wealthy, a group of 1.8 million, comprise 50% of Brazil’s wealth while the other 50% is distributed among 178 million people. This enormous gap between classes has severe social consequences, chief among which is social and economic inequality. Nearly one-third of the population lives in poverty, which means they have a less than minimum salary¹ per month (one hundred dollars). One-third of Brazilians live below the poverty line, earning three dollars a month or less. They face economic, educational, and cultural barriers, which create an environment of exclusion and prejudice.

Our past research (Macedo & Saleh, 2001) has supported Foucault’s (1979) tenet that people in such a context become “docile bodies,” living through daily hardship and suffering as if this is “natural.” Many of the poor cannot be assisted by the overburdened Welfare Services system. Public programs in health and education are very expensive in Brazil, as in other developing countries around the world. Further, each time the government needs more money, the welfare budget is reduced. So, the financial aid that public

¹ In Brazil, the minimum salary is the least amount an employer can pay to an employee by federal law.

institutions and private social clinics target for the poor is chronically insufficient. When families succeed in getting those services, they wait so long for an appointment that frequently it becomes purposeless. It is common to see both professionals and institutions burned out and numbed by the pressure of public demand and chronic shortfall of assistance.

As family researchers and therapists, committed to ethics in relationships, we are sensitized to the problem of inequality and the challenges it represents. At our agency, Nucleus for Family and Community (NUFAC—PUC-SP), we felt that we could not remain indifferent to the ethical and social justice questions in our clinical work. We agreed that it was necessary to break down the boundaries of traditional psychology practice, and to move toward bringing it to the community: schools, churches, clubs, nongovernmental organizations, and even public meeting spaces such as parks and squares.

Our model is based on the work of authors with culturally sensitive practices in community settings, such as Freire (1987), Minuchin (1998), Stephens, Waldegrave and Frater (1997), Waldgrave (1990), Dabas and Najmanovich (1995), Barreto (2005), Macedo (1986, 2001) and Grandesso (2000). These authors all affirm that the experience of chronic frustration and

deprivation creates feelings of powerlessness and a belief in the incapacity of managing one's own life. Therapists must consider the context of social, political and economic exclusion as a prime factor in the development of psychological problems and suffering.

In the formative years of NUFAC, we were a group of eight doctoral clinical psychologists specializing in family therapy, professors in the graduate training program at the Pontifical Catholic University of São Paulo, Brazil. Over time, the group expanded to include affiliated professors from other universities, undergraduate and graduate students, and externs in family and community therapy. We knew that we would need to begin by understanding how families living in the greatest poverty handle the stressors of their everyday lives, as well as their beliefs, lifestyles, challenges, and hopes. Our goals in creating NUFAC have been to: (a) deconstruct and challenge stereotypes and myths about families living in poverty; (b) identify family strengths, promote members' self-identification as citizens with rights and abilities, and strengthen resilience in the face of adversity; (c) teach healthcare and social science professionals a competence focus in order to serve the families more effectively; and (d) sensitize our public health system to the importance of implementing better public policies and programs for the families.

NUFAC's research and clinical work is based on the constructivist model, i.e., the world of meanings as "constructed" by the observer. We assume a nonhierarchical position with the families and community members we plan to serve. Our clinical interventions are narrative techniques, developing goals, and creating change in dialogue with community groups based on their life experiences and their ideas (Freedman and Combs, 1996; White and Epston, 1999). We also have used group techniques such as role-playing, sculpturing, and some other nonverbal techniques to enhance therapeutic conversation. The larger purpose of the agency is to develop alternative approaches that will

allow creative intervention with a large number of individuals and families within their home communities. During the past five years we also began to adopt principles from the System Integrative Model for Community Therapy. This approach was created by Adalberto Barreto (2005), a psychiatrist and anthropologist who sees human suffering as the central organizer of therapeutic conversation. The objectives of System Integrative therapy are: (a) to promote social networking and experiential exchange among participants; (b) to emphasize competence, improve self-esteem, and facilitate self-empowerment; and (c) to develop "another story" of clients' lives, in which problems are redefined (Barreto, 2005; Grandesso, 2005). This model of therapy demands study about larger systems, since communities are unpredictable and complex human systems.

Our project began in 1989, and was developed in four stages: (a) research interviews with families about their needs and concerns; (b) reflexive conversation family groups, in which families share their experiences with one another; (c) focus groups to discuss the special themes and problems that emerged from the research interviews and reflexive conversation groups; (d) training groups and workshops to target specific populations such as parent groups, teacher groups, and healthcare provider/service provider groups; and (e) open community therapy groups for members of the community.

Our Program

Reflexive Groups and Focus Groups. These are offered to parents with sons or daughters enrolled in social programs at nongovernmental agencies or schools in the community, parish members, public school teachers, public health professionals and agency workers (healthcare professionals at all levels of administration are combined together).

Training Workshops. Professional workshops and practical exercises address problems and teach skills needed for childrearing,

educational interventions for students, and family structure-family intervention. These are targeted to parents, teachers, community aid workers, and social service workers.

