

Chapter 9

School-Based Community Family Therapy for Adolescents at Risk

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Paradigm Shift

The transition from an individual- to a relationship-oriented paradigm constitutes the decisive epistemological turning point in the evolution of psychotherapy during the twentieth century. This shift happened in all fields of human endeavor. Post-Newtonian physics, especially quantum mechanics, cybernetics with technological innovations such as the computer and the internet, microbiology, literary criticism, sociology, anthropology, ecology, chaos theory, hermeneutics, and related developments in philosophy (phenomenology, existentialism, structuralism, post modernism) all represent expressions and indications of the same epochal movement of the human mind (Auerswald, 1987, 1990; Bateson, 1971,1979; Capra, 1984). A mechanistic worldview of fixed entities, objects, material things that exist as real "out there," independently from an observing mind, was balanced by an ecological view emphasizing the interdependence of all beings, particularly human beings, and including the observer in the observed field. In this ecological perspective, our relationship to other human beings as such is unique and profoundly different from the connectedness of material objects. We find ourselves in relationship to other human beings and challenged into responding to the other, that is, an individual who is "other" to us, before we can make a choice about being related. This openness toward and for the other and, in fact all others defines our very uniqueness as individuals. Relatedness to others constitutes the self as such (Davis, 1996; Levinas, 1961/1992, 1974/1981).

Personal experiences with partners or friends, mass phenomena that led to genocide or ethnic wars, or the interdependence of nations on a global level equally have taught us to conceptualize individuals as embedded in a network of personal, socioeconomic, and global relations. The same holds true for larger units, such as a city or a nation. The individual, the self (i.e., the traditional subject of psychological inquiry and consideration), is woven into comprehensive intersecting networks to a degree that it threatens to disappear behind the various collectives and totalities (Mikesell, Lusterman, & McDaniel, 1995; Rabinow, 1984; Wetzel, 1994a, 1994b).

This movement of the collective mind during the past century is definitive. A return to a naive realism or individualism is not possible. Rather, we are faced with living in two worldviews: the mechanistic world of things, which we can manipulate and which are in multiple ways interconnected; and the human, interpersonal, relational world of people and societies, where individuality and personhood are constituted through relatedness to others. In this worldview, as observing, thinking people, we are part of the observed. There is no

objectivity; and we interact with others with whom we are already in a relationship prior to the act of reflecting and interrelating.

History of the Therapeutic Approach

Family Therapists Discover the Other: The History of the Relational Paradigm

The relational orientation in psychology and psychotherapy forms part of the overall paradigm shift during the twentieth century. It is fitting that systemic couples and family therapy grew out of the experiences of psychiatrists and psychologists during World War II and the postwar years. Therapists discovered what social workers had always seen: the emotional power of families and the dynamics of dyadic units such as couples that deeply influence the experience of the individuals involved (Hartman & Laird, 1983). Out of initial intervention strategies, entire schools of thought and particular focus arose and led to the training of a new breed of therapists and initiated a new profession: systems therapy for families, couples and, in some instances, individuals.

Community Health Centers

Initially, the new movement of family-systems therapy was focused on people who often could not afford private, individual, long-term therapy psychoanalysis. Together with other efforts to expand the social-welfare network (Head Start, President Johnson's anti-poverty programs), the community-health and mental-health centers network began to make therapy available for people in poverty areas and in ethnic neighborhoods who would otherwise never have received psychiatric or psychotherapeutic care (Schorr, 1997). Structural Family Therapy (Fishman, 1993; S. Minuchin, 1974; S. Minuchin & Fishman, 1981; S. Minuchin, Guerney, Montalvo, Rosman, & Schumer, 1967) and research into the communication processes of families with a schizophrenic offspring (Bateson, 1971; Schefflen, 1981; Sluzki & Ransom, 1976; Wynne, 1988) exemplify applications of systems models particularly fitting for couples and families outside the mainstream of psychotherapy. Recognition of local community initiatives and concern for people who live in poverty, under conditions of racial and social oppression and without access to affordable medical treatment, led to the establishment of community health centers and, in the mental health field, community-oriented approaches (Auerswald, 1983; Brown & Parnell, 1990; Simon, 1986; Wistow, 1986) and to the growth of family systems therapy in the 1960s and 1970s (S. Minuchin et al., 1967; Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996).

Stagnation of Initiatives

Two developments contributed to the stagnation of initiatives applying the principles and practice of systems therapy to the unfamiliar worlds of poor and ethnically diverse family groups. First, family therapy matured gradually into one of the accepted models of psychotherapy, similar to behavior therapy, rational-emotive therapy, and psychoanalysis. Family therapists, therefore, became a respected group of professionals and researchers who were less likely to branch out into the chaotic worlds of youngsters growing up in urban or rural poverty areas. Similarly, the development of the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2000) by psychiatrists reflected a more medicalized view of human behavior. Family and couple therapists began to adopt a diagnosis-guided and pathology-oriented perspective on psychological disorders. Often, they ended up with uneasy compromises between the epistemological basis of family systems therapy (i.e., its focus on relationship, its inclusion of therapists as part of the systems that we observe and interact with in therapy, and therapists' orientations toward the relational contexts of an "identified patient") and the requirements of a professionally acceptable practice (i.e., focus on the individual who has insurance benefits, diagnosis of the individual instead of assessment of the dynamic family system, need or pressure to prescribe medication, and suggestions of hospitalization).

Second, the advances of pharmaceutical research have resulted in the medical treatment and, often, cure of conditions that hitherto were considered fatal (e.g., polio, tuberculosis, small pox). These advances, together with the establishment of health maintenance organizations, supposedly to better manage health and mental health care, also favored reductionistic thinking and the widespread prescription of psychotropic drugs based on poor research and little or no regard for the relational aspects of an individuals' symptoms or behavior or for the societal impact of these drugs. The health and mental-health fields have become subject to narrowly defined pharmacological interventions. Psychopharmacology in many ways has supplanted psychotherapy. Individual human behavior is being regulated by the prescription and use of drugs researched and promoted by the pharmaceutical industry. This exclusive, medically guided focus on mind-altering drugs for problem behaviors viewed as brain disorders as the treatment of choice for many mental health conditions, including those of adolescents, made it more difficult to advocate for psychotherapy in general and family therapy in particular (Breggin, 1999).

Many Family Forms

In recent years, one can observe another shift in the field. Family therapists are overcoming their exclusive focus on the mythological (Coontz, 1992, 1997, 1999) white, middle-class, nuclear family, and fewer therapists are Euro-American. Family psychologists are increasingly aware of the normative influence of the dominant discourse about family life in general. Family theoreticians and researchers have expanded and deepened their perspectives to recognize the enormous diversity in ethnic culture, socioeconomic class, gender, sexual orientation, and religious traditions among the families they encounter. Single parents, poor families, ethnic and religious minorities, gays and lesbians, the chronically sick, older people, criminals, drug- and alcohol-addicted people slowly became visible to the community of relationship-oriented therapists (Inclan & Ferran, 1990; Wetzel, 1998a). Therapists can now see them as representing one of many diverse family forms, each with often considerable strength and resilience as well as uniqueness and vulnerability (Coontz, 1997).

Therapy with Outsiders

People traditionally invisible to Eurocentric family therapists became a focus for research and practice (Wynne, 1988), especially for therapists who did not think in abstract-formalistic systems categories alone, but were able to perceive the unmistakable uniqueness of a specific relationship context that wove individuals and families together in powerful ways. These professionals had the capacities to be impressed by the mundane phenomena in the lives of others (Auerswald, 1968, 1983). They perceived the special vulnerabilities and strengths rooted in the embeddedness of an individual or family in context, even though these were alien to therapeutic observers leading middle-class lives.

