The link between family processes and children’s school behavior and learning is longstanding in the clinical literature and well established in research. Quite early Friedman (1973) eloquently argued that the family provides the child’s first social learning experience; quality of parent–child and family relationships may facilitate or impair school behavior and achievement; children’s behavior or learning problems in school can disrupt family harmony. Research consistently finds that family factors influence academic achievement (Christenson, Rounds, & Gourney, 1992). More specifically research finds the pathway to adolescent deviance originates with ineffective family management practices in young children that are associated with poor academic achievement and peer rejection in elementary school that, in turn, predicts low parental monitoring and association with deviant peers in adolescence (e.g., Dishion, Patterson, Stoolmiller, & Skinner, 1991). Given the family antecedents to school problems, family-based treatment would appear to be a logical and widespread choice. Many clinical resources have, in fact, proposed family treatment models and methods to effect a change in school behavior (e.g., Amatea, 1989; Dowling & Osborne, 1985; Fine & Carlson, 1992; Okun, 1984).

The identification of reliable and valid psychological treatments has become increasingly important within both psychology and education. What evidence do we have, however, that family-based treatment effects a change in the school behavior of children and adolescents? Whereas a considerable body of evidence has been gathered that finds both parent training and family-based treatment to be efficacious in reducing the onset or severity of many child and adolescent problems, and especially externalizing behavior disorders, published reviews, (e.g., Carr, 2000; Liddle & Rowe, 2005; Sexton, 2002), have not examined the generalization of treatment effects to the classroom or school setting. Thus, with several co-authors, I recently completed a review of the parent training and family-based treatment literature specifically focused on efficacy in changing school behavior or learning (Valdez, Carlson, & Zanger, in press). Although a substantial number of parent training articles were identified that measured school outcomes, our review yielded only four family-based treatment models that demonstrated a change in the school behavior of children or adolescents: Social Learning Family Therapy; Multidimensional Family Therapy; Multisystemic Family Therapy; Functional Family Therapy. In addition, our review identified one school-based, family-centered treatment program, the Adolescent Transitions Project, which is based on social learning theory. These family models were highlighted in a symposium at the most recent annual meeting of the American Psychological Association and comprise the bulk of the featured articles in this newsletter.

Within family psychology we are fortunate to have some evidence-based family interventions that show promise for improving not only the quality of family relationships but also aspects of children’s functioning in school. Sorely needed, however, are replication studies demonstrating school-based changes related to family-based treatment, family-based treatment directed to elementary school-aged populations, comparative efficacy studies of family-based treatment versus parent training, and the more frequent inclusion of measurable school outcomes in subsequent studies demonstrating the efficacy of family-based treatment.

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From the Editor

Mark Stanton, PhD, ABPP

This is the 2006 Presidential theme issue of The Family Psychologist. Division 43 President Cindy Carlson has elected the theme, “Changing School Behavior with Family Intervention.” President Carlson begins the theme with her cover article on the importance of evidence-based treatments in the school arena. The feature articles in the issue summarize presentations made at an APA Convention symposium chaired by President Carlson in Washington DC in August 2005. They represent the state of the art in evidence-based school-related interventions. Scott Henggeler and Phillippe Cunningham of the Family Services Research Center at the Medical University of South Carolina describe Multisystemic Therapy in school-related interventions. They detail the overall results of 14 studies of MST in school-related situations and describe research challenges. Tom Sexton and James Alexander describe the application of Functional Family Therapy to school-based interventions. They describe the conditions that are most likely to lead to success when using FFT in school settings. Kate Kavanagh, Tom Dishion, and Arin Connell of the Child and Family Center at the University of Oregon present their model for prevention of adolescent substance abuse in public school contexts. They use the Family Check-Up, based on motivational interviewing, to engage families and strengthen family relationships to reduce potential substance abuse. Craig Henderson of Sam Houston State University joins Howard Liddle & Francoise Marvel of University of Miami School of Medicine, Center for Treatment Research on Adolescent Drug Abuse, to present an article on Multidimensional Family Therapy in the school environment. They detail five specific interventions that facilitate collaboration between therapists, families, and the schools to reduce adolescent substance abuse and improve school outcomes. In the Diversity Column, George Hong describes the particular benefits of school-based family services in ethnic communities and important considerations in implementation of such programs. Tamara DeHay, the 2006 Division 43 Student Representative from the University of Texas at Austin describes her experience of education and training in a program that emphasizes school-based services in the Student Column. Lou Turchetta of the Coventry Public Schools stresses the importance of a systemic orientation for work with families in the schools in the Clinical Notebook. Lou describes practical issues that may arise and possible approaches, based on a systemic orientation. Finally, Jay Lebow writes The Final Word on the theme, summarizing the thematic material into four primary themes that stress the importance of school-based interventions in family psychology.

DSM-V

The Science Column in this issue provides a review of recent efforts to further the work on relational diagnoses and improve the inclusion of relational processes in DSM-V. Brian Doss and Erika Lawrence are co-chairing a Division 43 committee that is working to contribute to this important discussion. Please review their article for an update on this important project. The Fall 2006 issue of The Family Psychologist will be devoted to the theme of Relational Disorders.

Transitions

This issue includes the final columns edited by Nancy Elman and James Bray. Nancy has faithfully managed the Reference Corner, our review of books and videos that are relevant to family psychology, for several years. She has recruited reviewers and selected texts for review that are central to our field. This column has been consistently strong and Nancy’s efforts are greatly appreciated. Farrah Hughes assumes this position with the spring 2006 issue.

James Bray has been a Division 43 APA Council representative for two terms and he has managed the Reference Corner, our review of books and videos that are relevant to family psychology, for several years. She has recruited reviewers and selected texts for review that are central to our field. This column has been consistently strong and Nancy’s efforts are greatly appreciated. Farrah Hughes assumes this position with the spring 2006 issue of TFP.
Multisystemic therapy (MST) and other evidence-based treatments of juvenile offenders (e.g., Multidimensional Treatment Foster Care) include substantive school-related intervention components for both empirical and pragmatic reasons. Empirically, considerable research has shown that school-related difficulties (e.g., dropout, poor performance, low commitment) are important predictors of antisocial behavior in adolescents. Hence, the evidence-based treatments of antisocial behavior, each of which focuses comprehensively on multiple risk factors, explicitly address the role of school-related difficulties in the maintenance of antisocial behavior. Pragmatically, the school environment is critical to promoting key aims of MST. For example, MST interventions often aim to decrease youths’ associations with deviant peers while promoting prosocial peer contacts. School provides numerous opportunities (e.g., sports, clubs) to engage problem youths with primarily prosocial peers under adult supervision.

The MST treatment manuals (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998; Henggeler, Schoenwald, Rowland, & Cunningham, 2002) have devoted considerable attention to the important role that school factors play in the design and implementation of MST interventions. In general, MST therapists aim to empower caregivers to collaborate with school personnel in addressing needs identified by caregivers, teachers, and administrators (e.g., poor academic performance, behavior management problems). Such caregiver-school collaboration is viewed as critical for developing the cross-situational consistency needed to attenuate behavior problems and to promote academic and vocational success.

Conceptual Basis

MST is based on the theory of social ecology (Bronfenbrenner, 1979). From a social ecological perspective, individuals are nested within multiple, but interdependent, social systems that can have direct and indirect influences on their behavior (Bronfenbrenner, 1979). School-related difficulties, therefore, can be conceptualized as the reciprocal and bidirectional interaction of characteristics of the child and the key social systems in which the child is embedded—family, peer, school, and neighborhood/community. Each of these systems can have a unique influence on a child’s school-related difficulties. As such, these systems are each pertinent in the conduct of MST assessment and interventions.

Assessment

Determination of the need for possible school-related interventions begins with a careful and reasoned analysis of the child’s social ecology (family, peers, school, community) and its influence on the child’s school-related difficulties. MST therapists gather data from multiple sources regarding the most salient drivers of referral problems. Hypotheses regarding these drivers are developed and tested throughout MST treatment using the deductive and recursive “MST Analytical Process,” which is detailed in the aforementioned treatment manuals. For example, school-related difficulties might be associated with characteristics of the child (e.g., low motivation, ADHD, low intellectual abilities, learning disability), family (e.g., ineffective monitoring and discipline, parental problems that interfere with effective parenting), peers (e.g., support for truancy, drug use, and behavior problems in school), school (e.g., a zero tolerance climate, poor classroom management practices), school–family linkage (e.g., coercive interactions and low trust between caregivers and school personnel), and community (e.g., criminal subculture that does not value academic success).

To help the MST treatment team develop interventions based on clinical hypotheses, the drivers of school-related problems are depicted graphically in a “fit” circle (see Figure 1). The hypothesized components of the fit circle are continuously tested and revised based on emerging outcomes from corresponding interventions. Figure 1 provides an example of a fit circle for the behavioral and academic problems identified for 15-year-old Lenny. Briefly, his school-related problems seem to be linked with (a) low intellectual abilities, which make academic success challenging; (b) placement in a special classroom with behaviorally disordered youths (as a result of numerous suspensions for classroom disruption) who reinforce off task behavior and/or academic failure; (c) an inexperienced special education teacher with limited classroom management skills, who is demoralized from numerous failures trying to manage her classroom of behaviorally disordered youth; (d) limited, conflicted, and coercive interactions between the caregiver and school associated with the caregiver’s own history of school failure and poor communication between home and school settings (i.e., caregiver blames the school for her son’s problems, the school blames the caregiver); (e) ineffective parental discipline regarding school behavior as a result of parental depression and limited social support; and (f) living in a neighborhood that has a criminal subculture that does not value academic success.

Interventions

The overriding school-related goal of MST is to establish or reestablish a family-school partnership that supports educational and behavioral improvements by (a) carefully assessing the “fit” of school-related problems within their broader systemic context, as noted above; and (b) designing interventions to address those key fit factors associated with the child’s school difficulties. The design of these interventions is guided by the nine treatment principles that operationalize MST (Henggeler et al., 1998) and by the view that the youth’s
caregivers are the key to achieving favorable clinical outcomes in the long term. Hence, for example, intervention techniques are strength focused and as evidence-based as possible (e.g., using behavioral interventions); and the bulk of clinical resources is devoted to promoting caregiver effectiveness in addressing youth and school-related difficulties.

Based on the Fit Assessment for Lenny’s school-related problems described previously and depicted in Figure 1, the development of a collaborative caregiver-school relationship was viewed as the critical initial step in ameliorating Lenny’s poor academic performance and behavioral problems at school. Specifically, the therapist arranged caregiver-teacher/principal meetings and increased the probability that these meetings would be successful by role-playing ways for the caregiver to handle school meetings and possible confrontations with school personnel productively. Moreover, to gain greater cooperation from the school, the caregiver emphasized that she, with the school’s support, wanted to develop more effective ways of monitoring Lenny’s academic functioning, school behavior, and homework completion; and, importantly, was establishing contingencies at home for his behavior at school. Concomitantly and independent of the school-related interventions, the therapist worked to improve the caregiver’s parenting practices by treating her depression with CBT and helping her to build an indigenous support system. As the caregiver and school personnel developed a more collaborative relationship, the therapist was able to offer advice and support to the teacher on implementing evidence-based classroom behavior management strategies.

Although these short-term interventions decreased the probability that Lenny would be expelled from school, they were not a long-term solution to the larger problem of Lenny’s academic and vocational risk. In planning for more favorable long-term outcomes, the therapist (a) helped develop plans to transfer Lenny from his current class with other behavior problem youths to an academic/vocational setting that would better meet his needs, assuming that his in-school behavior improved substantially; (b) inventoried Lenny’s intellectual strengths and vocational interests to ascertain an optimal educational/vocational context; and (c) helped the family survey available educational/vocational opportunities in their community, with the intention of taking advantage of such. Many barriers to the effective implementation of this plan emerged throughout treatment, but key aspects of the MST model (e.g., low caseloads to allow intensive services; a strong quality assurance system to support therapist efforts to achieve favorable outcomes) helped the therapist and family overcome these barriers.

**School-Related Outcomes**

Of the 14 published MST outcome studies, two have examined school-related outcomes. One randomized trial focused on substance abusing juvenile offenders (Brown, Henggeler, Schoenwald, Brondino, & Pickrel, 1999), and the other addressed the needs of youths presenting psychiatric emergencies (Henggeler et al., 1999). In each study, MST was significantly more successful than the comparison interventions at sustaining youths in regular classroom settings at 6-month follow-up. In addition to these studies, a randomized trial of MST for youths in ED classrooms has recently been completed by Bahr Weiss and his colleagues at Vanderbilt University, and several Safe Schools grants have used MST as their principle intervention, though absent rigorous evaluations. Although MST evaluation of school-related outcomes has lagged behind evaluations of outcomes in other key domains

(continued on p. 28)
Externalizing behavior disorders are the primary reason for referrals to practitioners working with adolescents. Externalizing behavior disorders represent a wide range of more specific behaviors including drug use/abuse, school truancy, violence, family conflict, and oppositional defiant behavior problems (Kazdin, 1997; Kazdin, & Weiss, 2003; Sexton, Gilman, & Erickson, 2005). These youth have traditionally been viewed as “difficult to treat,” for good reason. Drop out and completion rates for traditional therapeutic approaches range from 50% to 75% (Kazdin, 1997), with treatment outcomes being as poor as 75% post-treatment recidivism (Sexton, Alexander, & Mease, 2003).