Community Therapy. Large numbers of people from local communities meet in an open group. Groups are held in public spaces easily accessible, such as hospitals, churches, and childcare buildings. Each session becomes a self-contained, single therapeutic experience to all the participants who are present that day. The meetings do not require a continuous commitment, as does traditional therapy. However, when a client attends multiple community therapy meetings over a period of time, the intervention is transformed into a long-term therapeutic process (Grandesso, 2005). Each session is structured in stages: (a) welcome and warming; (b) selecting the theme; (c) contextualization (naming and understanding suffering); (d) group sharing; and (e) closing rituals. These are heterogeneous groups, because within one community therapy session participants range in age and come from diverse social, economical, and cultural settings. A great variety of themes may be worked depending on the needs presented in each group; for example, alcoholism, domestic violence, depression, or abandonment. However, typically, one to two themes are selected for each session, and a member is chosen to present his/her problem. Everyone participates in sharing experiences, singing popular songs that are reflective of the themes that emerge, and discussing the comments of the day's presenter. The therapist functions as a facilitator. To open the reflexive group conversation, s/he identifies the problem, which is called a "mote," for that group meeting. The presenting member makes his or her comments and thus begins the conversation about the chosen problem. During the contextualization stage, the therapist opens up dialogue by inviting the other attendees to discuss the "mote" together. For example, the "mote" may be alcoholism. After listening to the presenter's narrative about how the alcohol has created

distress for him/her and the family, the therapist asks: "Who has experienced a situation like this one? Who has felt like the one who is presenting here today?" Each participant has an opportunity to connect with the "mote" (theme). The reflexive dialogue creates time to reflect about mutual experience, to revise members' view of the problem, to identify resources and competences, and to share learning with the others. In this approach, each dialogue is culturally rooted in the themes that emerge from the participants, in their own language, and their own way of understanding their experiences.

Violence, substance abuse, couple infidelity, robbery, gang disputes, sexual abuse, divorce, abandonment, and many other kinds of complaints are presented. Sometimes a person or family needs to be referred to individual therapy, or to a specialized provider (e.g., psychiatrist, primary care physician). The therapist is expected to know the resources in each community served, and to be in contact with its other systems as an integral part of the program. In our model, fortifying provider networks at the professional level is as important for success, as is fortifying the network among members of each community.

As a result of our project, many changes have been observed within the communities where we hold group meetings. For example, in our evaluation of the changes in parent attitudes and behaviors, we have observed:

1. Increased strengthening of primary affection bonds and a re-visioning of home as a privileged place for raising and caring for children.
2. Improved flexibility in authoritative and rigid patterns of discipline and increased ability to negotiate with sons and daughters.
3. A disposition to learn and participate more in community social projects, in child and adolescent development, and in understanding the problems in intergenerational relationships in the phases of the life cycle.

4. Development of solidarity and reciprocity with other parents of the neighborhood to share concerns about monitoring and guiding children.
5. Strengthening of investment in children by directing them toward studying when possible instead of/in addition to working for earnings.
6. Improvement of the relationship between parent and school and more attention to the school problems faced by children.

Testimonies that we received from families regarding this project included statements such as the following: "...today I've learned a very important thing: my son has grown and is changing...he is gaining more autonomy...;" "...I have learned today that I have to act differently...I have to stop yelling, shouting; to show limits and self control as an example for them...;" "I have learned that we have to be self-confident and not underestimate ourselves about our capacity to educate them...;" "...I discovered a way of having peace at home: instead of fighting against my daughter to do her homework, I gave her space in the kitchen table and I stay near, cooking the lunch, while she studies; so I keep calm and all...things go better."

Through delivery of the community therapy program we have also observed a change in group dynamics. The relationship among community members creates a sheltering and warm connection. There is more availability and respect for someone else's suffering. Members experience more generosity in giving and also receiving support. They come to recognize that each one learns from the other. We have also observed a mutual view taking form among members that legitimates differences and recognizes the competencies that of each individual. This view recognizes each person in the group as a legitimate honorable other, respecting their cultural values and the wisdom they have developed through life experience. As a consequence it promotes resilience, which we at NUFAC define as the ability to transform challenges into growth and autonomy through

the development and promotion of social and support networks.

There are many challenges, including lack of public investment in health and education, lack of money to meet the needs, and mistrust in new communities regarding the objectives of our program. We also have to address the doubts that public agencies, the local people, and even some professionals show about the possibility of change. Mental health and healthcare professionals also have to struggle against fear of the drug dealers, the "parallel power" that controls our slums. Dealers frequently threaten professionals and families with expulsion (exile), injury, or death if they disclose information regarding drug-related "business." Yet, the increasing involvement of health professionals from the public service and private clinics with this program has been very effective in galvanizing some authorities to introduce and develop similar ventures within the welfare system. Therapists in the welfare system are particularly enthusiastic about our intervention model because this way of working diminishes waiting lists. Our trainees and supervisees believe in just therapy, and feel themselves useful to a greater number of people with this model of practice.

What motivates us to continue this work is the strong feeling and consciousness of being able to contribute to the inclusion of people into social benefits they deserve as citizens. We are conscious also that we help them to improve their self-esteem, self-confidence, empowerment, and resilience. As a result, I believe that all professionals and volunteers involved are "constructing" a society with more justice, hope, and humanity.