Applying the relational paradigm to other than the middle-class family world involves therapy with people who live outside of middleclass society and the professional world of therapists. For many therapists, especially Euro-Americans, this process essentially constitutes an attempt to step out of the professional work context they are accustomed to and to bring the practice, concepts, insights, and creativity of systems thinking to bear on their work with people who live in areas defined by poverty, scarcity of jobs, substandard housing, and the ubiquity of drugs. The people living in these inner-city neighborhoods remained largely strangers to therapists, who rarely encountered them other than in the contexts of social-welfare agencies.

The Transformation Process Includes Therapists

These "strangers" live in schools and communities of the inner cities and in neglected rural areas. They teach therapists with European, middle-class backgrounds who listen carefully about their lives and their particular vulnerabilities and strengths. Everybody who becomes engaged in this work experiences a transformation process that originates in the encounters of strangers (Kristeva, 1991; Wetzel, 1994b). The school-based, community-oriented Family Intervention and Empowerment Program (FIEP) in New Jersey inner-city high schools exemplifies one project bringing together people from largely different backgrounds and experiences (Wetzel, 1998b). Therapists, clinicians, and supervisors with diverse cultural heritage had to learn how to listen to each other and to "see" from a specific perspective. The encounters between the teams (family therapists and community resource specialists) and the adolescents at risk (for drug abuse, school dropout, and criminalization) led to a profound reorientation of family therapeutic practice, on both the levels of personal experience and of conceptual reflection. In such a process, therapists reconnect with courageous approaches from the early phase of family therapy. At the same time, this practice constitutes the establishment of a renewed future for family therapy and theory beyond the middle-class and the dominant culture (Madsen, 1999; P. Minuchin, Colapinto, & Minuchin, 1998).

The comprehensive, resource-based, and community-oriented quality of FIEP is rooted in the awareness of the crucial importance of the psychological and socioeconomic factors affecting people's lives. It also originated in the conviction that people have the abilities to cope with their problems when provided with adequate support. The approach is based on the pioneering ideas and groundbreaking work of the early community health centers and of the originators of family therapy (Broderick & Schrader, 1991; McDaniel, Hepworth, & Doherty, 1995; Wetzel, 1998)

Approaches and practices similar to the New Jersey FIEP model include:

- Multidimensional Family Therapy for Adolescent Drug Abuse, a clinical research program under the leadership of H. Liddle and J. Szapocznik at the Center for Treatment Research on Adolescent Drug Abuse at the University of Miami, School of Medicine (G. S. Diamond & Liddle, 1996, 1999; G. S. Diamond, Liddle, Hogue, & Dakof, 1999; Liddle, 1995, 2000; Szapocznik & Kurtines, 1989, 1993).
- Functional Family Therapy, with affiliated sites around the country, centered around J.

Alexander (University of Utah) and T. Sexton (Indiana University) (Alexander, Pugh, & Parsons, 1998).

- The structured Strengthening Families Program led by Karol Kumpfer, University of Utah (Kumpfer, 1994).
- The FAST program (Families and Schools Together), also structured, initiated by Lynn McDonald, Wisconsin Center for Education Research, University of Wisconsin Madison, with centers in many states (McDonald & Frey, 1999).
- The therapeutic work rooted in the Philadelphia Child Guidance Clinic and in structured family therapy (Lindblad-Goldberg, Dare, & Stern, 1998; Lindblad-Goldberg & Dukes, 1985)
- The practice and research led by members of the Graduate School of Applied and Professional Psychology, Rutgers University (Boyd-Franklin & Bry, 2000).
- The work connected with the Family Institute of Cambridge, Massachusetts, described by Madsen (1999).

Conceptual Foundations

Post Modern Diagnosis and Assessment

The process and experience of encountering the unfamiliar world of adolescents at risk makes it plain that the approach represented in projects such as the FIEP model rests on several assumptions. First, therapists need the ability to understand and work through their usual predispositions and preconceived notions, so that those living in inner-city or impoverished rural neighborhoods will be able to open up to them and teach them about their world. Second, what therapists see and learn about the world of the other depends on the perspective they take and their capacities to listen. Rather than assuming that they know what life is like for these youngsters and families or presupposing that their views are accurate, therapists need to take a post modernist stance. They must let the young people and the families teach them. They need to listen and remain open for surprises and for what Gregory Bateson (1971) called "second order learning." In practice, this means employing a set of variable lenses that allows an outsider to perceive the multiple facets of families' realities. These basic attitudes of listening, willingness to learn, and curiosity are crucial not only to Euro-American and middle-class therapists working with an inner-city population, but also, in

varying degrees, for all therapists with cultural, racial, and socioeconomic backgrounds different from their clients'. We can never disregard the degrees to which racism, sexism, and class domination are institutionalized in society.

The Kaleidoscope

A kaleidoscope of seven perspectives or lenses helps in comprehending the various unique contexts that affect the experiences of the young people in inner-city ghettos. These perspectives themselves originated in the surprises contained in the encounters between project consultants with European background and middle-class lifestyle and high-school students with African or Hispanic heritage who grew up in a socioeconomic context of continuous deprivation (Wetzel, 1998b).

Looking at the reality of U.S. youth in impoverished inner-city and rural neighborhoods and endeavoring to understand their experiences, family therapists involved in various studies and projects (Alexander et al., 1998; Boyd-Franklin & Bry, 2000; Liddle, 2000; Lindblad-Goldberg et al., 1998; Wetzel, 1998b) learned to open the foci of their observing lenses wider to contain, if possible, the totality of people's relational and societal contexts. Specifically, it is helpful to conceptualize the various approaches to understanding adolescents in their relational contexts with the following seven lenses or particular perspectives in mind (Wetzel, 1998a):

1. A student's or family's *socioeconomic* class and *employment situation*.
2. Identification with a particular *ethnic heritage, culture, and race* and the family's *immigration experience*.
3. A teenager's gender-role experience and *gender identification*.
4. A youth's *sexual orientation*.
5. An adolescent's *religious experience and spirituality* and a family's *involvement* (or lack of) with *local places of worship and faith communities*.
6. A youngster's individual *bio-psychosocial development* and maturational age.

The conceptual and professional reflection regarding the interdependence and crossover effects among the various factors that become visible with these seven perspectives is only beginning [Cornas-Diaz & Greene, 1994; McGoldrick, 1998]. For the team members and consultants of the FIEP, it is indispensable to approach a teenager's experience of life in the inner city with these seven lenses in mind. Among the numerous influences that form a person's (or family's) experiences, the factors that become visible with the seven lenses are particularly

crucial for the conceptualization of treatment planning and for the success of any intervention.

The seven lenses allow a participant-observer to engage in a number of assessments. First, it is possible to perceive and assess the degree of alienation, even suspicion, or familiarity that exists between family and therapist (Falicov, 2000). Without a clear understanding of the exact nature of the relationship between client family and therapist, therapy cannot succeed because the human relationship between them will fail. Second, these categories make it possible to conceptualize the level of similarity or difference in a specific family, the neighborhood community, and the surrounding society. Third, therapists begin to appreciate the complexity of family reality made visible through these perspectives when they notice how powerfully these factors influence each other.

With the use of these diverse lenses, family therapists show the courage of earlier days. They break out of the confines of professional family therapy as a treatment modality among others and use systems thinking as a paradigm for understanding human problems and dilemmas in a relational context. They risk being labeled again as subversive or as breaching the boundaries between professional clinical work and political activism.

Diagnosis

From this point of view, diagnosis evolves into a highly complex process (Kaslow, 4). Relational therapists look at an individual and family in context, using the seven lenses and including their own relationships to the observed families. Any diagnosis has to include as referent, therefore, the perspective that has been used and awareness of the limitations of each particular view. Therapists also cease to search for pathology, a concept from the objectivistic worldview. They become reluctant to prescribe or suggest psychotropic medicines because the context-oriented perspective used in the FIEP model and similar programs usually highlights factors that would make it an improper reduction to see the problem behavior in question as a brain disorder. Adopting a much more comprehensive view, therapists find it easier to discover a given family's particular strengths and stresses. Most of the projects described earlier start with children and/or adolescents at risk and construct a version of an "interactional assessment" as part of the initial contacts (Madsen, 1999).