In addition, given the nature of family conflict, the typical context for such externalizing behaviors, adolescents and families typically present with highly negative and conflicted relational patterns that are tough to manage therapeutically. Furthermore, when treatment failures do occur, the impact can be dramatic, as represented by the pain and injury of crime victims and the impact of family conflict on siblings, parents, and communities. As a result, adolescents with behavior problems are often seen as among the “toughest” clients.

Because youth spend the majority of their time in schools, it is a natural place for many of the mental health issues they experience to become most apparent (Casey & Buchan, 1991; Porter, Epp & Bryan, 2000). In part this is because their “external” behavior threatens others, impairs learning, harms the “school climate” or interferes with family functioning to the degree that the adolescent has trouble managing the confines of the school day. Thus, schools are often faced with the daunting task of addressing the mental health needs of their students in addition to their primary purpose of educating them.

A number of viable treatments for mental health problems experienced by school-age youth have been identified and are being implemented (Dishion & Kavanagh, 2000; Kazdin, 1997; Mease & Sexton, 2005). While varying in their techniques, each of the effective treatments are based on the most current “lessons from the literature” including: keeping the adolescent in their communities for treatment, using treatments that address multiple risk and protective factors, focusing treatment on the naturally occurring social systems (i.e. family and community), and using systematic treatment models within systems of care that are implemented with high fidelity (Sexton et al, 2003). Of particular interest to Family Psychologists is that family-based interventions programs are among the most efficacious in reducing symptoms and behaviors exhibited by adolescents with behavior problems (Alexander, Holtzworth-Monroe, & Jameson, 1994; Elliott, 1998, 2001; Kazdin, 1997; Sexton et al, 2003). In fact, family-based treatment programs have become the “treatment of choice” for these very difficult adolescent problems.

**Functional Family Therapy**

Functional Family Therapy (FFT) is one of the current evidence based family psychotherapy models (Alexander & Sexton, 2003; Sexton & Alexander, 2003; 2004). FFT evolved from a long developmental history, through increasingly widespread dissemination in contexts representing extensive diversity, and with well developed quality assurance and improvement methods to ensure accountability and fidelity to the model. FFT is built upon many of the common therapeutic principles of its predecessors, more generic common factors of good therapy, and extensive clinical experience. However, FFT goes well beyond these common factors through the use of a systematic, relationally focused, research based approach to the complex mechanisms and processes of therapeutic change. FFT is designed to address complex clinical problems often seen as the most difficult to address: externalizing behavior disorders of youth who also often present with a myriad of comorbid conditions that include school problems, drug use and abuse, violence, delinquency, oppositional defiant and conduct disorders.

The clinical procedures of FFT represent a relationally-based, process-focused “map” that provides the critical and major process stages through which successful therapy progresses. The first goal of FFT is to engage and motivate the family through a decrease in within family risk factors by reducing negativity and blame, redefining the problem to one with a family focus, and building within family alliance. The subsequent behavior change phase targets the building of family behavioral competencies that build within family protective factors through the development of problem solving, communication, conflict management, and negotiation skills. Finally, the generalization phase guides therapists to establish and strengthen community (multiple system) links which maintain and enhance the positive changes experienced by youth and families at both individual (e.g., drug cessation & refusal skills) and relational (e.g., conflict resolution) levels. The core principles reflected in this map provide the therapist with consistent and theoretically sound ways to describe clients, their problems, and the change process. These theoretical principles are the boundaries of a treatment model that underlie the clinical procedures and provide a basis for making the many clinical decisions that are a normal part of good family therapy.

While having a strong foundation in process research, coupled with demonstrated and
sustainable outcomes obtained through manualized and systematic treatment, training, and supervision protocols, the “heart” of FFT is a relationally focused model (Sexton & Alexander, 2003). This relational focus is responsive to the uniqueness of clients and the individuality and creativity of the therapist. In each phase of FFT, specific relationally based change mechanisms guide the therapist in helping the family. However, this guidance is not constrained by specific behaviors or curriculum topics. Instead it is based on relational goals (e.g., create a positive and balanced alliance, establish hope) and a relationally based philosophy (e.g., respectfulness for all family members). Thus, while they are research based, these change mechanisms and the behaviors (“techniques”) designed to accomplish them must be creatively implemented within a relational context in a way that matches the client in order for successful therapy to occur. As such, FFT is a good example of ways in which an evidence-based therapeutic model can also be attentive to the transactional process (if not the “art”) of therapy as a unique and individual encounter between a skilled therapist and family struggling to find solutions. This uniqueness of the encounter requires the creativity and skill of the therapist in applying the FFT model in a way that fits the family.

In the last decade FFT has been designated as a “model program” and an evidence-based program in numerous independent reviews (Alverado, Kendall, Beesley, & Lee-Cavaness, 2000; Elliott, 1998; Surgeon General, 2000). It is one of the few psychotherapies with demonstrated positive outcomes for externalizing behavior disordered youth. As a result, FFT has been implemented as the primary intervention model in over 190 community sites in the United States and internationally between 1998 and 2005. In those community FFT sites, approximately 1600 therapists work with approximately 40,000 families each year using Functional Family Therapy. In addition, each clinical contact (roughly 200,000 per year) is tracked for quality assurance to maximize positive outcomes for these high risk youth and their families. The organizations, therapists, and clients at these replication sites represent a very diverse cultural, community, and ethnic group. To date, FFT has been used in agencies that primarily serve clients who are Chinese-Americans, African-Americans, White-Caucasian, Vietnamese, Jamaican, Cuban, Central-American, Dutch, and Moroccan families, among others. FFT is now provided consistently in eight different languages.

Implementing FFT in School Settings
Successfully implementing systematic treatment programs in any setting is difficult and requires attention to model fidelity, service delivery systems, and organizational structures that can support the treatment model. Implementing a family-based intervention program in schools is particularly difficult given the diverse pressures and multiple mandates on schools and school personnel. In most instances family interventions, like FFT, are not conducted by school personnel but rather are implemented through collaboration with community agencies who have trained therapists who work within a school- and home-based treatment delivery system that can support and enhance model fidelity (Sexton & Mease, 2005). School-community partnerships are most successful when:

- Partnership is based on relationships between community providers and schools. Partnership seems to flourish when there is frequent contact between treatment interventionists, teachers, and school administrators.

- Systematic and ongoing training on the principles and clinical procedures of FFT. Even though school personnel may not implement FFT, understanding the clinical model only enhances referrals, support, and common interventions to help adolescents.

- A systematic service delivery system that institutionalizes FFT into the fabric of the school. Sexton and Alexander (2005) suggest that a Family Support Team (FST) implementation model can build the collaboration necessary for successful family models. The FST model builds collaborative by bringing together the FFT therapist, the teacher, social worker, and the appropriate administrator at the initiation of treatment, throughout treatment, and at the end of treatment.

- Adherence protocols that ensure that FFT therapists implement the model as designed, thus enhancing the probability of successful change for the adolescent and their family.

Conclusions
The problems faced by adolescents are complex and require systematic treatment approaches. Family-based treatment models have become the treatment of choice for helping adolescents with some of the most difficult clinical problems: externalizing behavior disorders. School–community mental health provider partnerships hold the greatest promise in further enhancing the clinical service necessary to help adolescents with behavior problems that disrupt families, schools, and the future of the youth themselves. While the implementation of any systematic treatment program is difficult, family-based models for adolescents are most effective when embedded within service delivery systems that include teachers, social workers, administrators and community providers.

References
A Multi-level Approach to Family-Centered Prevention in Schools

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Early adolescence is a period of increased autonomy, more unsupervised time and exposure to a wider group of youth; and for some youth it is a time to begin experimenting with substances and for others to further develop existing use. Fortunately, it is also a prime period to create positive life course outcomes. (Dishion & Kavanagh, 2002) This article presents results from a comprehensive family centered intervention targeting early adolescent substance use, the Adolescent Transitions Program (ATP), designed for public school implementation. Program effects on adolescent substance use trajectories from grades 6–9; and the relationship of deviant peer involvement and parent monitoring to initiation and growth in substance use are discussed. Outcome analyses utilize both variable and person-centered strategies.

Thirty years of research has identified peer use and parent monitoring as strong predictors of early adolescent substance use (Chassin, Presson, et al., 1986; Dishion, Reid & Patterson, 1988; Kandel et al., 1986). Models that have included both parent monitoring and deviant peers have been shown to account for young adolescent problem behavior across cultures (Barrera, Castro et al., 1999; Chilcoat, Anthony & Dishion, 1995). Additionally, family centered interventions, and specifically enhancing caregivers behavior management and building strong family relationships are effective in reducing adolescent substance use and problem behavior. (Dishion, Kavanagh, et al 2002; Henggeler et. al, 1992; Spoth et al., 2002).

An optimum site for preventive interventions is the school as it is a primary setting for peer influence and for effecting large numbers of parents (Trickett & Birman, 1989). However, to be maximally effective, comprehensive strategies are needed that are sensitive to the heterogeneity of youth in schools and include information, support, and skill development for parents of youth exhibiting normative to serious problem behaviors. (Reid, Snyder & Patterson, Dishion & Kavanagh, 2003)

The Adolescent Transitions Program is a multilevel intervention designed for public school delivery (Dishion & Kavanagh, 2003). The model comprehensively links universal, selected, and indicated family interventions and titrates intervention intensity to the needs and motivation of the family. The centerpiece of the ATP is the Family Check-Up which is based on motivational interviewing and is designed to engage parents in change through assessment driven feedback on family management, relationships, peers, and background support and is followed by a menu of empirically supported family interventions (Dishion & Kavanagh, 2003).
Although the general associations between family dynamics, peer processes, and adolescent substance use are well documented, for an empirical understanding of adolescent substance use and for designing effective interventions that consider the variability in causal dynamics, a person-centered perspective is relevant.

In the current study, we used both variable and person centered analyses to best understand the outcomes from a longitudinal multiethnic, urban effectiveness trial of the ATP (DA 07031). Participants were recruited in 6th grade from three ethnically diverse middle schools within a metropolitan community in the Northwest and randomly assigned to intervention or control conditions. The sample included 698 adolescents and their families. Roughly half of the participants were female (46.3%), and 40.4% self-identified as African American.

Students completed an annual survey from grades 6 to 9 measuring youth reported substance use, deviant peer involvement, and parental monitoring (Irvine, Biglan, Smolkowski, & Ary, 1999).

Project interventionists followed a written manual and received training and weekly video based supervision. At the universal level, a Family Resource Center was established in each of the three schools to provide parent centered information and support to all intervention families through the 8th grade year. The goals were to support existing parenting practices in families of typically developing youth and to engage families of at-risk youth in the next level of intervention.

The Family Check-Up (FCU) was offered to all intervention families with youth showing risk behaviors. If needed parents were then offered services including parent groups, individual family sessions, and home school monitoring systems. The intervention in general, and the FCU in particular, are described in detail in Dishion and Kavanagh (2003).

To examine predictors of change in substance use over time, we employed a zero-inflated Poisson (ZIP) growth model using M-plus 3.01 (Muthen & Muthen, 2004). This model allows for examination of the rate of change from 6th through 9th grade, while accounting for the number of youth who report no substance use over time.

Next, we utilized latent growth mixture modeling to examine heterogeneity in developmental trajectories of self-reported substance use from a person-centered perspective. All analyses used full information maximum likelihood estimation (Muthen & Muthen, 2004) to accommodate missing data.

In the next step, we investigated predictors of trajectory class membership and within-class variability in substance use. Analyses examining the predictors of class membership followed a logistic regression framework, with results comparing the extent to which each predictor is related to the likelihood of being in a given trajectory relative to a normative trajectory.

While we found a slight increase in the mean level of substance use across grades, approximately half of the youth (n = 362) reported no use. The ZIP growth model analysis showed that the likelihood of initiating use in 6th grade was related to deviant peer involvement and less effective parental monitoring. Further, higher levels of use at 6th grade were related to random assignment to the intervention group, greater level of peer deviance, and less effective parental monitoring. Youth in the control group exhibited significant growth, while youth in the intervention condition showed significantly less growth in substance use.

Girls exhibited significantly greater growth in use relative to boys, and a diminished tendency to exhibit decelerating growth over time. Finally, higher levels of parental monitoring in 6th grade predicted lower substance use in 6th grade.