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Challenges and Changes to Family Therapy Practice in South Africa

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Family therapy in South Africa seriously challenges traditional theoretical paradigms as we struggle with horrific crime and violence at family and political levels. This paper examines published work modifying family therapy practice in South Africa since 1988. Whilst undertaking this exercise, it was interesting to observe the allegiance South African clinicians had to their international counterparts, by using international models, language and theory to understand, and articulate and test modifications. We propose in this paper that we need not confine ourselves to this mould and should be bold in charting new territories in family therapy. We must confidently embrace our own forms of theory and intervention. This paper addresses challenges facing South African family therapists, and resulting changes, which have enlivened and shaped family therapy for local and perhaps international consumption. Central to our work are innovations in several areas: (a) how our practice accommodates “difference;” (b) how we embrace “community;” and (c) how we use nature, drama, and the arts to creatively engage with families.

The Challenges

Our unique context and need for special understanding emerged as early as 1988 during the 4th National Conference of the South African Institute of Marital and Family Therapy. At this meeting practitioners spoke of practicing “western-style” family therapy in Soweto amid poverty and hopelessness (Nell & Seedat, 1988). So many of our couples and families suffer from poverty, oppression, disempowerment, and despair; rather than choosing either a macro view or a micro, within-family view, they suggested working with both. Lifschitz (1988) also invited therapists to take “psychotherapeutic contexts” to Black families by seeing the world through their eyes rather

than western tinted lenses. He referred to appreciating rituals of African religion and practices to co-create new context-relevant therapies for South African family therapists.

The South African context warrants deviation from traditional systemic interventions. Both South African family therapists, as well as those practicing in the western world among deprived communities, appear to appreciate the need for freedom from the mould. Some refer to the American “myth” of a melting pot of cultures and communities that apparently blend harmoniously, emphasizing that in reality there is no such blending and suggesting a need to co-evolve with context. Clearly, there is need for freedom from dominating influences to create culture-sensitive practice. Morkel (2004), a South African writer, has gone so far as to state that she has felt “handicapped” by “professional training and the isolated, privileged life I lead as a white South African,” commenting that training failed her in reaching disadvantaged communities respectfully.

Kasiram (2000) has discussed therapeutic “failure” as perceived resistance to therapy. She asks whether it is the family that is failing to respond, or the therapist that is failing the family. Disadvantaged communities pose the challenge to examine such “failings”.

McNamee (2004) refers to how “consistency is admired” when we should rather be creative when our learnt theories are not relevant or effective in application (p. 225). For example, Hall (2000) discusses Zimbabwean families whose members have been wiped out by AIDS. She has found that traditional casework and family therapy are not useful for these families facing

catastrophic illness and loss, and advises that creativity, humility, and humanity are crucial tools in searching for indigenous models of practice. Finally, Rundell (2000) expresses frustration with traditional supervisory methods when working within financial and human support constraints. Rundell advocates a model of therapists in training and client communities as “co-visionaries” in their own growth and change producing events (p. 150).

Respect for Difference

“Difference” has so many guises in the family therapy context. McDowell (2002) refers to developing a culture of “pluralism” where “multiple perspectives are cultivated and valued” (p.180). The key is to practice “in the moment” family therapy (McNamee, 2004, p. 224), where we give credence to ways of life and being and respect that which is different from the dominant culture. This may mean redefining “family” to capture its various faces, especially in South Africa where we have so many child-headed households where parents have died of AIDS. We also need to affirm the strength of these family structures, and deviate from promoting the autonomy and individuation of systems and individuals when there is community catastrophe. Indeed many therapists have referred to the family as “expert,” managing and controlling their circumstances via an array of supports and structures that we could not imagine possible. In this vein, Kasiram and Partab (2002) refer to the power of the family and community in facilitating grieving when a nation experiences multiple losses.

A further difference to be respected is that in many financially constrained families, male members do not avail themselves for therapy, a feature also noted by Bean (2002). Sliep (2000) has also commented on her decision to work with female family members who needed to tell their stories of courage in facing AIDS. Although she found that the men were not ready to use prevention services or participate in therapy, the women were prepared to fight the

horror of AIDS and take precautions to save their children even if it seemed to be too late.

There are linguistic differences that force us to be culturally appropriate. Ajila (2000) discussed the use of proverbs, prayers, and names amongst the Yoruba in Nigeria, Africa as adjuncts to therapy. Neuro-linguistics is being recognized as a force controlling behavior, since it is derived from culture and values. Sliep (2000), for example, used the axiom that the stick in a bundle is stronger than when it is isolated, to help women afflicted with AIDS to come together to search for solutions. Says Ajila (2000), names bearing the word “akin,” meaning fearless, could be employed in therapeutic conversations to re-introduce the fighting spirit in the individual or family. Jeewa (2005) discusses how language can disempower persons who have abused drugs, by referring to them as “recovering addicts” who must be constantly on guard should they fall prey to a past. Instead, he suggests they be praised for breaking free and could regard themselves as being “cured.” A new language introduces a fresh frame of reference, against which future change and progress may be plotted and valued. So, searching for culturally specific language that will achieve these ends becomes a process goal that pervades our therapy.