In part, because of similarities in ethnic and socioeconomic backgrounds, the FIEP team members brought from the outset an intuitive and empathic understanding to their encounters with inner-city teenagers. With the seven lenses in focus, they could highlight aspects of the adolescents' and their families'

lives that otherwise would have remained hidden from view or may have been ignored in planning a treatment strategy leading to empowerment, self-reliance, and community involvement (Ivey, Ivey, & Simek-Morgan, 1993).

Family therapists' experiences with the contexts of poverty, joblessness, and mutual self-help in inner-city and rural areas and their effects on family life (Ambert, 1998; Aponte, 1994; Inclan & Ferran, 1990; Wilson, 1997, 1999) make a compelling case that specific models of comprehensive care geared toward people, especially children and teenagers, living in poor communities need to be collaborative and need to reflect people's experiences of living in these neighborhoods.

Studies highlighting the relevance of ethnicity, culture, and race to family therapy have recently increased significantly in number and quality (Falicov, 1983, 2000; Fowers & Richardson, 1996; McGoldrick, Giordano, & Pearce, 1996; Pinderhughes, 1989, 1990; Saba, Karrer, & Hardy, 1990; Szapocznik & Kurtines, 1989, 1993). Many common assumptions and theories considered universal regarding psychosocial development, family dynamics, and therapeutic process are unmasked as Eurocentric when the experiences of people from different cultural and racial traditions are taken into account (Thomas & Sillen, 1979). In the ways they begin to overcome their initial mistrust, adolescents show clearly whether they feel their cultural heritages and racial identities are taken seriously by the professionals they meet (Liddle, 1995).

There is also a well-developed body of literature about gender-related aspects of treatment (Comas-Diaz & Greene, 1994; Goldner, 1985; Hare-Mustin & Marecek, 1990; Philpot & Brooks, 1995; Pravder Mirkin, 1994; Weingarten, 1994). In fact, professionals using the gender perspective deconstructed for the first time many common myths, assumptions, and unreflected practices in psychotherapy that were taken as universal and revealed them as white, male-oriented prejudices. The effects of differences in students' sexual orientation on context-sensitive treatment still need to be fully explored (Goodrich, Ellman, Rampage, Halstead, 1990; Laird, 1994; Savin-Williams, 1998; Scrivner & Eldridge, 1995).

The family-therapy field, for the most part, has finally begun to include appreciation for religion and spirituality as traditions with enormous impact on the interpretation and meaning of life and death (McGoldrick, 1998; Walsh, 1999; Wright, Watson, & Bell, 1996). In rural and inner-city lined neighborhoods, faith communities and religious congregations play crucial roles as sources of strength, comfort, and a sense of belonging.

Any program devoted to inner-city neighborhoods needs also to direct its focus to the individual student, specifically to his or her appropriate maturity,

and biological, psychological, social, and moral development. A thorough and contextualized understanding of adolescence as a phase of individual and family life needs to be part of the perspective with which family therapy teams approach their work in inner-city high schools (Fishman, 1988; Liddle, 2000). The professional community is only at the beginning of the process of assessing how specific aspects of cultural background and childhood upbringing or life in a poverty-stricken and drug-contaminated neighborhood influence the experiences of teenager.

Finally, close attention has to be paid to teenagers' and families' medical and mental health and health-care conditions (Landau, Stanton, & Clements, 1993; Wright et al., 1996). Alcoholism and drug abuse or drug addiction pose factors that have particularly destructive consequences for high-school-students' lives (Kaufman & Kaufman, 1979; Krestan, 2000; Stanton & Todd, 1982; Steinglass, Bennett, Wolin, & Reiss, 1987).

Clinically and conceptually, beyond applying these seven perspectives to the daily experiences of teenagers and their families in urban and rural poverty areas lies the even greater challenge of using the kaleidoscope of the seven lenses as a multidimensional matrix (Kliman, 1994) to stimulate curiosity and understanding of their complex interplay. Recently, several authors (Boyd-Franklin, 1995; Carter & McGoldrick, 1999; Kleinman, 1980; Kliman, 1994; Moore Hines, 1988; Parnell & Vanderkloot, 1994) have addressed this multifaceted interaction (Wetzel, 1998a).

An Unfamiliar World

Living in the Inner-City

Some U.S. inner-city neighborhoods at times resemble areas of poor developing countries. Surrounded by the ostentatious wealth resulting from the longest economic boom in U.S. economic history, children and teenagers in these areas do not live just in a context of poverty (Ambert, 1998). The environment outside their families is defined by deprivation and humiliation. Each glance at the TV and each foray into the well-to-do suburban neighborhoods reinforce in residents of poverty areas the notion that there is something wrong with them. They experience themselves as second-class citizens, marginalized, without the hopes of their more affluent contemporaries, invisible to the mainstream public (Ellison, 1947; A.J. Franklin, 1993), yet scrutinized by shopkeepers and "profiled" by the police. They are from the outset at a disadvantage in desegregated schools.

Families and teenagers from neglected inner city neighborhoods hardly seem to count for the politicians, are of no concern to the executives of big corporations, and are hardly mentioned in the media (except when reporting crimes or fires) or in the broader public debates

of the day. People from the surrounding society seem to have so much more at their disposal: material possessions, public respect, political influence, community services, and economic power. Young people from these areas learn that they have less power over their lives because of the neighborhoods they live in (with so many societal outcasts) or because of the color of their skins or their languages or all these factors together. Interactions with representatives of the dominant society (social-welfare offices, police, city and state bureaucracy, hospitals) often end in discouraging ways because even well-meaning gestures and initiatives for help carry with them the aura of condescension. Beyond the realm of their families and kinship networks, members of the local communities or teachers and other personnel from the inner-city high schools become the only ones who show interest in them and convey to them a sense that they are worthy of support and assistance.

The Socioeconomic Perspective

People in many inner-city areas of the United States live in an environment of progressive poverty (Ambert, 1998; Imber-Black, 1990; Inclan & Ferran, 1990; Wilson, 1997). Once flourishing manufacturing enterprises have moved away or abroad in search of a cheaper labor force. Small businesses in the neighborhoods could not survive. Entire districts gradually ruined through neglect or destroyed by fire and looting during the ghetto revolts or urban revolutions of the 1960s are only now being rebuilt. Grocery stores, bank branch offices, neighborhood restaurants, churches, public transportation, hospitals, daycare centers, police stations, in short, the infrastructure of a traditional neighborhood ceased to exist in many small towns and inner-city areas. The drug trade, constant danger from gun violence, the AIDS epidemic, and the erosion of housing contributed further to the deterioration of the quality of life in the inner cities (Pravder Mirkin, 1990).

Many people in these areas work full-time, yet find it very difficult to rise above the poverty level despite long hours in low-paying jobs without health-insurance or other benefits (Ambert, 1998). Only recently have state governments established health-insurance programs for people with incomes below a certain level. Most people from impoverished areas do not have the necessary training for jobs in computer-related fields, even if the opportunity existed in inner-city areas. Through the initiatives of federal and state governments, new job opportunities were set up by granting economic incentives and tax relief for local businesses, yet these measures met only partly with success. Frequently, the necessary job-training and general-education programs were missing. The industries newly established in the neighborhoods did not add jobs for unskilled workers.

And the tax relief for new companies, until recently, often prevented the financially strapped city-governments from building the required infrastructure (i.e., connections to the public transit system, schools, local neighborhood centers, hospitals). Even the most recent initiatives to expand jobs for people on welfare often prove unworkable for single mothers who are unable to get to work without public transportation, cannot find access to daycare centers, cannot afford medical care for their children or themselves, and spend long hours each day to get to welfare offices, employment centers, or hospital emergency rooms.