A five class model provided the best fit to the data (BIC = 6288.15), and yielded reasonably high classification accuracy for individuals (Entropy = .85). The no-use class comprised 51.82% of the sample and approximately 25% of the sample was in the rare/low-use class. The decelerating class (7.02%) exhibited significant levels of substance use in 6th grade and significant decreases over time. The early-accelerating class (6.30%) also reported significant levels of substance use in 6th grade and significant growth over time. Finally, the late accelerating class (9.03%) showed a burst in substance use with the transition to high school.

Overall differences were found for parental monitoring, deviant peer affiliation, and intervention status. Reports of parent monitoring in the zero-use class were significantly greater than for parents of youth in any other class. Additionally, youth in the rare/low-use class compared to the late-accelerating class reported greater monitoring. Analyses of peer deviance showed that youth in the zero-use class reported significantly less peer deviance than members of all other classes and early accelerators reported significantly greater peer deviance in 6th grade than members of either the rare/low class or the late accelerating class.

Follow-up analyses revealed that members of the decelerating class had significantly more frequent contact with the family resource room than did members of the rare/low-use, late accelerating, or zero-use classes. The average number of contacts for the high-risk group was five or six sessions over a 2-year period (Dishion et al., 2002). Approximately 60% of families of youth in the decelerating class received the Family Check up (versus no intervention, or universal-only). By contrast for those in the other use groups assigned to intervention: 36.7% of the rare/low use, 29.5% of the early accelerator, 31.7% of the late accelerator, and 30.7% of the zero-use families engaged in the FCU.

In this study we examined the effectiveness of a family-centered intervention embedded within schools on arresting the development of substance use during early adolescence. Despite study limitations, we believe that the current analyses serve to illustrate the complementary nature of variable and person-centered approaches in the analysis.
of results from randomized clinical trials. Moreover, they seem particularly relevant to understanding the timing and nature of effective intervention for the heterogeneous population of youth in early adolescence.

The results revealed significant intervention effects on both the likelihood of initiating and the level of substance use over time. Of particular importance to embedding the intervention within schools is the finding that approximately 85% of the youth reporting dramatic declines in substance use had been randomly assigned to the ATP. Further, families of these youth were disproportionately likely to engage in the most intensive form of treatment relative to any other trajectory class. More generally, it is worth noting that deviant peer involvement discriminated all of the substance use trajectories from the zero-use class.

The value of the person-centered approach is highlighted by a consideration of two groups—the early accelerators and the late accelerators. For early accelerators, deviant peer involvement was most important, whereas among the late accelerators peer deviancy and poor parental monitoring were equally important. While participation in the intervention was clearly beneficial for the highest risk youth, the person-centered analysis highlights the need for further innovations to improve engagement of a wider range of youth and families. In particular, the transition to high school appears to be a time of risk and for preventive intervention.

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References

Feature Article
Adolescent Drug Abuse: Mechanisms and School Outcomes Associated with Multidimensional Family Therapy

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Prospective longitudinal studies have indicated that adolescent drug use is related to a variety of educational problems including truancy, poor academic performance, and drop out (Bryant, Schultenberg, O’Malley, Bachman, & Johnston, 2003; Ellickson, Bui, Bell, & McGuigan, 1998; Fergusson, Horwood, & Beautrais, 2003; Lynskey, Coffey, Degenhardt, Carlin, & Patton, 2003; McCluskey, Krohn, Lizotte, & Rodriguez, 2002; Roebuck, French, & Dennis, 2004). Because school attainment is highly correlated with long-term social and economic outcomes (Levy & Murnane, 1992), research has begun examining the relationship between reductions in drug use and
improvements in school engagement and performance (Bryant et al., 2003; Lyskney et al., 2003).

Evidence from several lines of research suggests that reducing drug use also reduces school problems. This includes longitudinal population studies (Fergusson et al., 2003; Roebuck et al., 2004), as well as treatment studies in which school functioning is the direct target of intervention. For instance, prospective studies of youth following discharge from substance abuse treatment have shown that adolescents who reduced their drug use following residential treatment attained higher levels of schooling than those who resumed drug use (Brown, D’Amico, McCarthy, & Taper, 2001). Further, national treatment evaluations have suggested that community-based substance abuse treatment has resulted in improved school attendance and academic performance (Hser et al., 2001). Finally, specialized treatments targeting a wide-range of problem behavior including school performance have been developed and found to be effective in randomized controlled trials (Rowe & Liddle, 2003; Waldron, 1997; Williams & Chang, 2000).

Family-Based Treatments

Both prevention and treatment studies have evidenced improvements in school functioning (Maddox & Prinz, 2003; Williams & Chang, 2000). Family-based treatments for adolescent substance abuse have been among the most effective interventions in improving school-related outcomes, primarily attendance (Azrin et al., 1994, 2001; Friedman, 1989). For instance, Brown et al. (1999) randomized 118 adolescents who met criteria for a substance use disorder to receive Multisystemic Therapy (MST) or Usual Services (US). School outcomes were assessed by parent and adolescent reports of school attendance. Results indicated that participants receiving MST showed a sustained increase in the percentage of adolescents attending school through the 6-month follow-up. In contrast, for youth receiving US, the percentage of adolescents attending school decreased at treatment discharge, although a modest increase was evidenced at the 6 month follow-up.

Although previous studies of family-based interventions are promising, they also possess several methodological limitations. First, the majority of studies have primarily relied on adolescent or parent reports, and are therefore subject to self (or collateral)-report biases. Second, the majority of studies have investigated decreases in truancy or other indicators of school problems and either have not examined or have not shown effects on academic performance. Third, these studies have relied on fairly limited follow-up periods, limiting the conclusions that can be drawn regarding the durability of treatment effects.

Multidimensional Family Therapy

One family-based substance abuse treatment that has consistently studied the impact of treatment on school performance is Multidimensional Family Therapy (MDFT). MDFT is an outpatient family-based treatment for drug involved and delinquent youth (Liddle, 2002) that is one of the empirically supported Best Practice treatments for teen substance abuse and related problems (Drug Strategies, 2003; DrugScope, 2002; NIDA, 1999; USDHHS, 2002). The approach is grounded in developmental psychology and family systems theory and reflects the multidimensional nature of adolescent problems (Bukstein, 1995). MDFT assesses and intervenes at multiple levels and in multiple domains of the adolescent’s life—individual, familial and extrafamilial (e.g., school).

How MDFT is Designed to Work in the School Environment

Assessment in MDFT creates a therapeutic blueprint. The blueprint directs therapists where to intervene in the multiple domains of the teen’s life. A comprehensive, multidimensional assessment process involves identifying risk and protective factors in all relevant domains, and then targeting these identified dimensions for change. Assessment of extrafamilial influences involves gathering information from all relevant sources and combining this information with the adolescent and family’s reports in order to compile a complete picture of each individual’s functioning in relation to external systems. The adolescent’s educational/vocational placement is assessed thoroughly. In essence, MDFT uses a knowledge of known determinants of school problems (e.g., negative peer influences, inappropriate school placement, lack of parent involvement) to develop a framework for intervention.

MDFT then approaches treatment by targeting and effecting change in these adolescent, parent, family, and external system factors, including the school, that present a problem for the adolescent in question. For an overwhelmed parent, help in dealing with complex bureaucracies improves his/her ability to parent effectively by reducing stress and burden. The following interventions have proven to effectively establish the therapist and school officials as collaborators as well as promoting youths’ prosocial development in the school environment:

- Start with School Records—In the school realm, the therapist begins by obtaining the adolescent’s records to identify his or her needs (e.g., are they in the appropriate placement?).
- Arrange a School Meeting—A school meeting is immediately scheduled to introduce the MDFT program and establish a collaborative relationship with teachers, counselors, and other school officials.
- Facilitate Placement—The therapist facilitates placement in the best possible school/educational situation and monitors it closely to make adjustments as necessary.
- Help Parents Develop Skills to Effectively Work with School—Parents are taught how to assess school problems and interact with various systems to obtain the best services for their child.
- Adolescent is Stabilized in the Best School Environment Possible—At the end of treatment, the youth should be stable in the most appropriate educational system.

Research Findings from MDFT Studies

From the first studies evaluating the approach, MDFT developers have examined
the effect of interventions in the school environment. In several studies, MDFT has improved school outcomes more effectively than comparison treatments. These studies have utilized objective indicators of school-related outcomes (i.e., abstracted school records), they have examined changes in both problem behaviors and academic competence, and they have tested the durability of treatment effects by examining change through one-year follow-up assessments. In most cases, these studies were conducted in community-based clinics and compared MDFT to active, manualized treatments. The exception was an MDFT transportation study that utilized an interrupted time series design to examine program changes and adolescent outcomes following extensive training in MDFT (Liddle et al., 2002).

Liddle et al. (2001) examined the efficacy of Multidimensional Family Therapy in comparison to Adolescent Group Therapy (AGT) and Multifamily Educational Intervention (MFI). Repeated measures analysis of variance (RM-ANOVA) showed that youth receiving MDFT significantly improved their academic grades more than the comparison treatments through a 12-month follow-up. In addition, one year after treatment, 76% of the youth receiving MDFT had passing grades as compared to 60% of AGT and 40% of MFI. A second study compared MDFT to a manualized group treatment among a sample of early adolescents (ages 11-15; Liddle et al., 2004). Latent growth curve (LGC) modeling showed that relative to youth receiving group treatment, youth receiving MDFT showed more improvement in academic and conduct grades and more reduction in absences from school. A third study compared an intensive outpatient version of MDFT to residential treatment for youth meeting local criteria for placement in a residential substance abuse treatment facility (Liddle & Dakof, 2002). LGC modeling showed that youth receiving MDFT showed more improvement in academic grades, more reduction in absences, and were less likely to be suspended from school through a 12-month follow-up. Finally, MDFT investigators recently completed a systematic attempt to train agency therapists to implement the MDFT model in an existing community-based drug treatment program for adolescents (Liddle et al., 2002). Results from the study indicated that following training, therapists dramatically increased their contacts with school officials. These changes in therapist contacts were accompanied by a decrease in school suspensions (Liddle et al., 2005).

Summary and Conclusions
Results from the MDFT research program contribute to the growing evidence base indicating that family-based treatments are impacting the broader social ecology of youth engaging substance use and delinquency (Carlson, 2005). As a result we recommend that studies of treatment efficacy and effectiveness for adolescent drug abuse continue to report treatment effects on school outcomes. At the time this article was written, although family-based treatments have effectively improved school functioning, only a handful of treatment studies (approximately 25%) have reported the impact of treatment on school outcomes. In addition, this research shows that MDFT protocols designed to impact school attendance and performance are achieving their desired effects. These are among the first studies showing improvements in academic performance as well as improving school attendance and behavior, and examining the durability of effects through one year following entry into treatment. However, to be even more effective, research is needed on how MDFT and other family-based interventions achieve their effects on school performance and behavior. A first step in this effort is to disentangle the temporal sequence of improvements in drug use and school outcomes (i.e., do changes in substance use precede changes in school outcomes or vice versa). Such research will help treatment developers refine intervention models to facilitate positive adolescent development in part through increased scholastic competence.

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Dr. Brian Doss and Dr. Erika Lawrence have taken on the daunting task of organizing the Division 43 reactions to the idea of Relational Diagnosis and developing a unified response in advance of the DSM-V planning process. In their article, they outline a number of activities that have occurred or that are underway to extend the breadth of the discussion of this important topic. They invite each of you to participate in the process. Many thanks to both of them for taking on this important leadership role.

Steve Beach

The Interpersonal Process in the DSM-V Committee

Brian Doss and Erika Lawrence

Interpersonal processes are one of the central organizing forces in human life. Indeed, many of our most important and formative psychological experiences involve interpersonal processes such as romantic, platonic, and parental relationships. However, despite the central role that interpersonal processes play in the development and maintenance of psychological functioning, they appear only in a scattered and fragmented manner in the DSM-IV-TR. Perhaps most notably, partner relational problems and parent-child relational problems are included as V-codes to allow for their designation as foci of treatment or, likely more often, as contextual factors impacting the treatment of formal Axis I disorders. Interpersonal processes or dysfunction also occur sporadically as symptoms or consequences of formal disorders (e.g., depressive disorders, anxiety disorders).

There seems to be general consensus that the manner in which interpersonal processes are incorporated should be improved from the DSM-IV to the DSM-V. However, the specific nature of these modifications has remained a topic of much debate. One central issue is whether relationship difficulties should be promoted from V-codes to formal diagnoses. Proponents of this position note that the inclusion of formal relationship diagnoses makes sense conceptually and methodologically, and would likely improve the likelihood of third-party reimbursement and federal funding. The potential inclusion of formal relationship diagnoses, however, raises concerns about further pathologizing aspects of the human existence. For example, some ask, where do “normal” relationship difficulties end and relationship disorders begin?