Another type of linguistic intervention that we use comes through the use of “cultural metaphors,” such as the “trickster” in African-American communities. The “trickster” has weaved himself into the life of the family to make life difficult. Using the concept of the trickster in therapy allows distance between the problem and the people, a concept similar to externalization within the narrative therapy framework (Akinyela, 2004).

Difference in the form of dissonance among generations within a family is also an issue that challenges therapists to practice outside of the box. Lee and Mjelde-Mossey (2004) argue for using multiple sets of values even when they are seemingly conflicted.

Such dissonance occurs all too easily because of different responses by generational groups within a family, to mass media portrayal of dominant cultures. Family members are often at varying levels of acceptance or rejection of dominant influences and these become the agenda for negotiation when therapists recognize the effect of such dissonance. In this light, Barnard (2004) refers to how traditional foundations in South Africa are hurt and disintegrate in the face of modern values and moral codes of conduct. Winfield et al. (2004) uses role-play to hear these multiple perspectives within families and communities in order to restore relationships and promote social harmony. Morkel (2004) also demonstrates the disillusionment parents experience when their children adopt values different to theirs. She uses the metaphor of "rites of passage" from a narrative perspective to bring together dissenting voices to create understanding and harmony.

Respecting difference may mean getting in touch with our cultural roots to experience liberation from materialism, where love, enjoyment, and laughter are considered indicators of "success" and happiness. We appear to have accepted and become trapped by a world that is achievement oriented. We are no longer human "beings" but human "doings," taking no time for ourselves or simple pleasures. Perhaps traditional villages and peoples that celebrate happiness or living through dance and song, sharing a smoke, or taking time out to just "be" need to guide us again, so that we may be less wearied by the world. These differences ought to be highlighted.

Community Responsiveness

Many therapists/researchers acknowledge the ever-present and powerful context of community. McDowell et al. (2002) ask that we transform by increasing "awareness of the systems of privilege and oppression that define equity and justice" (p. 180). Oliphant (2005) suggests that empowerment and uplifting of communities through the use of developmental

strategies must complement microsystemic strategies such as those of family interventions. Rojano (2004) agrees that family therapists combine family therapy with developmental and motivational theories, community mental health, economic development, and community mobilization strategies. Hernandez (2005) mentions the need for intervening at the intersection between family and community. They challenge family therapists to continue in the tradition of being leaders that produce cutting-edge thinkers, and invite us to critically engage in the process of allying with the community in this regard. Bean (2002) cautions that a past steeped in social injustice and discrimination makes some families wary and even distrusting of therapists.

How do we translate these ideals into practical reality? In realizing that individual therapy could not address families that were rebuilding after traumatic loss, Petty (2004) trained a group of kinship caretakers to act as therapeutic agents in their children's lives. This was an empowerment strategy to sustain not one, but many families simultaneously. When community members are taught to develop their consciousness about community issues, they take collective action and reaffirm their collective strength (Nair, 2004). However, one must not underestimate the difficulties in promoting collective action to address socio-political problems.

Indeed, the model of "community family therapy" proposed by Rojano (2004) offers to unravel some of these difficulties. A central tenet of his model, accessing community resources for sustaining growth, is mentioned along with leadership development and civic engagement. The reality is that apathy is often the hallmark of disenfranchised communities, and in order to begin the process of consciousness-raising, this trend needs to be broken. Naidoo & Kasiram (2003) agree that "office-bound" quick fixes via microsystemic family therapy interventions are a good deal easier than the long-term slog of connecting meaningfully with communities.

But office-bound microsystemic interventions are clearly no longer relevant as we enter an era of recognizing and valuing community. For example, in discussing issues of gender and equality, Hernandez (2005) discusses the formation of “culture circles” to raise critical consciousness. However, he challenges the feasibility of such work when the basic needs of communities remain unmet. Perhaps getting together the community to take social action on a critical need such as homelessness would be better supported than higher-order social changes. Techniques that work with a smaller system can also have a positive effect on groups of concerned citizens, as noted by Sliep (2005) with her work on narrative theatre, a locally adapted version of the narrative intervention we know as celebrating with a wider audience.

How do we train family therapists in South Africa? First, we need to encourage the adoption of multiple worldviews and then believe that aggressive networking will pave the way for multi-systemic growth and change. The family therapy clinic at the University of KwaZulu Natal is a case in point: the staff members participate in networking by wearing many hats such as community health worker and family therapist. In one such instance, family therapy was supported by the therapist’s efforts as a community empowerment officer that helped the family earn a better living through joining a self-help project in the community whilst simultaneously changing belief systems that undermined members’ self worth. Wearing both hats allowed the therapist to freely engage multi-systemically and achieve goals at various systemic levels. On the training level, such cases and models are presented to students in the under- and post-graduate programs in which one of the authors is involved, underscoring the point that family therapy is not an elitist approach for middle and upper class families only (Rojano, 2005).