Consequences for the Structure and Processes of Families

The consequences of the chronic scarcity of jobs in the inner cities prove worse than poverty itself: "The disappearance of work has adversely affected not only individuals, families, and neighborhoods, but the social life of the city at large as well ... The consequences of high neighborhood joblessness are more devastating than those of high neighborhood poverty" (Wilson, 1997, p. xiii). Socioeconomic data on joblessness, poverty, homelessness, and illness reflect the unraveling of the social fabric in the inner city (Wilson, 1997, 1999). These environmental factors constitute part of the daily experiences of young people in poor neighborhoods. Material deprivation, hunger, inadequate housing, and the absence of work alter the processes and structure of the families themselves and profoundly affect people's cognitive, emotional, and social functioning as well as physical health (Ambert, 1998; Aponte, 1994; Boyd-Franklin, 1995; D. L. Franklin, 1997; P. Minuchin, 1995). In this context, Madsen (1999) spoke of "multi-stressed families."

Strengths and Resources

Drug and alcohol abuse, physical and sexual violence, the high rate of teenage pregnancies, school dropout rates of up to one half of the students in the higher grades need to be understood in part as effects of the increasing marginalization, fragmentation, and demoralization of families in inner-city districts (Wilson, 1997). Families in these areas struggle to survive in a context of economic impoverishment, regularly experienced racial oppression, and often-witnessed institutional or personal violence. Without proper health and adequate nutrition, they are more susceptible to physical illness. Parents, especially women who are single heads of households, have to overcome difficult hurdles daily to stay afloat economically.

Entering the world of poor families presents a challenge to therapists in multiple ways. In P. Minuchin's

(1995) words, the "consideration of poor, multi-crisis families suggests that family therapists must move in a different direction: toward context, rather than toward the elaboration of internal family characteristics" (p. 124). Supposedly, in North American society, everybody has the chance to advance beyond poverty. Many therapists do not like to talk about poverty or admit to ignorance about the experience of a family living in poverty. Therapists are often not sure whether the perceived dynamics among family members are attributable to a misunderstanding of a family's ethnic culture (and racial oppression) and/or related to the family's socioeconomic class status (i.e., to an economically deprived, multi-stressed social context). Specific data about poverty in the United States and Canada and its impact on family life are very disturbing. Ambert (1998) and Wilson (1997) described the effects of poverty, in its various forms, on the structure and functioning of families, especially on children and adolescents.

However, with a context-oriented perspective and a lens focused on the culture of the poor, whatever their ethnic heritages may be, therapists can also discover strengths and resources in impoverished inner-city neighborhoods. Against the odds, many parents manage to effectively guide and support the emotional, intellectual, social, and cultural development of their children. An extensive network of personal relationships and local initiatives in the immediate neighborhood, often informally organized along ethnic or religious lines, support individual families (Boyd-Franklin, 1995; Falicov, 2000). Whoever is not blinded by traditional views of "typical" families (Coontz, 1992) will discover the manifold relational structures and networks that encompass even families who appear hopelessly fragmented and disoriented. With unbiased eyes and honest curiosity, therapists can detect personal contexts and relationship patterns that are vibrant. Traces of hitherto invisible renewal processes in the inner-city neighborhoods become obvious to those who have learned to see through the barriers that separate the various ethnically and socioeconomically defined groups. The recent inner-city rejuvenation initiatives by federal, state, and city authorities have been most successful where they support and continue already existing structures within the local communities (e.g., Schorr, 1997).

Cultural Identification and Immigration Experience

Living in U.S. society inescapably leads to one's being identified with a particular ethnic group. Skin color, language, accent, gestures, eating habits, and many other subtle details render people easily identifiable as White (i.e., having a European heritage), African American (i.e., with ancestors from Africa, mainly brought in as

slaves), Hispanic American (i.e., immigrated from a Spanish-speaking, mainly Latin American, country), Asian American (i.e., from the Far East), or Native American (i.e., descendant from original inhabitants of the North American continent).

People's experiences of their ethnic heritages and racial and cultural identities are vastly different for the various ethnic groups and subgroups. The same holds true for adolescents. Numerous authors have presented details about high-school-students' identifications with their ethnic heritages and cultures and the consequences and conflicts of their ethnic identities (see Boyd-Franklin, 1989; Falicov, 1983, 2000; Fowers & Richardson, 1996; McGoldrick et al., 1996; Pinderhughes, 1989, 1990; Pravder Mirkin, 1990). A number of particularly significant aspects of working with minority youth in the inner cities stand out.

Therapists' Culture Determined Lenses

Psychotherapists working in the inner cities need to be aware of their own culturally determined lenses. We need to acknowledge that we view adolescents and their family members differently according to their different ethnic backgrounds and the different ways of experiencing race and culture as such, and whether they share our racial identities. The ways we understand and conceptualize the issues with which we are confronted in working with a particular teenager or interpret a particular family structure and process are deeply influenced by the values, ethos, practices, customs, and rules prevalent in the ethnic communities that formed our own identities and value systems.

Ethnic groups in our society are not created equal. Members of one subgroup of the dominant European American culture may experience culture or race as a dimension out of awareness until they encounter people of different ethnic backgrounds; that is, culture becomes an issue only through the encounter with people of different ethnic or racial heritages. Conversely, people who belong to one of the African American, Hispanic American, Asian American, or Native American minority populations know that their experiences of color and ethnicity are from the start inseparably part of the experiences of their own humanity. They are reminded daily that they live in a world and a society to which they have contributed, but that all too often has imposed on them its values, lifestyles, traditions, expectations, concept of spirituality, and order. Those who are not of the dominant culture are treated as strangers and outsiders; they carry with them a long history of oppression and racial injustice.

An encounter between therapist and adolescent is also significantly influenced by whether the counselor and the teenager share the same ethnic background.

Therapists repeatedly experience mistrust, reservations, relational awkwardness, and closure when they are white and the student and family are black. Equally, if a Latina counselor is part of the team, the likelihood of Hispanic students congregating in her office is significantly higher than if she is black or white.

History of Immigration

In general, knowledge about the culture and ethnic background of high-school students and their families proves indispensable for therapists who work with them. Being curious and willing to learn is also crucial in regard to the history of immigration of the ethnic group to which a youngster belongs. Otherwise, easy generalizations can creep into our thinking. Therapists can understand a particular ethnic group only through learning about its history. African American, Hispanic American, and Asian American are general labels that do not describe the subcultures nor reflect the unique history and wanderings of the particular group of people who are the ancestors of our clients. Therapists need to respect and learn the collective memory of each racial group and to understand how it relates to the present-day experience of teenagers. This is particularly true regarding the history of oppression, torture, and murder of the ancestors of most African Americans experienced during the slave trade, the ensuing centuries of slavery, and subsequent racial oppression in this country (D. L. Franklin, 1997; Pinderhughes, 1990). Similarly, most Hispanic American teenagers carry with them the collective memories of centuries of imperialist oppression and exploitation of their peoples and countries by the United States (Galeano, 1973). Being curious about the immigration histories and the collective memories of these teenagers frequently represents not only a way of honoring the sufferings of their ancestors and an act of commemorative justice (Wetzel, 1994b), but also an indispensable step toward a successful engagement with a teenager and his or her family.

Current Immigration Status

Part of being eager to learn about teenagers' and their families' construction of their specific ethnic identities also entails exploring their current immigration status and recent histories. For example, the influx of computer specialists from countries in Europe and Asia represents a new kind of very mobile, well-adapted group of immigrants who are equally at home in many Western countries and symbolize the globalization of the labor market. The difference from earlier immigrant groups helps us not to overlook the recent immigration experiences of adolescents' families from other countries, especially from Latin America and Africa.