The Interpersonal Process committee will weigh these considerations as well as explore the implications for these broader issues in the formulation of any relationship diagnosis. For example, what type of relationship disorders should be represented? Some authors have advocated for the inclusion of domestic violence, generalized relationship distress, and/or parent-child dysfunction as formal diagnoses. Certainly there is a large body of research supporting the negative impact of distress in all of these areas on individual functioning. However, the broader the definition (and the increasing percent of relationships that would meet criteria for diagnosis), the greater the potential for reactivity to the new diagnosis.

Even within a specific type of relationship distress/dysfunction, such as domestic violence, there are issues for the Interpersonal Process committee to discuss. For example,
to receive a relational diagnosis, would the disorder need to be evidenced/reported by both partners, exist only within a specific relationship (not a general personality pattern), and/or be independent of cultural/power/status influences? What types of behavioral, cognitive, or affective symptoms would be necessary to meet diagnosis? Would the relationship difficulties need to result in impairment in other domains of an individual’s life or would the relationship dysfunction be sufficient for diagnosis? Finally, for a relationship diagnosis, would the symptoms have to be explained by individual disorders such as depression? If so, are shared symptoms better explained by relational or individual diagnoses?

In addition to considering the inclusion of relationship disorders, the Interpersonal Process committee will also explore whether, and how, interpersonal relationships should be included in the presentation of individual disorders. One possibility would be to expand inclusion of relationship dysfunction in the symptoms of other disorders. Indeed, outside of the general impairment criterion, relationship dysfunction does not currently typically appear in the diagnostic symptoms of individual disorders that have been shown to be strongly related to relationship dysfunction (e.g., depression, anxiety). Would such inclusion increase the reliability of the individual’s diagnosis and/or provide important information regarding the severity of that disorder? One could also advocate for more extensive consideration and presentation of interpersonal relationships in the etiology and consequences of individual disorders. For instance, it may be possible that co-occurring relationship dysfunction could indicate a different course for an individual with depression either because the causes of his or her depression were different or because the support available would be different. Embedded within these ideas are numerous other questions, including whether a relational diagnosis is best conceptualized as an individual or dyadic construct and what symptom criteria would be necessary for a diagnosis.

**Overview of Efforts to Date**

The movement to consider whether interpersonal processes should be considered more formally in the *DSM-V* has been a vital one for over a decade. In the 1990s, Drs. Florence Kaslow, Terence Patterson, Michael Gottlieb, and other members of American Psychological Association’s (APA) Division 43 (the Division of Family Psychology) founded the Coalition on Relational Diagnosis, which was one of the first groups to begin to explore the potential importance of—and gather data regarding—interpersonal processes in the *DSM-V*. The work conducted by the Coalition culminated in Dr. Florence Kaslow’s 1996 edited book, *Handbook of Relational Diagnosis and Dysfunctional Family Patterns*. In 2001, the National Institutes of Mental Health (NIMH) sponsored a close relationships workshop designed to promote translational research linking relational processes and mental health. Drs. Steven Beach and Marianne Wamboldt then coordinated the March 2005 Relational Processes in Mental Health Conference to “provide a foundation for data-driven discussions of the role that relationship processes may play in etiology, maintenance, and recovery.” Drs. Steven Beach and Nadine Kaslow have edited a Special Section on Relationship Disorders for the *Journal of Family Psychology*, which will be published in the next few months. Finally, Dr. Steven Beach will devote the fall 2006 issue of *The Family Psychologist* to the topic of relational diagnoses.

**Where We Go From Here—The Interpersonal Process in DSM-V Committee**

Earlier this year, an APA Division 43 committee approached us to form and co-chair the Interpersonal Process committee to explore these complex issues and formulate a position paper to present to the *DSM-V* development committees. We were approached because we have not come to any personal conclusions about the best avenues to pursue and because of our interest in integrating members of Division 43, ABCT’s Couple Special Interest Group (SIG), and other organizations to address these issues. To date, we have recruited 25 distinguished professionals representing Division 43 members as well as marital and family researchers from ABCT, the American Psychiatric Association, and other allied groups. In addition to belonging to different professional organizations, these individuals have various expertise including clinical and family psychology (both researchers and clinicians), psychiatrists, and public policy advocates. We are excited about inclusion of diverse expertise in the committee and expect to address these pressing issues from a number of productive views. Through structured online discussions, we will develop formal recommendations we wish to make for the *DSM-V*. These recommendations will be developed through conversations about the nature of the constructs of relational diagnoses and how best to categorize such diagnoses within the *DSM* format.

The committee’s initial conversations will be grounded in previous discussions and publications on these areas. As such, the committee co-chairs are currently gathering these resources and will be providing the committee with a summary of these previous discussions. To expedite this process and avoid duplicating previous efforts, we expect to enlist the aid of members who have been involved in previous activities to ensure that all committee members have an appreciation of the fruits of previous efforts. The Interpersonal Process committee will continue to discuss these issues through the middle of 2006. We expect to present our recommendations for whether and how to include interpersonal relationships in the *DSM-V* as part of panel discussions at the August 2006 APA and November 2006 ABCT conferences. Through this process, we hope to solicit comments from the broader APA and ABCT communities. Reactions and comments from the panel discussions will be discussed further in the full committee and the committee will have a chance to revisit the recommendations. In December, 2006, the finalized committee recommendations will be forwarded to the *DSM-V* planning committees.
The Rewards of Training in School-Based Family Practice

Tamara L. DeHay
University of Texas at Austin

As Division 43’s incoming student representative for the 2006 calendar year, it seems appropriate that I begin my first contribution to the Student Corner column with an introduction. My name is Tamara DeHay, and I am currently a fourth-year doctoral student in the School Psychology program at the University of Texas at Austin. I began my graduate training with an interest in family psychology. As I learned and read about systems theory and later began to apply that knowledge in direct service to families, this interest became an emphasis. The University of Texas is one of only a handful of accredited doctoral-level School Psychology programs that offers training in family psychology as a part of its core curriculum. I feel privileged to have had the invaluable opportunity to be trained in providing family services within the context of school-based practice. It is a fortunate coincidence that this discussion of my training provides a perfect segue into the theme of the current issue of The Family Psychologist: Family Practice in the Schools.

Students who train to deliver family services within a school setting are provided with a unique opportunity. Children function day to day within their families and their schools, and for many children these systems exist in near isolation from one another. The child moves between the two, carrying into each the struggles, accomplishments, triumphs, and failures he is experiencing in the other. He reciprocally affects and is affected by both systems, and lack of communication between the two can lead to little understanding of and support for the child’s needs. Learning to bridge these two systems means that a therapist-in-training may help a child to find success within the two most important domains of his life simultaneously. Affecting this level of change can be an extremely rewarding and motivating experience for a student therapist.

It is inarguably the case that the school frequently serves as the “front line” for detection of personal and behavioral problems in children. A child’s experience with familial conflict or any other difficulties within their psychosocial milieu will often manifest in academic, social, or conduct problems during school. When symptoms arise, then, the school is a setting ripe for early detection. This provides family psychologists who practice in the schools an opportunity to engage families in prevention strategies in order to provide help and support to the child within both systems at once. Through this type of early intervention, collaboration between schools and families can have profound effects on preventing subsequent psychological and educational problems for a child.

In regard to intervention, much can be learned about the value of school-based family practice through examination of the treatment literature for externalizing disorders in school-aged children. All of the well-established interventions in this area involve parent training and each have demonstrated enhanced efficacy when a school component is included (Breastan & Eyberg, 1998; Pelham, Wheeler, & Chronis, 1998). Intervening at the school and family levels concurrently results in greater and longer lasting change for these children.

Although the treatment literature for internalizing disorders has placed greater emphasis on individual therapies for children, many studies in this area have also provided evidence that parent involvement results in more significant improvement in the child’s symptoms (Barrett, Dadds, & Rapee, 1996; Cobham, Dadds, & Spence, 1998). Moreover, because these symptoms are frequently expressed within the academic and social context of the school setting, it follows that this would be an important setting within which to intervene. On the whole, the extant research is promising and exciting for budding therapists who have chosen school-based family practice as their preferred mode of service delivery.

In addition to providing direct services to intervene on behalf of a child, family psychologists in the schools can serve as effective catalysts for greater overall collaboration between schools and families. For many parents, the only communication they have with their child’s school occurs when there is a problem involving their child. For this reason, the bulk of contacts with the school may be aversive or embarrassing for the parents. It is not uncommon for parents to feel as if they are being blamed for their children’s difficulties at school. This can initially present a challenge to school-based therapists, due to the parents’ transference of bias against the larger school system to the therapist. Other parents, however, utilize the school as their primary resource for obtaining services for their child. Practicing in the schools means that a family therapist has access to these families that are unable or unwilling to obtain mental health services privately. Learning to build and repair relationships between families and schools in order to facilitate greater support for a child is a central focus of training for a school-based family therapist.

The rewards of training within the model of school-based family practice are numerous. Schools are a constant portal through which children can be educated and cared for, their problems detected, and their families accessed. Students interested in providing family services would benefit from seeking out experiences in schools and through forming mentoring relationships with professionals who are familiar with school-based practice. Moreover, due to the consistent need for school-based family services, expanding the training opportunities for students who wish to gain experience...
in school settings would be a practical goal for professors of family psychology and for the Division.

References

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Diversity Corner
George K. Hong, PhD, Editor

School-Based Family Services: A Promising Service Model for Ethnic Minorities

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The theme of this issue of *The Family Psychologist*, “Family-Based School-Linked Empirically Supported Intervention Programs,” is a topic that is particularly close to my heart, because I have been involved with this service approach for over two decades. In fact, currently, one of the academic programs offered by our department here at CSULA is called “School-Based Family Counseling,” a graduate degree option that combines school counseling with marriage, family, and child counseling. This program is based on the rationale that problems exhibited by students in schools are often extensions of the problems in their families, as well as communities. Rather than focusing solely on the individual child as in traditional school counseling, a counselor could address these problems more effectively from a family perspective, and work with the individual student or with the family as needed. This degree option trains school counselors who can apply the skills of family counseling in their work with students, and conversely, family counselors who are proficient in working in the school setting or with the school system.

School-based family counseling is actually one aspect of a larger model often called school-based family services or school-linked family services (Adelman & Taylor, 1993; Dryfoos, 1994; Fine & Carlson, 1992; Hong & Ham, 2001; Soriano & Hong, 1995, 1997). This innovative approach utilizes the school as a “one stop shopping center” where families can obtain a full range of services such as mental health, medical, and social services. The services may be provided directly on site at the school or at a close-by location. When this is not viable due to physical space or other limitations, the services are at least provided by an agency or a group of agencies closely coordinated with a school located in the community. This approach is aimed at serving the needs of children and their families through the school setting. It is found to be especially suitable for many immigrant communities as well as inner city lower socioeconomic neighborhoods where access to services in mainstream agencies are often challenging. Typically, school-based or school-linked family service programs are multidisciplinary. It can include medical providers, social service providers, probation officers and other law enforcement personnel, and, of course, mental health professionals. The components of each program are dependent on the actual needs of the particular community.

My first involvement with the school-based and school-linked family services model started in the 1980s when I worked as a psychologist at the South Cove Community Health Center in Boston. This is a comprehensive community agency providing mental health, medical, and social services, and it is located in the same building that houses an elementary school as well as programs from other service agencies, including an adult English program, and afterschool programs for children. The school provides an easy outreach to the children and their families, most of whom are Asian Americans. Many are immigrants who have difficulty accessing services, or even understanding the functions of the many mainstream agencies offering different services. The school-based and school-linked program proved to be an effective way of reaching out to these Asian American families since basically everyone is familiar with the school, and feels less inhibited if the services are linked up with the school or provided at the same location (Hong & Ham, 2001). In addition, teachers, through their daily interactions with the children,
are in an advantageous position to notice their problems, both individual and family, and can refer them for services. Linking up services with the school enhances the likelihood that a family will follow through with referrals for mental health or other services. Interestingly, when I came to Los Angeles and started teaching at CSULA, I met some colleagues (Drs. Marcel Soriano, Michael Carter, and Ray Hillis) who, from their own experience, have also found the school-based and school-linked service model very helpful for other populations, such as Latinos and inner city communities. Subsequently, we developed the school-based family counseling program here at CSULA. It is currently one of our most popular counseling degree options.

Providing family psychological services in the context of the school or through a school-linked program is clearly an arena where family psychologists can make major contributions. However, to do so effectively, family psychologists must be knowledgeable about the “culture” of the school as well as the community. Moreover, in the larger context of a comprehensive school-based or school-linked family services program where a variety of services are involved, psychologists as well as other service providers must develop their skills in interdisciplinary collaboration, consultation, and liaison. In addition to working side by side with each other and sharing information as needed, professionals from different disciplines must also work together to streamline referrals, identify and address gaps in service plans, avoid duplication of services, monitor service delivery or client compliance, and advocate for needed services, etc. (Adelman & Taylor, 1993; Dryfoos, 1994; Fine & Carlson, 1992; Soriano & Hong, 1995, 1997).