Having a multi-systemic perspective also means that we network or link with other systems that affect families. Clearly, we cannot be everything to the family. To this end, there are recorded successes of involving the clergy and accessing client

spirituality for optimizing therapeutic gains (Bean et al., 2002; Joubert et al., 2004; Kasiram et al., 2003; Neethling, 2004). These authors refer to spirituality in promoting intrapsychic and interpersonal growth. Kasiram et al. (2003) point to the need to be “where the client is;” for example, being aware that unconditional positive regard is often not available in the support system when most needed by HIV-positive persons. Bean et al. (2002) add that many African American people are regular church attendees, and seem to seek comfort from their troubles and/or praise the Lord in gratitude through joint prayer and worship (Kasiram & Partab, 2003). Perhaps these communities have fewer financial resources to celebrate achievements or mourn losses in a material fashion, and therefore seek accessible communal prayer instead. It must be noted that not all families are religiously inclined, and not all therapists are comfortable to use spirituality; but this does not mean that this dimension be excluded as a resource.

Rautenbach et al. (2004) refer to including significant others such as community members as “extended family.” So pervasive is community influence in South Africa, that it is enshrined in legislation governing welfare where the spirit of “ubuntu” and “ukusukuma” should guide therapists. These terms refer to having community consciousness and care as “we are who we are only because of others.” This may mean using different settings for therapy to accommodate this extended family rather than the traditional clinic. Undergraduate students at the University of KwaZulu Natal take family therapy to the homes of people, where significant others such as neighbors or relatives participate in therapeutic encounters with ease. So too is the church, or a private corner in the court’s grounds, a popular place for practice. These have the advantage of allowing both for the entry of others in the family system and also for a natural atmosphere within which the realities experienced by the client system may be appreciated.

Nurturance through Nature, Arts and Drama

A land and community rich in diversity means many choices from a varying menu. In 2000, Brink took participants at his workshop on a “walk on the wild side” to demonstrate the power of using nature as nurturer to a tired spirit. He bade us picture the warmth of a fireside by the mountains, around which was told life stories. He marveled at how much people were willing to share and be open in such a fresh, unrestrictive environment; he told us of how the waiting list grew since his first “walk” and how this could not pressure him into accepting “more than he could chew” as by its very nature, it needed to remain free of pollution from clutter and busy-ness. Rycroft (2004) alludes to how much is achieved when reviewing after a therapy session almost as though it is exactly when we stop trying hard, that everyone relaxes and lets true concerns surface. McDowell (2004) discusses the value of using a wilderness experience to allow Mother Earth to guide young people that are left to manage households. The challenge of survival is used as metaphors of life through which they may review their lives and manage them more effectively. This appears to provide for life lessons for the future whilst simultaneously unleashing creativity inspired by a firsthand experience of nature. All too often we are locked into and obsessed with a past that we cannot change; trails and nature walks provide metaphors for looking outside of the pain. Such experiences, encouraged by courts in restorative work with youth, are also discussed by Thulani (2004). Thus it appears that there is recognition and even support for satisfying the palate with varying menus served by nature.

Creativity derived from the arts and drama has been noted for its ability to provide fresh, culture-specific ways for renewal in the face of hopelessness. The arts have historically enabled expression in the face of despair. The authors believe that when confronted with the intensity and high levels of pain and trauma such as those associated with death to AIDS

in Africa, we engage in exhaustive searches to make a difference even when these fall outside of accepted theoretical paradigms. Later, when we note their effectiveness, these searches culminate in new and indigenous theories for our context. In 1988, Lifschitz bade us develop psychotherapeutic contexts for Black families. By 2000, this bid became a resounding noise as it formed the core theme around which difference in practice was celebrated in South Africa when the Rankins (2003) boldly suggested visual arts as a narrative tool in opening up possibilities for re-authoring and healing. Wakerley (2004) used both group art therapy and dance movement successfully as expressive therapies in her work with AIDS orphans and rape survivors in Alexandra and Mamelodi, South Africa. Sometimes language is too confining to relate the problem-saturated story. So, individually oriented therapies provide a platform to initiate group and community-oriented interventions.

In this vein, Naidoo (2004) refers to the value of group acting and narration to educate an audience. Richter et al. (2004) mention the value of multimedia channels for influencing attitudes and behavior such as on male domination in non-use of the condom. Slipe (2005) uses another form of communication with “more than one,” i.e., narrative theatre, to hear stories of shame and horror amongst disempowered women who have had terrible injustices inflicted on them. United in this fashion, they may gain courage and strength.

Conclusion

Community as context cannot be ignored in South Africa or any other part of the world. This paper explored the many wonderful ideas and practices by therapists who wish to meaningfully exchange with their clients at individual, group, and/or community levels. Although these innovators demonstrate unusual ideas in breaking away from the pack, they couch changes and adjustments in traditional family therapy language. We believe that we have evolved, from merely thinking

about the need for indigenizing, to actually practicing differently. We have a wealth of changes to show off as we comfortably embrace community, culture and difference into family oriented work. We should actively collaborate to strengthen and publish our work for a local and international market that is increasingly working with families and communities that do not fit the traditional, dominant mould. Let us set forth on this journey with energy and enthusiasm, knowing that practices today may last but a season, until change and evolution take us into the possibilities of the future.

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The Community Practice of Multidimensional Family Therapy: A Science Based Treatment for Adolescent Drug Problems and Delinquency

Howard A. Liddle, Ed.D.