Many high school students in the inner cities come from families who have been separated and disrupted by the attempts to immigrate to the United States to find a better life. They often are here illegally. Sometimes, only the children are U.S. citizens, and the parents have to avoid contact with the authorities; consequently, they lack even the rudimentary services that would be available to them if their immigration status were legal. The parents' attitudes toward school personnel understandably may involve suspicion and reluctance to come to family meetings. Often, only a professional who shares the same ethnic background will be able to overcome these barriers.

People who have recently immigrated from an African country, for instance, experience the racism in our society differently compared to their African American counterparts. They may not have a history of slavery; instead, they may have grown up in a country with a long history of German, Portuguese, French, or Anglo-Saxon colonialism, which may constitute a significant difference from the centuries of slavery that define the history of African Americans.

Issues of Acculturation

Highlighting cultural experience is also important because many of the students' families present the additional issue of acculturation. Conflicts arise between the more traditional values, customs, lifestyles, and language of the parents' generation and the tendency of the young people to assimilate into the dominant U.S. culture and civilization. Each family has to work through this conflict in their own way. The desire of the young people to be accepted by their peer group, to be able to function in the school and work environment, and to be of help to their parents can often lead to a reduction of parental authority and ability to be appropriately in charge of their teenagers' lives. The adolescents often end up as the de facto leaders of their families, negotiating most outside contact and making decisions that generally would be considered beyond their competencies. This happens frequently in families in which the parents or grandparents (who often become the guardians when the parents are in jail or have died of AIDS or still live in the family's country of origin) have only limited command of the English language or are not able to read.

Gender Roles

Working with young people requires particular sensitivity to and knowledge about the gender rules transmitted to children and youth together with their cultural and ethnic heritages and their socioeconomic status. Manifold cross-fertilizations and confluences exist among socioeconomic class, cultural traditions, racial

identification, and gender-role constructs, especially in the minds of young people (Comas Diaz & Greene, 1994; McGoldrick, 1998).

For example, it is quite instructive for an outside observer to learn how often Black men are exposed to daily humiliations, mistrust, and small-scale aggression (Boyd-Franklin, Franklin, & Toussaint, 2000) by members of the White dominant culture. Fellow classmates sometimes give minority students from inner-city areas a hard time when they do outstanding work in school, as if people who belong to the impoverished class and to racial or ethnic minorities are not entitled to academic excellence, or are breaking loyalty bonds to their group if they flourish in their work. Poor young women from ethnic communities may become pregnant partly as a way to gain status in their communities, but also to give their lives a center of meaning otherwise unattainable for them. Many single mothers (and grandmothers) cooperate with others in the same position, gaining strength from supporting each other.

Schools in the Inner City *Transformation of Schools*

Reconnecting with the very beginnings of family therapy, advocates of a renewed concern for discouraged and abandoned youth in the inner cities broke open the narrowly defined boundaries of systems therapy (Wetzel, 1994a, 1994b). A new paradigm evolved that proved particularly useful for families of lower socioeconomic status: *school based community-oriented family therapy* (Boyd-Franklin & Bry, 2000; Winawer & Wetzel, 1999).

With the emphasis on an ecosystemic or context-oriented perspective in work with teenagers and their families from poor areas, the immediate neighborhoods of families unavoidably came into view. Family counselors could not disregard the larger human and physical *environments* in which adolescents grew up. The assumption that a family lives in a vacuum and that a therapist needs to focus only on intra-familial dynamics manifested itself as an illusion in working with youngsters from poor urban or rural areas. How is the life of a grandmother attempting every day to raise her grandchildren because the children's parents died from AIDS or drug abuse comprehensible without consideration of the various environmental factors that bear on the daily life or tragic history of her family? How can a professional support a 17 year-old who saw her parents killed in a homicide/suicide, her brother later murdered in a drug deal gone sour, her only remaining brother imprisoned, so that she now lives with her 72 year-old grandfather who is grieving the recent loss of his wife of 50 years? How different is her "depression" from that of a 17-year-old who feels lonely, isolated, and discouraged while living in the context of a well-to-do

family where the parents are too busy working and leave caring for her younger siblings up to her? Working with youth from the inner cities and their families forces the walls of the interview room to open up. Socioeconomic, cultural, and all other factors relevant to the immediate neighborhood become transparent because they deeply influence the dynamics of the families seen in these districts.

As soon as the perspective transcends the youths and their families, considering the schools becomes imperative. This is hardly surprising. Schools and small religious communities with roots in the surrounding district are often the sole institutional survivors of the gradual decline of the inner cities during the past 30 years. The mission of a high school located in a poor area, therefore, has to be much broader than its original educational goals. Psychotherapeutic work in poor areas inevitably has to proceed in tandem with a fundamental transformation and reorientation of the identity of a school in these districts.

Schools as Locales for Education and Therapy

For many young people from close-knit ethnic neighborhoods in the inner cities, schools seem to be the only geographically accessible institutions familiar to them (aside from places of worship) that they may not experience as hostile. Some teenagers view school as a place to learn and to prepare academically for college; others value that they can meet their friends in an environment not yet poisoned by the mercantile and criminal aspects of the *drug culture*; many attend school because there they can meet teachers, social workers, coaches, or other adults who will support them and make a commitment to them. For all of them, high school represents a context that suggests *the* hope of eventually escaping a context in which they feel powerless and disheartened.

New Tasks for High Schools in Inner-City Districts

Given poverty, scarcity of jobs, drug trafficking, and racial discrimination in inner cities, it is easy to understand how the schools would end up with many roles and tasks not normally associated with the function of a high school in the United States. This development results not from careful planning. Quite the opposite: Initially, city and state administrative or human-service and health departments reacted pragmatically to what they perceived as specific needs not met by other institutions. Insufficient or unavailable medical care, lack of affordable health insurance, and higher susceptibility to illness among the student population prompted the establishment or expansion of health centers located in schools. Nurse practitioners and physicians keep regular

practice hours, especially for high-school students, many of whom have not had a physical checkup for many years. The high number of pregnant students forced the establishment of day-care centers in some school buildings. Infant care became a required course for all young mothers; the infants were taken care of while their mothers attended regular school classes.

Pregnancy counseling, prenatal medical care, sexual and birth-control information belong to the normal duties of the medical personnel. In some settings, even dentists and ophthalmologists are regularly available.

For many older students from the inner city, contributing to their own and their family's earnings by working in the afternoons or evenings is an economic necessity. Consequently, employment offices were organized in which students not only receive help finding suitable jobs, but also learn proper behavior at job sites, appropriate attire, and the right language fit for doing business with adults. Through their job-related training and empowerment, these students received needed support to succeed in a fast-paced and technology driven work environment.

Naturally, the schools had to find counselors (beyond the staff of the guidance departments and the child-study teams) who could assist students in personal or school-related crisis situations. Drugs are present everywhere, near school property or in the vicinity, and are readily available to everybody; accordingly, the number of violent incidents among students increased. Thus, counseling offices had to be made available to deal with drug-related or other crimes. Many school administrators formed crisis teams made up of counselors, teachers, medical personnel, and other experts to have a rapid-response group available for quick intervention in cases of sudden violence from outside the school or between hostile groups in the school itself (e.g., rival drug-dealing gangs or hostilities motivated by ethnic antagonisms).

Integration of Services and Institutions

The need for integration of all these services and the various institutional responses to the needs of students in poor districts could no longer be overlooked. Without organizational and administrative integration, the danger of a chaotic disarray of assistance, of unnecessary duplication of efforts, and, at times, of unwitting obstruction and confusion would only increase. To coordinate the well-intentioned, but disjointed, services, an attempt had to be made to envision a conceptual framework that would unify the approach and goals of student assistance. On the part of the school, as an educational institution faced with a steady accumulation of roles, the need for conceptual clarification and deepening at the understanding of its

function in the inner city became evident, lest the integration of student assistance into the school remain superficial and tenuous.