While school-based and school-linked family services make good theoretical and practical sense, implementation is not always straightforward. Service catchment area restrictions, resource allocation, funding conditions and limitations, and even turf battles among agencies are common problems that challenge the establishment of multidisciplinary school-based or school-linked service programs. Moreover, some school administrators may still hold the traditional position that schools are for “education” only. They may frown upon the suggestion of providing other services in the school setting, or extending their attention beyond the children enrolled in their schools to parents or other family members. In such situations, advocacy along with parents and other community members may be necessary.

In view of the array of problems faced by children and families in many inner city and ethnic neighborhoods, school-based and school-linked family services are a promising approach. The school is an institution that possesses well-established channels to children and their families. By collaborating and aligning their efforts at the school setting, professionals can have a better chance to address the complex problems facing the family, the school, and the community. This is clearly an area where family psychologists interested in community work can take a leadership role.

References

APA Science Leadership Conference: The Public Face of Psychological Science

James H. Bray, PhD

I had the honor to represent the Division at the first annual APA Science Leadership Conference (SciLC), December 2–4, 2005 in Washington, DC. The Science Directorate and Board of Scientific Affairs brought together about 120 of psychology’s leading scientists to develop a common agenda that will advance psychological science and shape the future of the profession. The theme was chosen to emphasize the importance of psychological science to the public and policymakers. The APA arranged for the two-hour National Public Radio (NPR) program, “Science Friday,” hosted by Ira Flatow, to be part of the conference. Two panels were organized regarding gender differences and psychology and health—they were interesting and informative. Callers from all over the country listened and called in to ask questions from leading psychologists in the field. The SciLC was organized after the successful Practice State Leadership and Education Leadership Conferences. I will provide more details in future columns.

Please contact me (jbray@bcm.tmc.edu or http://www.bcm.tmc.edu/familymed/jbray) if you would like further information about the SciLC conference.
This article on systemic approaches in school psychology, written by Lou Turchetta, represents a shift in direction for the Practice: Clinical Notebook section of The Family Psychologist, toward providing articles written by clinicians about specific treatment programs. I want to invite brief (500-1000 word) papers for this section that detail the research-informed treatment approaches in which you are involved that you would like to share with colleagues. Future issues of TFP in 2006 will involve the themes of domestic violence, school psychology, and efforts toward the inclusion of criteria for relational disorders in the DSM-V. While these topics will be specifically sought for the Practice section, we welcome papers written on other areas of treatment as well. If you would like more information, please contact me, Deborah Cox, at dlc350f@MissouriState.edu or 417-836-6267.

A Perspective on the Use of a Ecological Interventions by School Psychologists

Lou Turchetta, EdD
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Ecological Theory has been recommended as a base for conceptualizing psychology in the schools (Sheridan & Gutkin, 2000). However, implementing a systems perspective as a school psychologist can be challenging. Some of the challenges include an emphasis on the medical model, the historical role of the school psychologist, and the gap between research and practice. Despite these difficulties there are several ways to circumvent the obstacles and utilize systems theory to address student needs within the schools.

There is a gap between research and practice (Levant, Tolan, & Dodge, 2002). Although some of this gap may represent a disconnection between practitioners and researchers, it seems that outside systems also influence the maintenance of this gap. Reimbursement patterns of insurance companies may influence psychologists in private practice, for example, to hold on to a disease model of treatment when alternative, perhaps more efficacious ways of framing problems may be available. School psychologists, because their work is intertwined with the culture of the school, can be caught up in a systemic resistance to change inherent in such a large organization. The following represents a perspective on how and why this resistance influences and maintains a gap between psychological research and practice in schools and how the use of a more inclusive systemic view is a challenge.

Special education law has had a significant influence on school psychology practice. Approximately thirty years ago federal special education law focused on insuring that schools recognized and provided service to children with special needs. As a result, school systems hired school psychologists in order to fulfill mandated individual testing requirements. School psychologists diagnosed students who were having difficulty as handicapped (learning disabled, attention-deficit-disordered, etc.) in unprecedented numbers. Recently, school systems in Rhode Island have identified as many as 20% of their populations as handicapped. As a result of the increased numbers of identified special education students, more special education teachers were hired. As helping professionals, we felt that we were doing great things for students who were struggling. But we unwittingly set up an expectation within the schools that our job was to be the gate keepers of special education in the schools.

While much of what we did was positive, we didn’t appreciate the effects of labeling and separating the students from their peers. Meta-analyses of special education placement have revealed small effect sizes, most of which are negative, suggesting that for many children special education placement may be somewhat harmful (Kavale & Foreness, 1999). An underlying assumption in this process was that regular classroom teachers were doing the best they could to address the needs of the “regular” students and that the students who were not performing were, in fact, different and required specialized instruction that was not possible within the regular classroom. What we didn’t understand was that as we identified students as handicapped, they became the problem of the “special education” departments. The classroom teachers assumed that the fact that the students were not learning was the result of their internal problem and had nothing to do with their instruction or the system in general.

With regard to behavioral difficulties, a similar problem developed. School psychologists traditionally utilize a medical model for conceptualizing problems and providing services (Sheridan & Gutkin, 2000). We would identify students as having some type of “behavioral disorder” as defined by the special education regulations and proceed to intervene. Again the assumption was that the system was fine, it was this one student who needed fixing.

There are pragmatic challenges to working in a systems fashion within the school. It is difficult to work with families during the school day. In addition, there is pressure from teachers and administrators to see students individually. Their assumption is that if you are working with a student, “one on one,” then you are going to solve the problem. The responsibility for change is between the psychologist/change agent and the problem student and nothing further will have to be done by the teacher, the school, or the parents. The problem is that effecting change through individual work with a child is difficult and the literature on the effectiveness of individual therapy in the schools bears this out (Sheridan & Gutkin, 2000).

(continued on p. 26)
This issue of The Reference Corner is my last as editor of this column. It has been gratifying and pleasing to write and edit for my family psychology colleagues reviews of the most contemporary writing in our field. This column begins with a review of a book on multisystemic interventions with adolescents, a complement to the theme of this issue on family and school partnerships, coupled with one on helping family members deal with substance abuse. I review yet another complex and comprehensive book for the field, Jay Lebow’s just published Handbook of Clinical Family Therapy.

Beginning with the next issue, the Editor of this column will be Farrah Hughes, PhD, from Francis Marion University in South Carolina, who has graciously agreed to this role and will bring a new perspective and direction to the column. What better introduction can I give you than her first review for the column, an important contribution to family research. If you are the author of a new book in family psychology that seems appropriate to review in this column, please make arrangements to have a copy to be considered for review sent as close as possible to the publication date. Send books (or galleys if possible) to Farrah Hughes, PhD, Francis Marion University, Department of Psychology, P.O. Box 100547, Florence, SC 29501; email: fhughes@fmarion.edu.


Reviewed by Meredith Cohen

What happens when you set out to fix a troubled neighborhood? Any psychologist with a healthy respect for ecological models of development would quake in her boots at the mere thought of it. Thankfully, however, Drs. Cynthia Cupit Swenson and Scott Henggeler along with Union Heights residents and community leaders, Ida Taylor and Oliver Addison, were willing to give it a shot. Their research, described in Multisystemic Therapy and Neighborhood Partnerships, is a comprehensive and multisystemic intervention aimed at reducing adolescent violence, substance abuse, problematic school behaviors and expulsions.

While traditional multisystemic therapy (MST) seeks to reduce problem behavior in an individual by engaging the central environmental “systems” (e.g., parents, school and community), Swenson et al’s application takes the process several steps further. With their “Neighborhood Solutions Project,” a community-wide intervention based in the neighborhood of Union Heights, in Charleston, South Carolina, they set out to improve the lives of troubled teens, reduce problem behavior and improve family interactions throughout the community. They also marshaled community support to improve the quality of education and to repair strained relationships with law enforcement.

It was a tall order. A very tall order. This book not only brings home the enormous complexity of the endeavor, but also demonstrates that success is possible. The authors begin by building a compelling case for the successful application of MST to treating adolescent criminal behavior and substance abuse. The book is divided into three parts. Part I (Chapters 1-3) provides empirical and clinical background information, including a thorough review of the literature on the antecedents and long term implications of youth violence, substance abuse and community violence. The authors explore a number of evidence-based treatments along with a well-supported literature review of the types of interventions that have been most successful and cost effective. They conclude Part I with an overview of the multisystemic model, including appropriate grounding in social and ecological models and systems theory.

Part II (Chapters 4-10) represents the bulk of the book and includes a thorough discussion of the issues in implementing multisystemic intervention at a community level, foremost of which is engaging the whole community in the intervention. The authors tackle the issues faced when combating the problems of anti-social behavior, adolescent substance abuse, and school expulsion, each of which is discussed in a separate chapter. Detailed case examples, in addition to making this portion of the book highly readable, are used to illustrate the utility of engaging multiple systems to treat the individual, while working within the bounds of the neighborhood to support the efforts of individuals and their families. This part of the book also includes a chapter on benefits of neighborhood-based law enforcement, written by three community police officers.

Part III (Chapters 11 and 12) reflects a “lessons learned” approach to the research. It addresses a number of topics, from providing an overview of how to create a non-profit corporation, to applying for tax exempt status, to how (and where) to apply for funding. The authors also suggest that communities don’t need researchers to help them fix their neighborhoods. They provide numerous examples of the residents of Union Heights driving aspects of the intervention, such as bringing in an affordable health clinic and developing a wide range of programs aimed at promoting health and wellness in the community.

The most impressive aspect of the Neighborhood Solutions project, aside from its apparent success, is the high level of participation and cooperation achieved among disparate...
groups. The project was not formulated by a team of ivory tower researchers; rather, it represents a truly collaborative effort between the seasoned professionals and experts in the geographical area of Union Heights, i.e., the community leaders and residents themselves. Drs. Swenson and Henggeler are both clinical psychologists and researchers who have published extensively on the uses of MST for treating substance abuse and criminal violence. They and their staff, many of whom moved into the neighborhood for large parts of this project, clearly understood the need to engage the residents of Union Heights and pursued an untiring, intelligent, sensitive and compassionate quest to do so.

The Neighborhood Solutions project reflects both the possibilities and the challenges inherent in attempting to analyze the effectiveness of a community-wide intervention. Historically, there has been a disconnect between hands-on community intervention and traditional psychological research. Across the U.S. there may be many community programs that seek to make improvements at the local level, but only rarely are such programs rigorously studied. It is often easier to obtain the funds and human resources to do interventions than it is to do the research to investigate their effectiveness. While many of these programs can at least point to anecdotal evidence of their effectiveness, few have been subjected to careful empirical validation. The authors here attempt to provide some empirical evidence, yet the group comparisons they use raise as many questions as they answer.

Specifically, the authors compare outcomes across four groups. Group 1 is comprised of Union Heights youth referred by community leaders and targeted to receive the multisystemic therapy; Group 2 includes youth referred by leaders of a neighboring community facing similar threats; Group 3 is comprised of youth from Union Heights who were referred to the Neighborhood Solutions project because they were threatened with suspension or expulsion from school; and Group 4 is comprised of healthy, well-adjusted youth living in the Union Heights neighborhood. Comparing the well-adjusted youth to the clinical sample in the neighborhood that is undergoing significant change is of questionable utility. Perhaps the most interesting comparison, between youth referred to multisystemic therapy in Union Heights and youth from the neighboring community referred to more traditional therapies, likewise is suspect because youth in the neighboring community had significantly lower pre-existing rates of criminal behavior.

The authors frankly acknowledge these and other methodological limitations of their research. This, however, does not overshadow the value of this incredible body of work. Value cannot always be measured by t-tests and ANOVAs, where there is persuasive evidence of lives saved, families strengthened and children’s futures secured.

This book, written in a simple and readable style, can be a valuable addition to a sophisticated undergraduate course or to a variety of graduate courses in psychology, social work or public health. It is also accessible to the lay reader, and serves as an inspiring “call to arms” to community leader and other committed citizens who are not afraid to work for better lives for themselves, their children and their communities.

Meredith M. Cohen, Ph.D. is a developmental psychologist in Pittsburgh, PA, specializing in children’s social and emotional development.