Introduction

The divide between research and clinical practice is well documented (IOM, 1998). But much of the literature bemoaning the disconnection between these two realms has been heavy on theory but thin on practical solutions or examples of successful change efforts. Just as case studies are indispensable in fleshing out a therapy model's conceptual framework or clinical theory, case examples can be used to concretize and articulate efforts that are attempting to address this long-standing challenge. This article uses the focus of the AFTA Monograph Series, the lens of community practice, and a case study mindset to show how our ongoing Multidimensional Family Therapy (MDFT) research program addresses the research-practice gap.

Basic Elements

I direct a research center, the Center for Treatment Research on Adolescent Drug Abuse (CTRADA), which is funded entirely by federal grants. We have been, somehow, maintaining and even growing this research business since 1985. Our center houses many diverse projects that are located here in Miami, in different parts of Florida, elsewhere in the U.S., and in six countries in Europe. Community practice for our project means implementing MDFT in communities as diverse as Hialeah and Tampa, Florida; Hartford and Waterbury, Connecticut; Norman and Oklahoma City, Oklahoma; Paris; Berlin; and The Hague in the Netherlands. Our center at the University of Miami Miller School

Of Medicine is multicultural, and includes four full-time faculty investigators and about 35 other staff. Our research studies revolve around the refinement, testing and dissemination of MDFT into a variety of community practice settings. We conduct four different types of research studies. Our outcome studies (Liddle & Dakof, 2002; Liddle, Dakof, Parker, Diamond, Barrett & Tejada, 2001; Liddle, Rowe, Dakof, Ungaro & Henderson, 2004) are controlled randomized trials that compare MDFT with other active substance abuse treatments (such as residential treatment, individual CBT for adolescent clients, multifamily groups, or group therapy for teens). Process studies (Diamond & Liddle, 1996; Diamond, Liddle, Hogue & Dakof, 1999; Jackson-Gilfort, Liddle, Tejada, & Dakof, 2001; Schmidt, Liddle & Dakof, 1996; Shelef, Diamond, Diamond & Liddle, 2005) illuminate core aspects of therapy, viewing them under the microscope of different research methods such as videotape analysis of therapy sessions or contemporary statistical techniques. Our economic or cost studies (Zavala et al., 2005) reveal the ways in which MDFT treatments can speak to those stakeholders concerned with the cost benefit or cost effectiveness of family-based approaches. Finally, our technology transfer or dissemination studies (Liddle et al., 2002) determine the most effective ways to teach and train community practitioners, those clinicians who work in non-research treatment settings, in the skills and ideas of MDFT, investigating the systemic factors

that need to be targeted for change or taken into account in order to transport evidence-based practices to community settings.

Population

The kids and families in our studies come from economically disadvantaged backgrounds as well as from affluent suburbs. They represent a wide variety of cultural and racial populations, including African American and Hispanic groups from a variety of countries. In Miami, our work includes studies with Caribbean Basin families, South and Central American families, and European American families. In our Europe-based studies, we conduct projects with adolescents and families in six countries. Thus, a variety of countries and cultures are using MDFT at present.

Routines, Rituals, and Practices

Given all of this cultural, racial, ethnic, and socioeconomic diversity, one might assume a fair amount of model adaptation has had to occur. The extent to which any empirically supported therapy needs to be adapted or changed to meet the needs of the local circumstances (e.g., population, community clinic, service delivery characteristics) in which it is being practiced is a major topic in the field (Elliott & Mihalic, 2004). We have not found the need to change any major aspect of the MDFT approach in training providers from these diverse communities or in the approach's application with these diverse groups.

Why might this be so? MDFT (Liddle, 2002) is intuitive for most clinicians and for that matter, for most families as well. Our focus on facilitating and retracking, by very practical and basic means, positive developmental changes in teens, parents, and families, in terms of intrapersonal, interpersonal and family competence vis-à-vis other social institutions (schools, juvenile justice systems) seems to be a philosophy and clinical strategy that is accepted, and indeed embraced by therapists and families alike.

MDFT therapists work closely with school personnel to help advocate for adolescents. The goal is to help adolescents become more connected to school, to improve academic outcomes and help parents become involved in their teen's school by developing positive, goal-focused relationships with school personnel.

MDFT has specific protocols and parent guides regarding how to facilitate relationships with the school. These protocols include a variety of specific interventions to guide therapist and parents in achieving successful outcomes. Other protocols guide a therapist's work with juvenile, family, and drug court judges and other court personnel, including probation officers. We work with parents both alone and in conjunction with their teens, as well as with adolescents alone and in joint sessions with their parents.

A multidimensional sensibility requires us to attend to a variety of areas of human experience. Social, cognitive, emotional, and behavioral realms are all included as targets and as mechanisms by which new relations are forged. MDFT is a flexible treatment system rather than a "one-size-fits-all" model; by this we mean that we have successfully developed and tested different versions of the approach. There is an intensive version lasting several months of more than one session per week including case management type services, with treatment in the clinic and home-based, therapists having caseloads of 6-8 cases. In other studies, the treatment may have included less attention to extrafamilial services, based in the office versus home, may have focused on early instead of older adolescents, and may have been fixed at 12 or 16 sessions of weekly treatment (Liddle, 2004). The core logic of the approach is straightforward. Adolescent drug and behavior problems are multidimensional in origin and current expression. Generally, multiple areas of impairment can be found. Development is off track in several realms of the teen's and family's life. Given this complex clinical profile, multidimensional and multiple

systems-oriented solutions are required.