Model: School-Based Community-Oriented Family Therapy

The New Jersey FIEP represents an attempt to practice and implement the conceptual vision for youth and family services articulated previously. The theoretical and educational sides of the endeavor toward integration and the clarification of the educational vision of schools in poor districts remain to be defined.

The FIEP Teams and their Administrative Contexts

During 1992 and 1993, a group of systemic family therapists (notably, Charles Fishman) and representatives of the New Jersey Departments of Health and Senior Services (T. O'Connor) and Human Services (R. Knowlton) developed and financed a school-based family intervention model for the treatment of youth at risk for drug abuse, school dropout, and other behavioral problems (originally called the New Jersey Family Intervention Program). Other states have adopted similar models of counseling for inner-city youth at risk. The FIEP model evolved further to include not only school and family contexts, but also the community. In addition to the original four counties, the FIEP model has recently been implemented in a fifth district thanks to financing through a grant from the federal Substance Abuse and Mental Health Services Administration. Despite local varieties in the functioning of the teams at the five schools, the FIEP model is operating from a similar conceptual and practical framework.

In each of the high schools, located in particularly difficult inner-city areas, the FIEP teams are administratively integrated into the School Based Youth Services Program, which provides medical, social, and crisis counseling, usually sharing the same offices within the school building. The ecosystemic orientation of the teams and the practice of bringing all available family members into the counseling process stimulated a transformation process that, to varying degrees, led to the adoption of a more contextual view by other youth service personnel. In some settings, the shift from an individual to a family-systems perspective, even for the FIEP teams, necessitated adjustment, education, and a collaborative process in a host setting that is traditionally child-oriented,

The FIEP teams are composed of a family therapist, usually a master's-level social worker, and a community resource specialist, whose main qualification is intimate knowledge of the community from which the students come. The mission of each team encompasses

the counseling and empowerment of the adolescents at risk who come to the FIEP offices. Part of the ongoing case management involves the strong effort to involve all available family members and everyone else who is part of the "intimate relational network" of a student (Wetzel, 1998a). The supervision of the teams, guided by an ecosystemic orientation, the conceptual model of the project, the annual collection and analysis of the data, and the overall guidance of the FIEP model, is in the hands of consultants from the Princeton Family Institute. Administratively, the teams are accountable to local site managers from the New Jersey School Based Youth Services program (i.e., the teams have to be part of the local administrative structure). FIEP teams do not automatically adopt views of the dominant-culture mental-health and human-services systems. In many service-delivery systems, "acceptable" client behaviors are often defined without regard to the dystonic relationship between the family's culture and style and that of the service-delivery system. The family's informal connection that continues after "treatment" and their positive experience potentially leave a clear path for work in the future, and, most important, respects the clients' agency and competence, not only in the ending, but, by implication, in the entire therapeutic endeavor.

Contexts for Therapeutic Work

The School Context

The gradual integration of the FIEP teams into the general school-based youth services and into the school as an institution implies the goal of an integrated school context in which the learning process includes students' acquisition of academic/curricular knowledge, their gradual mastery of social-relational dynamics, the gaining of work-related skills, and their emotional-cultural maturation. The initial steps toward these goals are pragmatic. All school-based youth services staff become one collaborative group, encompassing medical, crisis-counseling, recreational, youth-employment, and family-empowerment teams. The ecosystemic orientation of the FIEP teams helps the transformation of this group toward seeing adolescents in their most relevant context and tailoring the interactions accordingly.

Then it becomes important to intensify the collaboration between the school-based youth services and the school's administration and teachers. The boundaries between traditionally defined school roles (i.e., instruction, additional learning assistance, homework help and supervision, academic guidance) and the various youth services (i.e., medical care and prevention, social work, psychological counseling, after-school recreational activities) gradually became more and more permeable. Teachers and school administration collaborate with youth services to remove obstacles to

learning in its many forms. At the same time, social workers, medical staff, and counselors are more available and able during regular school times to work with students individually or in groups because their responsibilities are no longer viewed as in competition with the learning that takes place in the classrooms. Unconstrained by school regulations, students are able to meet others during lunch hour and can address related problems within a group of peers in which a counselor is a resource person whenever the input of an adult is desired. With the use of questionnaires, team members attempt to understand the learning contexts and the emotional experiences of the students to deal with both. In crisis situations (group conflicts, suicide, and panic), teachers and counselors are able to rely on already established and practiced communication channels.

Through patient practice steps, the relational and systemic orientation of the FIEP team exerts a transformative influence. School administration, teachers, and the staff of the preexisting youth services began to see the context-oriented FIEP teams as allies who assist them to join together disparate parts of the life context of the students in these districts (e.g., absent fathers, repressed memories of early injuries, lost siblings, neighbors who deal with drugs and others who can help).

The Family Context

With the employment of teams consisting of a context-oriented family therapist and a specialist rooted in the community, the FIEP model is founded on the critically important assumption that an individually centered perspective is hardly sufficient and rarely successful in counseling students who are at risk in so many ways. In a planful, step-by-step process, family members of students are actively drawn into the therapeutic dynamic after the students contact the team or are referred by school authorities, teachers, guidance counselors, or parents. Team members make phone calls, do home visits, visit family members in hospitals or prisons, and, in short, attempt everything that seems necessary to get all the relevant adults in the life of the students to participate in the counseling from the start. This is particularly important in cases of truancy, risk of drug abuse or drug addiction, and physical or sexual violence.

The central role of family members, especially the legal guardians, is immediately evident when a job has to be found for an adolescent, when other social agencies or the family court are involved, or when parents or grandparents are overwhelmed with the care of a teenager. Frequently, counseling happens at a youth's home. The fragmentation of family units in poor inner-city areas carries with it the consequence that many mothers or grandmothers raise their children or

grandchildren alone and are unable to leave their homes at night (Wilson, 1997). Therapy at home enables everybody to participate in the counseling process: parents, partners of single mothers, and older relatives or neighbors who like to help out and support a youngster (Lindblad-Goldberg et al., 1998).

The Personal Relational Network: "Virtual Families"

The context-oriented perspective in the counseling process prompted team members to pay attention to the boundaries of the inner-city families (Aponte, 1994). Multistressed families (Madsen, 1999) do not show the same neat boundaries observed in families from other socioeconomic classes. In addition, the rigidity or porosity of boundaries varies according to family idiosyncrasies often linked to ethnic and cultural heritage (McGoldrick et al., 1996). The FIEP families' boundaries are frequently more permeable (i.e., vulnerable to outside destructive factors) but also more able to incorporate and accept people who can contribute to stability and provide resources. While focusing on a student counselors search the horizon for others who belong to the web of personal relationships of the student or his or her family and could be attracted to become a support in the process of "family" counseling.

FIEP guidelines emphasize making connections rather than isolating, including someone rather than separating people. In a typical "family" session, a rather disparate group of people, only some of whom are biologically related, may meet. One dynamic, the willingness to support an adolescent and to contribute to his or her success at school, connects everyone present. In some situations, the goal may be simply to help the youth complete school or to at least prevent entry into the juvenile-justice system, which, for most youths, presents almost insurmountable obstacles for a respectable life.

A crucial task of the relationship-oriented family counselor revolves around building a group around a teenager, with everybody's agreement, that meets with the counselor until the group is strong enough to carry on their task without professional assistance. Part of the skills repertoire of a family empowerment team, therefore, entails being able to deal with the complex relational problems and boundary issues resulting from an often unpredictable pattern of individual sessions, sessions with the teenager and the most important family members, and meetings with the entire larger relational network.

The Community Context

Consideration of community contexts leads to the next step beyond a traditional understanding of school

and therapy. Active interest in the immediate neighborhood where students live and in the entire economically depressed inner-city area forms an integral part of the FIEP model (Winawer & Wetzel, 1999). The FIEP Community Resource Specialists, now middle-class professionals themselves, often come from economic backgrounds similar to the conditions prevalent in the neighborhoods. Their ethnic backgrounds and heritages usually match one of the major groups in the community. Thus, they are not strangers to the life circumstances of the students and, significantly, are well-respected in the neighborhoods. The teams receive weekly supervision and attend monthly family-therapy training sessions conducted by the authors.