Reviewed by Farrah M. Hughes

To be honest with the reader, I initially approached Douglas Sprengle and Fred Piercy’s Research Methods in Family Therapy (2nd ed.) with some trepidation. It is, after all, an edited volume on research methods, so I feared that it might be a little on the dry side. I was fearful that the gaps in my knowledge of marriage and family therapy (MFT) theory and practice would put me at a disadvantage in terms of grasping the full meaning that the chapter authors intended. With much relief I am delighted to report that, contrary to my expectations, I enjoyed reading this volume. I found it to be an extremely informative, useful, and accessible book, and I expect that other readers will have a similar experience despite varying levels of research expertise and training in somewhat different models of clinical work with families.

This 21-chapter volume is an updated edition of Douglas Sprengle and Sidney Moon’s 1996 edited volume on family therapy research methods. Sprengle and Piercy added 13 new chapters to this second edition, and eight of the chapters have been substantially revised to reflect theoretical and methodological advances in the field. The book runs the gamut of research methodologies and is divided into five sections accordingly: introduction, qualitative methods, mixed methods, quantitative methods, and advanced quantitative methods. With this volume the editors intended to “enhance the status of research in the field, while also making the science of MFT more accessible to clinicians and students” (p. 3). Moreover, they aimed to create a volume that would help expand the reader’s “understanding of what constitutes ‘research’” as well as “add a few planks across the chasm that divides researchers and clinicians” (p. 8). The “smorgasbord of methodological options for doing family therapy research” (p. 17) presented in this book and the clear, comprehensive manner in which the methodologies are presented help the editors achieve their goals.

Sprengle and Piercy’s guidelines followed by chapter authors create uniformity throughout the volume, despite great diversity among the chapter authors’ topics and writing styles. Most authors adhered to the structure, which included, for example, a background section on the development of the method being discussed, an overview of the methodology with an example for illustration, and a discussion section that includes exemplars of the particular method. These exemplars point the reader to various applications of research methods that have been published in the MFT literature.
In order to make the topic of MFT research accessible to students, Lenore McWey, Ebony James, and Sara Smock have authored a chapter for graduate students, which is in essence a beginners’ guide for conducting research. To make MFT research more accessible to clinicians, the chapters are full of clinical research examples and practical advice that help practitioners apply the methods to the clinical practice of MFT. As one example, Silvia Echevarria-Doan and Carolyn Tubbs present a study regarding clinicians’ assessment of clients’ resources and strengths in therapy as an example of the application of grounded theory to MFT research. They introduce a clear, theoretical background for grounded theory and then smoothly transition to an applied clinical example of the methodology.

In this volume, Sprengle and Piercy expand the reader’s thinking about what constitutes research, as they intended. The section on qualitative methods presents research methods that are less commonly encountered in the field. As one example, the chapter on feminist autoethnography (by Katherine Allen and Fred Piercy) opened my eyes to new ways of understanding marital and family relationships. Autoethnography is a powerful methodology for exploring connections among one’s inner experience and external factors that impact or shape that experience. Indeed, it appears that “good autoethnography holds promise as a research method that can touch the soul and raise the dead” (p. 163) and has the potential to greatly inform our understanding of marital and family dynamics. The other chapters on qualitative methods, including Silvia Bava’s chapter on performance methodology, Carla Dahl and Pauline Boss’s chapter regarding the use of phenomenology, Fred Piercy and Katherine Hertlein’s chapter on focus groups, Tai Mendenhall and William Doherty’s chapter on action research, and Jennifer Metheson’s chapter on computer-aided qualitative data analysis software (CAQDAS) all present methods for painting pictures about marital and family processes with increased color and depth. The authors presented these methodologies in clear terms, utilizing concrete examples. I now have a better understanding of these qualitative methodologies and am inspired to incorporate some of them into my own research. These methodologies, as they are presented by the authors, offer multiple ways of understanding and connecting with participants. Moreover, some of them blur the boundaries between art and science, thus offering a fresh perspective for many researchers seeking to understand marital and family processes.

Included in the section about mixed methods are chapters on survey research (by Thorana Nelson and David Allred), the Delphi method (by Linda Stone Fish and Dean Busby), task analysis of change events (by Brent Bradley and Sue Johnson), and program evaluation (by Jay Mancini, Angela Huebner, Eric Mc Collum, and Lydia Marek). Again, each of these authors presents potentially complex methodologies in clear, comprehensible language. Moreover, they seamlessly bridge theory and application and present clinical examples to illustrate their utility. For example, Nelson and Allred illustrate the principles of survey research by describing the Basic Family Therapy Skills Project (BFTS), which was designed to assess the skills that MFT supervisors perceived as most important for therapy trainees. They also convey important information about conducting survey research, including principles related to sampling, data-gathering (including strategies for increasing response rates), coding and storing data (including guidelines for creating a codebook), data analysis, and reporting findings.

The quantitative methods sections include chapters on clinical trials (by Kevin Lyness, Stephanie Walsh, and Douglas Sprengle), meta-analysis (by Karen Wampler, Alan Reifman, and Julianne Serovich), economic evaluation methods (by David MacKinnon), approaches to prediction (by Doug Snyder and Laurel Mangrum), multilevel growth modeling (by Margaret Keiley, Nina Martin, Ting Liu, and Megan Dolbin-MacNab), and covariance structure analysis (by Margaret Keiley, Mary Dankoski, Megan Dolbin-MacNab, and Ting Liu). Although most researchers will be familiar with many of these methods, the manner in which they are presented here beg readers, no matter how experienced they might be, to engage themselves in the authors’ process of empirical investigation. The use of practical examples and understandable language will facilitate the novice’s grasp of these methodologies. For example, Keiley, et al., walk the reader through the complex process of multilevel growth modeling with ease by using a study of three forms of drug abuse treatment as an example.

This research methods “smorgasbord” indeed has something for everyone and should appeal to many types of readers, including clinicians, researchers, and students. This volume will serve as an informative reference book not only for MFT researchers, but also for others interested in expanding their repertoire of methodologies, as each chapter is an elegant interplay of theory and real world application.

Farrah M. Hughes, PhD, is Assistant Professor of Psychology at Francis Marion University in Florence, SC. Her clinical and research interests include parent and child well-being, including forms of psychopathology that hinder the development of marital and parent–child relationships.


Reviewed by Brenda Davie and Lisa Maccarelli

Motivating Substance Abusers to Enter Treatment: Working with Family Members fills a critical and unique niche in addressing the needs of families. Jane Ellen Smith and Robert J. Meyers present a comprehensive skills-based unilateral family therapy designed for the loved ones, or Concerned Significant Others (CSOs), of substance abusers who are resistant to entering treatment. This empirically-based program is entitled Community Reinforcement and Family Training (CRAFT) and has its roots in the Community...
Reinforcement Approach (CRA). CRAFT identifies three main goals: (1) to decrease the substance use of the Identified Patient (IP); (2) to get the substance user to enter treatment; and (3) to increase the CSO’s own happiness regardless of whether the IP enters treatment. In contrast to other models and philosophies, the CRAFT program does not advocate confrontation or loving detachment from the CSO, but offers skills and builds on the CSO’s motivation to support change in a loved one’s substance use. Although the CRAFT approach is, perhaps, a natural addition to the repertoire of behavioral and cognitive-behavioral therapists, it is also a potential addition to the skill set and toolbox of any therapist working with this challenging population, particularly if the therapist is open and willing to use a more structured, directive approach than she/he may typically utilize.

Jane Ellen Smith is at the University of New Mexico in Albuquerque (she has also served as Director of Clinical Training). Robert J. Meyers is at the clinical research branch of the University of New Mexico’s Center on Alcoholism, Substance Abuse, and Addictions, and is Associate Director of the Life Link Training Institute. The authors have extensive experience in the field of addictions, including treatment-resistant substance users and the application of CRA with concerned loved ones (i.e., the development of CRAFT).

The chapter presenting empirical evidence for CRAFT reviews numerous studies by the authors and others demonstrating the superior effectiveness of CRAFT when compared to other CSO interventions. Special attention has been paid to increasing methodological rigor in the later clinical trials as the research has evolved. Evidence to date supports the goals outlined by the program, particularly with regards to increased quality of life for the CSO and treatment engagement of the IP.

The book is comprised of ten chapters, beginning with an overall description of the approach. Subsequent chapters cover building the CSO’s motivation, communication skills, domestic violence issues, behavioral assessment and treatment strategies such as functional analysis, positive reinforcers, and negative consequences. Later chapters address enhancing the quality of life of the CSO, inviting the IP into treatment, and finally, empirical evidence for the CRAFT approach. The text is detailed and user-friendly. In addition, the authors present meaningful and well-organized tables throughout the book to summarize the central information. Reproducible scales and worksheets are also provided.

CRAFT emphasizes thorough assessment and increased understanding of the IP’s substance use, including the identification of internal and external triggers. This is done, in part, through application of the functional analysis procedure. Specifically, CRAFT includes two types of functional analyses. The first is used to identify problem behaviors, i.e., substance use, to be decreased, and the second targets prosocial behaviors to be increased. Through the use of structured sessions, the CSO is taught a series of behavioral interventions, including identifying and implementing positive reinforcers for sober/clean time or reduced substance use, and similarly using negative consequences to address problem behaviors, particularly substance use/abuse.

Communication training lays the foundation for implementing the core behavioral interventions of the CRAFT program. CSOs are taught to communicate in a responsible, positive, assertive, empathic, and helpful style. Role plays are an important part of the program, used to establish and practice skills prior to the CSO utilizing interventions with the IP.

A noteworthy strength of this book is that in addition to the detailed presentation of the program, there are regularly occurring examples of lengthy and realistic session dialogues focusing on how to actually implement CRAFT. The examples also include notes to clarify and highlight critical points, rationale, and philosophy. There are specific suggestions on presenting the material to the CSO in a clear and understandable way. With this, the reader is also offered information regarding what to anticipate in various therapist/client scenarios. The book identifies a range of responses that the CSO may have to treatment, and that the IP may have to behavior changes made by the CSO. The reader is presented with potentially anticipated challenges and given strategies to handle them as they occur.

The text insightfully includes a chapter on domestic violence issues that may be associated with substance abuse and recovery. In keeping with CRAFT’s proactive approach, the program brings awareness of key domestic violence issues and presents interventions in both a supportive and directive manner. In the case of violent behavior, basic CRAFT interventions (i.e., functional analysis, altering of CSO behavior to change outcome) are used to address both the domestic violence and substance use. Importantly, specific interventions encouraged for each CSO are tailored to minimize the risk of violence.

Motivating Substance Abusers... appears, at times to be most applicable to a relatively high-functioning clientele. Examples in the book may not reflect the diversity in economic status, culture, ethnicity, and psychopathology that is seen in many front-line community clinical settings. For example, the ongoing and, at times, unique challenges presented by dually diagnosed consumers are not directly addressed, although many of the principles do apply. However, it is exciting to think about how this model may evolve in its application to different populations, including those with a dual-diagnosis.

This book is an enjoyable and extremely informative read for those looking for a systematic treatment approach to working with the loved ones of treatment-resistant substance abusers. Weaving the principles, philosophies, and application of the treatment through all aspects of the text make for a coherent, cohesive, and well-integrated treatment approach.

Brenda Davie, PhD is a therapist at The APT Foundation’s Residential Services Division in Bridgeport, CT. Lisa Maccarelli, PhD is an Associate Research Scientist in the Yale University School of Medicine’s Department of Psychiatry.

Reviewed by Nancy Elman

There have been handbooks of family therapy before—hefty, typically theory or model driven, and in my experience often frustrating in their lack of applicability. Jay Lebow’s new Handbook of Clinical Family Therapy is none of these—well, it is hefty at almost 650 pages! Always a centrist focusing on core concepts and how things really work, Lebow has now given the field a clinical handbook that represents in both plan and action what he calls “the new family therapy” (p. xvii). That therapy, according to Lebow in an extraordinary introductory chapter, is integrative (searching for effective strategies and interventions rather than theoretical models and their differences), addressed to specific difficulties within families and their members (rather than families in general) and “generic”—a word that generally connotes least-common-denominator blandness, but in this case is intended to convey a centrality and integration of approaches.

This Handbook has some familiar components. The authors were chosen for their expertise; each has published and worked deeply in the field. Many will be well-known to readers of The Family Psychologist through their published work and/or their involvement in the Division of Family Psychology; others are not so familiar. The authors are distinguished importantly by demonstrating both research and clinical relevance. A requirement in Lebow’s construction of this book was that each approach included must be grounded in “some modicum of support through empirical and clinical testing...” (p. 5).

Consistent with this structuring idea, Lebow’s authors have provided chapters that demonstrate empirically supported treatment in a way that speaks to clinicians as well as researchers. Each author was asked to include a clinical example, specific intervention strategies and a “step-by-step guide” that readers can use for treatment, along with at least some research evidence about the effectiveness of the treatment. In the directional guidance to authors he told them to “think of your core reader as an advanced clinical graduate student or professional (p. xvii). The outcome is a book with four sections (a total of 23 chapters), focused on problems of children and adolescents, problems in adults, couple relationship difficulties and relationship difficulties in families.