Summary of Outcomes

We have completed six controlled trials of MDFT against a variety of comparison treatments for adolescent drug abuse. MDFT has demonstrated more favorable outcomes than several other state-of-the-art interventions, and has been successful at treating samples of teens with diverse serious drug abuse (i.e., heavy marijuana users, with alcohol, cocaine, and other drug use) and delinquency problems. Here is a summary of some noteworthy findings from the MDFT clinical trials:

Decreases in substance use¹

- MDFT reduced substance abuse between 41% and 66% from intake to completion. Treatment gains are maintained up to one-year post-treatment. (Liddle et al., 2001; Liddle, 2002; Liddle, Dakof et al., 2004; Rowe, Liddle, Dakof & Henderson, 2004; Rowe, Liddle, Dakof, Henderson, Gonzalez et al., 2004).
- MDFT reduced the severity of substance-related impairment. 93% of youth receiving MDFT reported no substance-related problems at one-year post-intake (Liddle, 2002; Rowe, Liddle, Dakof & Henderson, 2004).
- MDFT promoted abstinence from alcohol and drug use. 64% to 93% of young adolescents receiving MDFT reported abstinence at one-year follow-up (Liddle, 2002; Rowe, Liddle, Dakof & Henderson, 2004).

Reductions in negative attitudes/behaviors

- MDFT decreased delinquent behavior and affiliation with delinquent peers significantly more than peer group treatment. In addition, MDFT clients were less likely to be arrested or placed on probation than group clients (Rowe, Liddle, Dakof & Henderson, 2004; Rowe, Liddle, Dakof, Henderson, Gonzalez et al., 2004).
- MDFT decreased family conflict, improved parenting practices, and improved family

¹ Decrease in substance abuse is based on measurements taken from intake to treatment completion and one-year post-treatment follow-up.

functioning to a greater extent than family group therapy or peer group therapy (Liddle et al., 2001; Rowe, Liddle, Dakof & Henderson, 2004).

- MDFT clients showed a significantly greater decrease in disruptive school behaviors and absences than youth receiving comparison treatment (Liddle et al., 2001; Rowe, Liddle, Dakof & Henderson, 2004).
- Improvements in positive attitudes/behaviors MDFT improved school functioning (grades and behavior)
- MDFT clients return to school and receive passing grades at higher rates (43% in MDFT vs. 17% in family group therapy and 7% in peer group therapy). MDFT clients also show significantly greater increases in conduct grades than do clients in peer group treatment (Liddle et al., 2001; Rowe, Liddle, Dakof & Henderson, 2004).

MDFT effectively engages and retains a range of adolescents in treatment

- Ninety-five percent of clients in intensive outpatient MDFT stayed in treatment for 90 days as compared to 59% in a comparison residential treatment (Dakof, Rowe, Liddle & Henderson, 2003).
- Eighty-eight percent of clients in intensive outpatient MDFT completed treatment (180 days) as compared to 24% in residential treatment (Dakof et al., 2003).
- Ninety-six percent of the early adolescent sample in MDFT completed treatment (120 days), as compared to 78% of their peers in group therapy (Dakof et al., 2003).

Cost effectiveness of MDFT

- MDFT costs significantly less than standard treatments. Average weekly costs of treatment for MDFT are \$164, which is significantly less than community-based outpatient treatment that cost \$365 (French et al., 2003).
- Average weekly costs of an intensive version of MDFT are less than residential treatment.

Weekly costs for MDFT are \$384; residential substance abuse treatment costs \$1,068 (Liddle & Dakof, 2002; Zavala et al., 2005).

Summary of Challenges and Lessons Learned

Many challenges come with the territory that our team has traversed over the years. First there is the issue of funding; we need to worry about crafting new proposals that successfully compete for federal funding. Competitive proposals require not only grantsmanship abilities and technical proficiency, but fundamentally, they require the research program's team to think through the cutting-edge clinical questions that need to be addressed and answered, and then articulate these puzzles in researchable terms.

Research is a true team sport in which different positions are played by different team members, and stability comes from developing a shared commitment to a Big Picture—what our overall endeavor is about. In our case, this Big Picture item, or as we put it, our North Star, is treatment development. We do research, clinical work, and clinical trainings all under a treatment development rubric. We are committed to continuing to develop and test, and then refine as necessary on the basis of our limitations and failures, our family-based treatment for multi-problem teens and their families.

Rewriting the same old proposals won't do. Fresh ideas and novel approaches and skills to execute these ideas (e.g., using cutting-edge design or statistical methods) are always required. In recent years, for example, the issue of technology-transfer and how to adapt therapies to regular clinical settings has taken hold at agencies such as the National Institute on Drug Abuse (NIDA), National Institute of Mental Health (NIMH), and the Center for Substance Abuse Treatment (CSAT). Keeping a solid team together is fundamental, and so management and administrative skills are important. Letting the data and findings tell us what has to change about the clinical model or

the way we teach it, has facilitated our capacity to evolve and grow. The maintenance and deepening of connections in our communities have been instrumental to the success of our studies and our therapy approach as well. I have gone through the “new kid/researcher on the block” cycle in three cities: San Francisco, Philadelphia, and, early in the past decade, here in Miami. The principles of making clinical research work, getting one's projects and therapy approach accepted, and of working in collaboration are identical in all of these locales. And, these principles are proving to be relevant in our international studies as well. Following through on commitments, not promising more than you can deliver, providing top quality and effective clinical services, and understanding the nature of true collaboration (doing relevant and clinically useful research, making sure the community receives proper overt credit and rewards for the research that has been done) are examples of core guidelines we follow every day.