Augmenting school based teaching and family counseling with the school's and the team's active integration into the surrounding community constitutes a crucial innovation in the FIEP model. Community resource specialists incorporate and represent the commitment to this view. As part of the learn, they may participate in a family session (especially during home visits); find after-school jobs for students and train them for interaction with employers or customers; organize assistance for families who lack basic necessities of life, such as food, housing, electricity, heat, and health care; Or use contacts with police or other public authorities to intervene before a student's anger or drug use causes irreparable harm.

School-based counseling and support, reintegration and renewed participation of the student in the process of learning, and conversations with the family or "virtual family" converge in a process of empowerment that generates innovative impulses to transform the environments from which the students come every day to school and to which they return. In one school, family members who had regained power over their own lives through the family meetings and who participated in retreats organized jointly by FIEP teams from several cities have begun to organize on their own and learned to address successfully some issues with their school board that were of concern for them. Thus, the three contexts – family, school, and community – overlap while remaining centered on the person of the adolescent at school.

Case Example

The first interview with the entire Dawson family felt tense. "Teresa Dawson," an African American Christian woman, and her four daughters sat silently with the FIEP team. The family and the team had greeted each other, and the team had acknowledged that the family members all managed to attend the meeting. A long silent pause ensued. Teresa began, saying that the family had never been to any counseling before. Her 23-year-old daughter, "Stacey," addressed Teresa, charging her

mother that she "never did anything about anything." There was an edge of rage in the daughter's voice, and the mother took up the challenge. The next few sharp, quick exchanges the FIEP team, the family therapist (FT), and the community resource specialist (CRS) could not remember verbatim. The words, however, were incendiary. Within moments, there was a physical fight between Stacey and her mother. The FIEP team, an African American middle-class Christian woman (the CRS) and an Irish/ English American woman of working-class Catholic background (the FT), were eventually able to calm the fight. They used the moment to engage mother and daughter around the common ground of strong feelings about the family's situation.

The family had come into therapy because "LaToya," the youngest, 16-year-old daughter, had been referred to the FIEP team for poor school attendance, failing grades, signs of depression, and suspected abuse of marijuana. The oldest daughter, Stacey, was living in another household with her two young children, but kept a close connection with the rest of the family. Teresa's parents were deceased. Her only brother had died of AIDS. Only "Shiniqua" and "Latisha," the second and third daughters, had any knowledge of the whereabouts of their father, but had little contact with him. There was some kinship network, aunts that were not blood relatives with whom Teresa had lost contact in recent years. Stacey kept in touch with those women periodically.

The CRS had met with LaToya several times while she and the family therapist made numerous phone calls and home visits in an attempt to engage the entire family. Teresa said that she was concerned about her daughter, but was unable to set up a time when the team could visit with her and all family members. LaToya did not keep her assigned appointments, but appeared almost daily unannounced at the FIEP office. A bright and articulate teenager, she talked about school issues, but, when her feelings or home situation were addressed, she generally fell silent. During one of these meetings, Stacey, who had not been mentioned, emerged in the conversation as someone who had frequent contact with the family. With Teresa's permission and LaToya's knowledge, Stacey was called. That same week, the entire family met finally in the FIEP office, located in the high school of an economically depressed city in central New Jersey.

During the family interview, it was revealed that Teresa had been using crack cocaine with her boyfriend, who, unbeknownst to Teresa, had been molesting LaToya. Stacey launched a seething indictment of her mother, primarily to protect her younger sister. Under the protective rage she revealed years of hurt and vulnerability because she, too, had been abused by Shiniqua and Latisha's father. Stacey had been in and out of depression with frequent suicidal ideation. In fact, each of the girls

had been either beaten or sexually abused by one of mother's partners. In fact, Teresa herself was being "shoved around" by her current partner.

Teresa at first denied her daughter's allegations, but Stacey used the therapy sessions as an opportunity to confront her mother. The FIEP team supported all family members in their first attempts to face their pain as a family. The team thought it remarkable that the family returned for subsequent visits given the difficult content of the sessions.

The FIEP team helped to keep the conversation open between the mother and her daughters, to enlist the mother's leadership in her family, and to help all work together to heal the interpersonal and individual wounds of the many years of abuse. The primary goal all agreed on was to help LaToya perform better in school. Although the family did not stay in formal therapy beyond 10 meetings, there were a number of changes. After therapy ended, LaToya dropped into the office now and then to give the FIEP team update about her family, and there were occasional exchanges of phone calls between the FIEP team and family members.

The therapeutic objectives were supported by a number of efforts in the school and community. When it was clear that the family's spirituality was an untapped resource in their lives, the minister of their church was invited to a session and subsequently followed up with outreach efforts to reengage the family in the life of the church. Furthermore, the CRS, herself a spiritual person, would often assist at family therapy sessions and end those meetings by joining the family in a brief prayer.

The meetings continued for a while. Teresa was helped to find a detoxification program. The most striking event occurred when she was able to ask her partner to leave the home. The family reported that Teresa had never before ended a relationship; her partners generally drifted away. This time, Teresa's partner did go when she was clear about her position. This bold act seemed to set off a ripple effect. Stacey, who had been living away in rather stark circumstances, admitted that she had been staying away out of anger. She and her children moved back into Teresa's large apartment. Concurrent with family sessions, Stacey was assisted in securing individual psychotherapy to deal with her long-term depression. LaToya joined a homework help program in the school; her attendance and school performance improved. Teresa did not want to meet with LaToya's teachers, but did consent to the team's contact with the teachers to work out a plan to help LaToya pass her subjects, which she did. LaToya's use of gateway drugs had been minimal and stopped during the course of the school year.

The involvement of Teresa and her children with FIEP is not atypical of many of the families who use the program. They did not resolve all of their problems, but

made strides in areas of individual and family functioning that had been associated with an adolescent's difficulties. The adolescent improved significantly in the areas of behavioral difficulty for which she was initially referred.

From a supervisory perspective, it may be useful to examine some of the critical aspects of the team's work with the Dawson family (Winawer-Steiner, 1979). In ongoing supervisory conversations with the FIEP team who worked with Teresa and her daughters, it was clear that the team was somewhat shaken by the intensity of their first encounter with the entire family. However, they were not daunted or blinded to the resources within this multi-stressed family (Madsen, 1999). The team recognized a number of family strengths from the outset. Against many odds, the family had attended a session together. They had shown their conflicts to strangers and did not abort the session when tensions surfaced. The team was able to identify these behaviors as a probable indication of the family's investment in their relationships and in the unit as a whole. Their ability to face conflicts was seen as a sign of their courage and ability to endure emotionality. As part of their assessment, the team was able to discern both the family's common "cultural borderlands" (Falicov, 2000) with the team and the degree of social alienation exercised by the family. In many respects, the supervisor-team relationship was isomorphic to the team-client relationship. The team's expertise about their setting, cultural perspective, and firsthand experience with the family were privileged. Their interactions with each other, the supervisor, and multiple systems levels evolved through a synergy of multiple idiosyncratic factors, which gave the work its own unique imprimatur.

The cultural lenses came into focus at different phases of the work with the family and, at times, several overlapped. Socioeconomic factors (Teresa was on welfare), issues of gender and sexuality, religion and spirituality, ethnic culture, biopsychosocial development, and health issues (substance abuse) interfaced in the life of the family and in the efforts to establish a therapeutic alliance to develop conversations to help the Dawsons identify inner, interpersonal, and community resources that would clear pathways out of their despair and sense of victimization.