Guy Diamond provides the first chapter in the section on Problems in Children and Adolescents, demonstrating Attachment-Based Family Therapy (ABFT) for depressed and anxious adolescents. He provides a compelling case of a 14-year-old girl and her family, addresses key challenges such as building the parents’ capacity for providing security-promoting parenting, and then lays out in some detail five treatment tasks and how these unfold sequentially. While not a cookbook, the chapter is detailed enough to provide guidance on both conceptualizations and actions for working with families. Tom Sexton and James Alexander provide the bookend to this section with a chapter on functional family therapy for externalizing disorders in adolescents. Their long-researched model is introduced and reviewed, and is followed by careful demonstration of key aspects of intervention—engagement and motivation (including phase-specific assessment) followed by behavior change and generalization. All this is done within a relational focus not often clarified in behavioral models, emphasizing the connection between the family and the therapist, particularly when some of the most difficult adolescents and their families are the focus of intervention. Again, the detailed case example is satisfying in its thoroughness.

A few other examples will highlight the depth and richness of the chapters in this clinical handbook. The Problems in Adults section focuses on adults with severe mental illness, depression, substance abuse and trauma. Particularly impressive is the chapter by Scott Miller and colleagues called “Making Treatment Count: Client-Directed, Outcomes-Informed Clinical Work with Problem Drinkers.” The authors describe how they match treatment to specific clients, grounded in their research findings, and how the ongoing feedback/data process contributes to continually modifying the therapeutic action. This chapter seems particularly relevant because as therapists we so often need to deal with alcohol dependence or abuse in the context of broader individual or family intervention. While the formalities of this research model may not be followed by an individual clinician, the case material and examples make it possible to incorporate the key strategies into one’s work to more effectively address the impact of alcohol on an individual and family.

In the section on Couple Relationship Difficulties, several chapters address interpersonal dynamics, notably Alan Gurman’s brief model for interpersonal-intrapsychic marital therapy and Scott Woolley and Susan Johnson’s well-researched and well-known emotionally focused couples therapy. The remaining chapters focus on specific issues: domestic violence in couples (Stith et al.), affair couples (Baucom, Gordon, & Snyder) and couple sex therapy (McCarthy & Bodnar). The Baucom, Gordon and Snyder chapter is another example of a model, grounded in some research, with wide applicability to the practitioner seeing couples, particularly given the data suggesting the increasing numbers of partners have affairs outside of their marriage or committed relationship. Baucom et al.’s 3-stage model of forgiveness parallels a model of trauma, including dealing with the impact, searching for meaning or understanding, and recovery. Key aspects for intervention at each stage are detailed, including, for example, a rationale for addressing forgiveness later in treatment when the relational disruption is better managed and that exploration has a better chance for success. While helpful in its specifics when addressing affairs with couples in treatment, the chapter implies treatment for traditional heterosexual couples and would have been richer had it included committed gay relationships. “Affairs” of one type or another conducted by a partner using the internet have burgeoned in the past few years and in my clinical experience have a similar emotional impact on the injured partner and the couple relationship, so it would
also have been helpful to have a consideration of cybersex affairs within this model.

Finally, the Relationship Difficulties in Families section addresses common developmental challenges for families: stepfamilies, high-conflict divorce, intergenerational relationships, health and illness in families and later life. James Bray summarizes his long-term research with stepfamilies and presents a detailed case with intervention strategies for a struggling family. His focus on the challenges to stepfamilies with adolescent children was particularly helpful since higher conflict may be expected at this point in development. Jay Lebow contributes his own chapter on high-conflict divorce families, focusing on families “unable to reach the minimal level of agreement . . . to stabilize the family” and for the approximately 10% of families for whom . . . “the judicial system looms as a constant preoccupation” (p. 520). His model is called Integrative Multilevel Family Therapy for Disputes Involving Child Custody and Visitation (IMFT-DCCV); it is notable for utilizing the very integrative approach that Lebow has espoused, and its specificity regarding aspects of family therapy when the court system is involved. As such it is a helpful addition to the literature of the past several years on the psychologist’s role in custody disputes.

In sum, this Handbook of Clinical Family Therapy does very well what Lebow designed it to accomplish. It has both breadth and depth enough to be useful to clinicians, while integrating the available empirical research with clinical process, and culling from diverse theories or conceptual models the core interventions of clinical action. It addresses the core research finding named by Lebow of the reciprocal impact of individuals and families. Alan Gurman and the late Neil Jacobson provided this complexity and integration a couple of years ago with the Clinical Handbook of Couple Therapy (3rd ed.; 2002) and this new family handbook will join that book in my clinical library, an up-to-date and useful resource for honing and enhancing specific interventions for challenging couples and families.

Glimpsing Family Life in Eastern Europe: August–September, 2005

Recently we took a cruise on the Danube River from Bucharest to Budapest, on a River Boat holding about 150 passengers. It turned out to be an excellent, convenient way to travel in order to visit small towns and villages and engage in close cultural contacts with the local people. We met and talked with local guides, walked through villages ravaged by war a mere decade ago, made home visits for lunch with local host families, and had university professors and other knowledgeable people from the specific locales come to deliver lectures and answer questions aboard ship—all as part of familiarizing us with the five countries we were visiting: Romania, Bulgaria, Serbia, Croatia, and Hungary.

After a day or two, I realized I needed a framework around which to absorb, organize, and try to comprehend all the material I was hearing, observing, sensing, and reading. What tumbled back into memory was a paradigm learned many years ago in a basic sociology course, used periodically since—and elaborated slightly below (the portions after the slash marks represent the additions).

Each society is made up of five basic interlocking and independent institutions:

• Family
• Political/Government/Military
• Economic/Financial
• Religious
• Educational/Cultural

As one institution changes, all of the others change reactively—just as is true in family systems. For example, when communism became the dominant political ideology, force and political system in Eastern Europe in the 2nd quarter of the 20th century, almost all vestiges of free enterprise disappeared and the state controlled all business and agricultural ventures. The USSR and its politburo determined who could study what and where, what they would be paid, and demanded that one’s primary loyalty be to the Communist Party, not to one’s family, one’s God or religion. Since religion was seen as offering a system of beliefs and guideposts for living that gave different and competitive meanings and values to life than communism did, attendance at and involvement in church (or synagogue) was actively discouraged and held to be suspect. Church attendance dropped off sharply, churches fell into disrepair, and priests and ministers could no longer exert much influence over non-existing congregations nor speak out publicly on behalf of humanitarian values without being imprisoned. Values were instilled by “the party”; the family and its influence was relegated to a low second place. If need be, one would turn against a family member on behalf of the party.

Now that the Communist stronghold has crumbled, a new and more variegated phoenix is arising in each of the break-away countries. Each has turned westward toward the European Union. Each country has recently joined NATO, and Hungary, which is the most prosperous, sophisticated and westernized of these five countries, is already a member of the EU. The other four countries are all preparing for entry, and have tentative acceptance dates ranging from 2007 to 2010. There have been various conditions placed upon acceptance that are the same for all countries, and which
include the cessation of graft and corruption. For instance, we did not see any of the black market money exchange practices that were easy to come by in our prior visits to Budapest in the early and mid-1980s. This is now all well regulated; there is also now much less bargaining with street vendors.

In light of my continuing special interest in International Adoption (Schwartz & Kaslow, 2003), I used the opportunity I had in Bucharest, Romania to query several knowledgeable lecturers and guides about the changing picture of Romanian orphans and the Romanian orphanages. The EU has told Romania unequivocally that it must be able to take care of its own children and not permit them to be adopted by families from overseas who sometimes pay exorbitant fees to a variety of people, like facilitators, for them (i.e., no more “selling” of children), a picture everyone is reluctant to acknowledge actually transpired. When I asked what has happened to the children, I was given two explanations: 1) The women are no longer having as many children; and 2) Romanian families are coming forward to adopt them. I could not get an explanation as to how the birth rate could have dropped so substantially so rapidly, nor where all of these Romanian families were coming from now when they had been non-existent or unavailable formerly. But this is definitely a qualification the EU has set for admission, and one the Romanian government and people are determined to meet. This was one of the few issues about which I found my questions evoked resistance to answering, so obviously it is a raw and sensitive one.

Generally, they see many benefits to becoming part of the EU. However, on the local level, families engaged in cottage industries are frankly worried that they cannot compete. As malls come to their areas and super markets a la Wal-Mart penetrate their local economies, they realize they will have difficulty marketing their wares. Those in Croatia who returned to their destroyed homes after what they called The Homeland War of 1991-1995, have been rebuilding their bombed-out, shrapnel-pierced homes on the small parcels of land returned to them, as close to the road as possible so that they can maximize the amount of ground used to grow fruits and vegetables – for their own consumption, and to sell whatever extra they can produce at the local market. They fear the encroachment of supermarket giants and already are competing with imports from Western Europe.

In Croatia our group was subdivided into small groups of 6 and 8 so we could go to private homes for lunch. Families there had responded to an advertisement; being selected for this program after careful inspection for cleanliness, excellent culinary skill, gracious hospitality, and some English-speaking ability was an honor. They are all given the same basic menu to prepare, and then can embellish it as they choose. They are licensed and compensated, and this has become a way of supplementing their meager incomes as well as of reconnecting with the outer world and telling their stories. Some have become what we would call licensed Bed and Breakfast Inns, new to their country, and part of the vanguard of what should become a fine tourist industry in this lovely Croatian countryside. Our hostess, Eva, cooked a marvelous lunch and had made her own slivovitz, an Eastern European brandy imbibed before meals, and a light cherry wine. She also had wine and other cooked goodies for sale, which we purchased. What she exemplified to us was the resilience and courage we saw and heard from everyone we spoke to. Eva emphasized how her family had clung together during the long years of the war and deprivation—hiding out together, sharing whatever they had in a 4-generation extended family. Now they continue living close to one another, and together when need be, as her mother and grandmother had done with her and her husband until they died. It truly is an all-for-one and one-for-all family mind set, and from this they draw strength. Any thought of labeling this “enmeshment” would be so erroneous.

In Serbia there is a different version of the war of the 1990s. Much sadness remains about the horrible conflagration. In many of their families, the ethnic strife was internal. To illustrate, the story one of our guides told was fairly typical of what we heard. Her mother was Catholic and born in Belgrade, which was then Yugoslavia. Her father was Eastern Orthodox, and born in what is now Croatia. One grandparent was Jewish and came from Hungary. All of the ethnic diversity had co-existed intrafamilial without problems for decades. During the war they had to choose sides, and the turmoil and inner struggle was intolerable. No matter the choice, some loyalty was breached, some hearts were broken. These wounds are still healing, as are the bullet and shrapnel wounds.

Yet beauty also is blossoming again. In the Bohemian artists’ quarter, where good restaurants abound, we ate across from this trellis-covered bistro. Many outdoor patios adorn this thoroughfare and the music of Eastern European composers is heard as one stroll by. The culture of the centuries lives on.

There is so much more to say, but space does not permit. In closing, I return to the original paradigm as it is generically applicable to the five countries today. The family seems to be cherished as the keystone of each society. The political systems are becoming increasingly democratic, and therefore the corresponding economic systems are more and more entrepreneurial and engaged in free market enterprise. Churches are being refurbished, and a variety of denominations are flourishing; people are not afraid to go to church and practice their religion. Conversely, those who are agnostics and atheists are free to pursue their own beliefs. Education is highly valued and everyone we met is pursuing the best possible education they can get for themselves and their children. They study hard and long hours, and see education as the way to be upwardly mobile financially. Many hope to be able to go to Western Europe or the United States to get a college education. They have many wonderful dreams and are doing all they can to fulfill them. And families help each member to get their turn to reach that elusive goal. Culture abounds with theatres, opera houses, concert houses and schools for the arts in every city and town and many excellent companies rendering performances.

If you have not been to these countries since the dawning of the millennium, they have much to offer that is informative and provocative. This trip gave a big boost to my resilience, also.

Reference

Welcome Home: An International and Nontraditional Adoption
Having a systems perspective doesn’t necessarily mean providing family interventions in a traditional way. Several years ago my colleagues and I decided to implement a parent education program. It made sense to us to include more of the multiple systems that influenced our students. After implementing the program, we were excited to see a good percentage of the parents changing their perspectives and subsequently changing the atmosphere in their homes. In order to make this program more accessible, we provided child care. In the interest of enticing more parents we designed services for children that required simultaneous parental participation in our parent groups. We included study skills, social skills classes, and teacher trainings.

In addition to these group approaches, the systems perspective we employed was also used in problem solving strategies for individual students. Over the years, when asked to see a student for individual counseling, we have moved the modality to work with the teachers and the parents, simultaneously to move the perspectives of the people involved with the student so that change is more likely. We are no longer looking only to the students to change but asking the teachers and the parents to look at their contribution to the behavior that is troublesome. We have a great deal of anecdotal confirmation that our approach is effective too. Our hope is that program evaluation will be part of our work in the future and that through our success we will shorten the gap between the discovery of effective interventions and practice.