My latest thinking on the topic of the research-practice gap concerns how policy in general, and involvement in policy-making and policy formation in particular, can help bridge the clinical practice and science divide (Liddle & Frank, 2006). Policy-informing and policy-making groups now routinely use findings from various scientific specialties to assert and to make new public policy in areas such as drug and alcohol abuse. Reports such as the one published by the foundation Drug Strategies (Brannigan, Schackman, Falco & Millman, 2004) now inform funding and system of care policy decisions in state and local jurisdictions on mental health and substance abuse issues. Federal agencies that provide funding in substance abuse through block grants (grants that provide monies to states to pay for empirically-based treatment services) or other funding mechanisms now routinely require the states and their new grantees to train public sector practitioners in evidence-based therapies such as Multisystemic Therapy, Functional Family Therapy, Brief Strategic

Therapy, or MDFT when seeking government funds to create or continue teen substance abuse programs. The clinical programming landscape has changed dramatically, and evidence-based therapies are in demand. Indeed, they are mandated as integral parts of today's clinical services delivery systems.

These developments underscore the potential of macro level policy changes that include evidence-supported family-based therapies as fundamental parts of a re-formed mission and service delivery system. Thus, because of the science that has been done with many of these family therapies, policies have been changed to improve the amount and quality of services for formidable clinical problems such as adolescent substance abuse. I think it's safe to say that although those of us in the clinical research field feel that we have "miles to go before we sleep," in our optimistic moments, we realize that progress has been made. Perhaps most important of all, we know that many families and kids have benefited and can continue to benefit from these research-based study advances and from systematic and quality controlled efforts to disseminate evidence-based family interventions.

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Afterword

Laura Roberto-Forman, Psy.D.

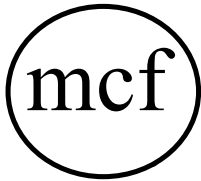
It was my great pleasure, as incoming Publications Chair of the new AFTA Monograph Series, to be invited into the planning of this fascinating issue. At the request of the Guest Editor, I was privileged to read and reflect on the papers sent by our colleagues here and abroad on the subject of community family therapy. Ramón's enthusiasm and love for this specialty is present in every paper he invited, as well as in his choice of authors from far-distant corners of the globe with different communities to serve and different challenges facing them in their work.

When I was in psychology training back in the early 1970s, "community psychology" was a service offered to at-risk children. It was not part of the family therapy movement. The idea allowed us to move into the places that children lived—schoolyards, classrooms, recreation centers, homes—to offer support and problem-solve with them and their primary caregivers about social and academic problems. We never served the families themselves, and so our work teams did not profit from their wisdom and perceptions. The vision for this issue, community family therapy, closes a triangle in healthcare—the exciting old idea, the years of systemic model-building, and a mission that is purely now.

These articles captivated me. As Kasiram and Oliphant discussed their decision to meet with female family members in AIDS-ravaged towns to support their commitment to protected sex, as they commented on their experiment of bringing the character called "the trickster" into South African family therapy, I found the doors of my imagination open. Rosa Macedo's description of "community therapy" in which very large numbers of townspeople come together to witness each others' stories and name important problems together, gave the feeling of witnessing a new social movement. Eleanor

Nealy's history lesson reminded me that the LGBT Community Center gave rise to ACT UP, the famous HIV/AIDS activist group. Howard Liddle's project shows that family therapy can span the globe to teach crucial family and community skills to help addicted teens in many nations. Beatriz Molina and colleagues gently discuss the enormous task involved in creating a home for the poorest families of the Colombian coast to come for counseling. And Marcelo Pakman finds a way to re-envision medication evaluation and management as a sociopolitical event.

These authors also put forward confirmations and challenges for us as writers, policy makers, researchers, trainers, and therapists. As Macedo's reprinting of Friere tells us: utopia is not an ideal, but a humanized vision. Peter Fraenkel speaks at some length about how he built a team to do his work with homeless families by first sharing feelings and concerns with his own colleagues and consultants. Jeri Hepworth tells us that her colleague's comment, "move the big rocks," progressively enlightened her that the key pivotal element in a movement is the moving-in-concert piece. In fact, each contributing author from his/her own unique project discusses how s/he found that work together is qualitatively different than work alone, just as existence together is different than existence along, creating a synergy that envelops professionals with families and to move every community forward. There is a message for AFTA and for our profession in these findings. In the choreography of community family therapy, partners dance in patterns among family partners and agency partners in a large and stately waltz that can humanize governance again. Viva community family therapy.



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Envisioning Our Future: Discovering What Matters through Collective Inquiry
Facilitator: Patricia Romney

Plenary III:

Strengthening Adolescents, Young Adults, and their Families:
Discoveries and Conundrums
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