The professional community believed that part of the motivation for establishing this commission was a series of several articles in the New York Times that discussed whether forensic psychologists had too much power in evaluating custody disputes and whether some judges deferred to their recommendations.

Many forensic psychologists believe that there are problems with the divorce process in NYS. Coming from a family systems perspective, I saw the appointment of this Commission as a potential change point and knew I had to give input. In my testimony, an attempt was made to address some of the system problems, i.e., problems related to the interaction of the mental health and legal systems and how the legal system uses forensic psychologists. One example is that many judges in NYS will not appoint a forensic psychologist unless that professional is willing to make recommendations about the ultimate issue. Some of these issues were discussed in the workshop: Grossman, N.S., Okun, B.F., Connell, M., Gindes, M., and Heilbrun, K., Child Custody Evaluations: Uses and Misuses, American Psychological Association Annual Convention, August 2005.

The following are excerpts from my testimony:

This presentation will cover areas of child custody evaluations (CCE) and interventions with high conflict families. Written material will be submitted.

A. The existing process for divorce
If we designed a system dealing with divorce & custody, I doubt it would look like what we have. The challenge is how to move from what we have to a process that would work better.

We could examine the process and attempt to identify its strengths and weaknesses. I believe that problems can be found at all levels. Some are built into the system and others are caused by the way individuals work with and interact with the system. My focus today is on problems under the control of the judiciary.

B. Specific Focus on CCE
The purpose of a CCE is to inform the Court about the parents and children and to suggest factors that should be considered by the Judge in reaching a decision about custody and developing a parenting plan.

There are problems with CCE.
1. Some people doing evaluations are not qualified.
2. Some people who are qualified do a poor job.
3. There are problems with how a CCE is used.

The forensic evaluator is often asked to make custody recommendations. This is under the assumption that when seeing these recommendations a number of litigants will be prompted to settle.
There are questions we need to answer about CCE:
1. What should be the minimum qualifications and training for professionals?

A number of guidelines from professional organizations exist. However, these do not specify what training and experience is sufficient. We need to establish these criteria. Some basic guidelines are readily available, but Judges do not always use them in appointing a professional. For example, in some instances, non-licensed professionals have been appointed.

2. What should be the scope of a CCE? What issues should be evaluated?

CCE should be used to rule out whether personality issues should be a factor in determining custody. A CCE can be helpful when it is important to have an understanding of family dynamics, parenting capacity, or the extent to which, family violence is an issue.

3. How can we determine the quality of CCE?

There are many appropriate ways to conduct a CCE and the same evaluator may use a different approach based on the particular family or the issues addressed. However, there are minimum standards that can be agreed on.

Why are Courts appointing evaluators who do not meet the minimum standards? Professionals who review CCE for rebuttal find that evaluators who use inappropriate procedures and tests are appointed and continue to be appointed. Judges may not know what is appropriate and may need more training in relation to this.

Regarding rebuttals: Why do attorneys ask the peer-review expert to interview some of the parties? This is not appropriate. The rebuttal expert should limit the review to the manner in which the evaluation was conducted and the written report. Are judges permitting testimony beyond this into the court room?

4. How do we educate Judges, attorneys, and custody evaluators about the minimum standards and how to assess the quality of an evaluation?

It would be helpful if feedback was given on the quality and adequacy of an evaluation. Perhaps there could be reviews involving custody evaluators, attorneys and judges where, with identifying information removed, a custody evaluation was critiqued.

III. How the court uses information provided by the child’s therapist.

Problems occur when mental health professionals who are not knowledgeable about the dynamics of divorce provide information to the court. The court needs to know how to determine whether the child’s therapist has appropriate expertise regarding divorce and will provide useful information.

Numerous times well meaning professions, who are treating a child, give erroneous or incomplete information to the Court that is taken as valid, and relied upon, when making important decisions.

IV. New interventions for high conflict families:

1. A Parenting Coordination Pilot Program has been started in Nassau County in conjunction with the Supreme and Family Courts. It is hoped that once the program is fine tuned it will be adopted throughout NYS.

2. Case Management is another important approach to working with high conflict families. It is underutilized.

Recommendations

1. Every judicial order should be considered a therapeutic intervention – similar to therapeutic jurisprudence.

2. When we think of the outcome of a divorce we should also look at the post-divorce adjustment of the family in addition to the legal divorce.

3. Judges and the professional groups representing child custody experts should work together to identify what qualifications are needed to conduct an evaluation, what is the sufficient training and experience and what are the minimum standards.

4. Some CCE should be subjected to blind reviews as a training tool for judges, attorneys and child custody evaluators.

From the President
(continued from p. 1)


Kagan Paul.

Academy of Family Psychology

John E. Northman, PhD, ABPP, President

As the calendar turns to a new year, the Academy of Family Psychology continues to turn toward Division 43 members as the primary source of candidates to apply for the ABPP diplomate in Family Psychology.

Ask yourself a few questions.

• Do I have a background in family psychology?
• Am I licensed to practice psychology?
• Do I practice with children, couples, and families?
• Do I wish to stand out among my colleagues?
• Do I wish to be at the top of my field?

If the answers to the above questions are “Yes”, then it’s an easy, “doable” step to attain the preeminent professional credential, the ABPP diplomate. The top-level status of the ABPP diplomate, and the steps to attain it, have been outlined in an excellent annotated flowchart. Prepared by Mark Stanton and Rodney Nurse, this article titled “The Development of Family Psychologists” appeared in the Fall 2005 edition of The Family Psychologist.

AFP/ABFamP Scholarships

How “doable” is the ABPP diplomate? Let’s first talk cost. As of this past fall, the Academy of Family Psychology and the American Board of Family Psychology, working together, have contributed $1,000 each to make available $100 scholarships for the first 20 applicants to successfully complete ABPP board certification (diplomate) in family psychology. Since September 1 several scholarship candidates have already begun the application process.

AFP Mentoring

Following initial submission of application materials, a candidate can request a mentor to assist in any way possible. The position of mentoring chair is the responsibility of the president-elect. In his role as mentoring chair, AFP president-elect John Thoburn has developed a one-page outline of the mentoring process. The goal is to help every qualified applicant succeed in attaining the diplomate, and connection with a mentor can be most helpful in making that happen.

Yes, attaining the ABPP diplomate is eminently attainable. To begin the process, download an application from the ABPP website (abpp.org) or contact Nancy McDonald at the ABPP office (800-255-7792).

AFP at Division 43 Midwinter Meeting

In the Fall 2005 issue of The Family Psychologist, I thanked Mark Stanton, 2005 Division 43 president, for his key role in bringing together the leaders of the four family psychology organizations: Division 43, the Academy of Family Psychology, the American Board of Family Psychology, and the Family Psychology Specialty Council. The four-way meeting during the APA convention this past August was most productive. This February, at the gracious invitation of Cindy Carlson, 2006 Division 43 president, AFP will be making a presentation at the Division 43 midwinter board meeting in San Antonio. Assisting me with the presentation will be Mark Stanton on going through the process from the candidate’s perspective, Florence Kaslow on the process from the test examiner’s perspective, John Thoburn on the mentoring process, and Irene Goldenberg on the senior option.

Recognition…and Mobility

Unlike ABFamP, which administers ABPP examinations and has no “members” other than its elected board, AFP is a membership organization. As such AFP can conduct a wide array of activities for the benefit of its members.

There are currently 13 specialty ABPP boards, and each has a corresponding academy comprised of board certified members. Four times annually the presidents of all 13 academies meet via conference call. Working together to pursue common goals, the Council of Presidents of Psychology Specialty Academies (CPPSA) has now become incorporated and as such is now joining the American Association of Medical Colleges (AAMC). Joining the AAMC brings with it increased visibility, representation and recognition of ABPP board certification.

Mobility has long been an issue within psychology. Currently 34 jurisdictions recognize ABPP in some manner as part of their licensing process. A current CPPSA goal is recognition of ABPP by all states and provinces in the licensing process.

AFP at 2006 APA Convention

At the most recent AFP quarterly board meeting (yes, the AFP board now holds conference call meetings four times per year), we began to outline plans for activities at the APA convention in August 2006. Many ideas were discussed, including social as well as professional activities. Stay tuned.

School-Related Interventions...

(continued from p. 5)

(e.g., substance use, criminal activity, out-of-home placement), this is due primarily to the logistical challenges of the corresponding research methodology (e.g., high cost, the research participants change schools frequently, and administrative records are often lacking), rather than to a view that school-related outcomes are not a high priority. Indeed, we are currently pursuing funding to evaluate an innovative educational/vocational program for troubled youths, using MST programs as the platform for the research.

References

This is my last report as your Division 43 Council Representative. My second term on the APA Council (6th year) is over and it has been a “priceless” opportunity and honor to work for you and serve the APA and our profession. Our new Council Representatives, Drs. Florence Kaslow and Susan McDaniel, will continue to represent us even more effectively than I. Dr. Kaslow will be returning to Council and Dr. McDaniel will start her first term. Both are highly respected and experienced in the politics of APA. The Division’s interests will be well served with their representation.

During my tenure I learned a great deal about the breath and depth of psychology and how the APA works or sometimes doesn’t work. I am proud of a number of accomplishments that occurred during my time on Council. Several issues that were Division priorities were addressed by the Council. These include having Family Psychology recognized as a specialty in the field, passing the multi-cultural guidelines, promoting the role of psychologists in primary health care systems, gaining federal funding for graduate training in psychology, expanded funding for science programs, and many others. The APA is in excellent financial health, with a $90+ million budget, a new and effective CEO, Dr. Norman Anderson, and a hard working, professional staff of hundreds. The APA has become a strong, effective political force for practice, education, science and public policy in Washington, DC—it is now the case when APA speaks, “others stop and listen.” And yet there is much more to do to enhance our profession and address the psychological needs of our nation. It is in that context that I look to the future.

The Future—APA President

With the encouragement and support of many colleagues, I have decided to run again for APA President in 2006. I came in a close 2nd in 2002 and feel it is the right time for me to seek the presidency. I would like to continue our work to make psychology a full partner in the healthcare system, increase funding for psychological science, and expand our work on diversity and serving the underserved. I would greatly appreciate hearing from you about issues that you would like the APA to address.

The nominations ballot for APA President will be sent out in February 2006, so I hope you will keep me in mind. Please contact me if you would like to help me with my campaign.

It has been an honor to serve you as council representative and on the Division board of directors—I will miss this, but look forward to greater service as APA President. Please contact me (jbray@bcm.tmc.edu or http://www.bcm.tmc.edu/familymed/jbray) if you would like further information about the Council’s activities or my campaign.

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The set of feature articles in this issue and the symposium at the annual meeting of APA where versions of these articles were presented point to several dramatic developments in family therapy and family psychology:

1. “Family” assessment and “family” therapy are increasingly, to use Scott Henggeler’s term, multi-systemic. Systemic understandings do not stop at the boundary of the family.

2. Of the other systems beyond the family that must be considered in the treatment of adolescents, there is no system more important than the school. School performance provides an important foundation for later life. In particular, poor school performance and dropping out of high school are major risk factors for innumerable difficulties. Schools are crucial in other ways as well: as a source of information about the impact of treatment, as a source of information about factors important to be addressed in sessions, and as a valuable site for the delivery of treatment.

3. The articles in this issue highlight some of the wonderful developments in evidence based treatments in family psychology over the last decade. Work is presented from four different groups who have produced empirically supported therapies for externalizing problems in adolescents: Multidimensional Family Therapy, Multi-Systemic Therapy, Functional Family Therapy, and the Oregon social learning approach to prevention and treatment. Each of these treatments is highly effective, and each impacts on school performance as well as on other outcomes.

4. Ultimately, family psychology owes a considerable debt to NIDA for its support of the development of research on family based treatments. The process of treatment development and testing is one that is highly dependent on government support. NIDA identified early on the vital role families can have in helping resolve difficulties and family therapy can have in treatment. As early as 1980, NIDA put out requests for proposals that provided much of the initial momentum for research examining the impact of family therapy on adolescent substance abuse. Over the last twenty years, NIDA has broadly supported treatment development of family based therapies and research assessing the efficacy of these treatments. To see the extent of this impact, one has only to compare the substantial body of research on family based treatments of adolescent substance abuse and externalizing disorders with the extent of such treatment development and testing in relation to adolescent internalizing disorders, such as depression. The agencies responsible for funding of research on internalizing disorders, such as the National Institute of Mental Health, have not taken the proactive stance that NIDA has toward family treatment, and, thus, there has been much less in the way of treatment development and testing of family based treatments targeted at these disorders.