The social isolation, in large part associated with the mother's drug use and her reliance on public services, was a potential barrier to engagement. The team, however, was fully cognizant of the family's recurrent disappointments and fears in their encounters with other helping professionals, whom they had experienced as either ineffectual or disrespectful. The team realized that it was highly unlikely that the Dawson family would trust FIEP professionals (Ackerman, Colapinto, Scharf, Weinshel, & Winawer, 1991). In supervisory conversations, the family's suspicions were recognized as

an adaptive mechanism designed to protect the family from the pseudo-kindness of strangers.

The shared "cultural borderlands" (Falicov, 2000) that did facilitate a therapeutic connection were a similar class background with one of the FIEP team members and similarities of ethnic culture with the other team member (the CRS). Recognition of the family's suppressed spiritual life as a resource provided a powerful factor in the ongoing development of the therapeutic relationship and the work. Moreover, all central figures in the family, and the pastor as well, were women. The subtext of the conversation from the start was that the sorting out of the dilemmas of this family was clearly women's work.

The team heard from Teresa that she had renewed contact with members of her personal network. Shiniqua and Latisha had talked about contacting their father's family, but had not made any concrete plans to do so; Shiniqua was rather reluctant to do so. At last contact, Teresa was in early recovery, attending Narcotics Anonymous meetings and focusing primarily on her recovery. LaToya was on a good track, too, moving toward graduation and, in her mother's words, "keeping out of trouble."

The Dawson family's work with the FIEP team supported the family's primary objective: to improve LaToya's school performance. From a positivist perspective, one could certainly identify numerous areas of difficulty that warranted further clinical attention. Whether the FIEP team should pursue the family beyond recommendations could be controversial. However, just as the steps to engage the family respected their careful path to admitting outsiders, so did the end of therapy reflect the family's knowledge about its own processes with regard to how much outside help they want or think they can benefit from and for how long. The FIEP team's response to the family's ending of the formal relationship with the program was viewed through the complexity of the kaleidoscope of the seven lenses and informed by a postmodern stance that privileges a family's "expertise."

Three contexts emerged as most relevant for adolescents in the poor inner-city areas depicted earlier: school, family, and community. The model revolves around the adolescents in these contexts, viewing them through the kaleidoscope: of the seven lenses.

Outcome Research

The feedback that the FIEP teams have received from students, families, school personnel, and community leaders is very encouraging. Initial outcome studies confirm that the school-based and community-oriented approach of FIEP contributes significantly to the transformation of students, families, and schools that are connected with it (H. C. Fishman, F. Andes, & R.

Knowlton, 2001; Wetzel, 1998b).

The most recent evaluations, for the school year 1999-2000 are based on pre- and post intervention questionnaires of 223 students. The average age of the students was 15.45 years; the majority of the students were between 14 and 17 years old. In gender distribution, 63% of the students were female, 37% were male. In cultural distribution, 42% of students were African Americans, 33% were Hispanics, and 18% Caucasian. In economic distribution, 1% of the students' families were homeless, 12% were on public assistance, and 24% of the students belonged to a one-parent household below the official poverty level. Less than half (46%) of the students lived in households with two employed parents, and 12% came from middle-class families. In 64% of the families, the fathers were absent from the household.

The primary presenting problem for almost all students involved immediate risk for substance abuse or active use of illegal substances. Of those considered actively using drugs, 63% showed marked improvement through their involvement with the FIEP, and 34% reported no change. The secondary problems included violence or depression (28%), poor grades in school (18%), nonviolent behavioral problems at home (17%) or at school (15%), truancy (13%), and sexual acting out (4%). Taken as a separate issue, 28% of the students reported experiences of physical or sexual violence in the past or present. For 69.72% of the students involved in FIEP, these problems improved, whereas for 17.43%, there was no change, and for 12.84% the situation reportedly worsened.

Other programs that are similar in philosophy and practice to the New Jersey FIEP have done more extensive outcome research. Foremost among these groups is the Center for Treatment Research on Adolescent Drug Abuse at the University of Miami School Of Medicine (www.miami.edu/ctrada). Liddle and his colleagues [Liddle, Henderson, Rowe, & Dakof, 2001] presented an extensive report on this program with a comprehensive literature review during the American Family Therapy Academy's 23rd annual meeting on June 28, 2001.)

Summary

Not all stories that we hear from the FIEP teams end well. Even the combined collaborative efforts of the FIEP teams can hardly diminish the destructive forces of the psychosocial and economic factors that bear on the lives of the adolescents and their families in impoverished areas. But the mood of many young people in the inner-city school systems improved after they became involved with FIEP. A higher percentage of students seem to graduate from high school and to disappear from the drug rosters of the police. Frequently, older

students begin to get interested in the lives of their peers from lower and start to support younger students. Adults and young people speak differently to each other after participating in the meetings of the extended family relational network. In at least one inner-city high school, the adults decided to continue to meet in small groups with other families after the end of the active family-counseling phase and to organize and fight for practical changes within their housing area.

Hope and encouragement appear to have a lot to do with efforts to weave together the three contexts of school, family, and community. Thanks to initiatives by team members and to the creativity of the families, even small changes on the level of a school or within a family system work as catalysts in other contexts. So the process of transformation continues. Systemic changes that prove to be beneficial on one level (e.g., family or school) seem contagious; they tend to be transferred to other levels of systemic organization (e.g., from a family to school and community). Mothers and fathers realize that, in their interactions with the school or in the life of the community around them at home, they can apply what they learned during sessions with their teenagers and with an extended relational network.

FIEP implies the possibility of a transformative process with a ripple effect on many levels of systemic organization. At some FIEP program sites, the context-oriented and relational view of the teams has prompted, on occasion, other social-welfare agencies, even other institutions, such as the police, members of the justice system and the city bureaucracy, and child-protection agencies, to lean toward a similar ecological view, particularly those who previously had participated in meetings with FIEP teams and families. The FIEP model is viewed positively as adding new skills and new opportunities for success to the work these agencies and institutions are trying to do.

Above all, however, the transformation of those directly connected with the FIEP model is noteworthy. The teams, consultants, site administrators, involved administrators; all became encouraged and empowered themselves. Many team members have roots in groups that are ethnically and socio-economically similar to the people they work with in these inner-city schools. The teams' work, therefore, gave them hope for the people they were familiar with.

The transformation process was particularly visible in the way team members treated each other and dealt with the difficult challenges that surfaced in their work. In regular monthly training workshops attended by all teams from the various program sites, the consequences of transcending the boundaries of traditional psychotherapy needed to be dealt with. In some cases the point had to be delineated when counseling had to respect its own limitations to be effective

and where exactly the work of empowering and organizing, in the political sense of the word, would have to start (Wetzel, 1994b). These choices are not easy to make considering the deprivations, obstacles, and lack of opportunities characterizing the lives of high school students in inner-city regions.

The deep cultural, ethnic, and socioeconomic differences and conflicts present in U.S. society in general surfaced also in the process of developing the model. The members of the diverse FIEP group of family therapists, community resource specialists, site managers, and consultants addressed these issues openly and did not squelch them. Open, sometimes difficult, conversations about race, gender, spirituality, and the challenges of the work have transformed the FIEP staff into a community. This necessitated looking at personal, hard-to-discern racist mind-sets after some team members raised awareness of these attitudes that permeate every discourse. Gender issues were intricately mixed with racist biases and stereotypes. Diversity in religious beliefs and practice prompted questions about how to build a therapist's faith into counseling sessions and deepened respect for the strengths in these beliefs and for the religious communities that are such important resources in the FIEP work.

The transformation triggered by the FIEP also encompasses the ways team members and administrators interact with each other. As a professional group committed to a school-family-community paradigm and to the hope for a chance in life for the youth served, conversations have focused not only on the clinical complexity of the work, but also on the U.S. society and on the relationship between each in that societal context. It is our hope that the process of transformation, as we could observe it within ourselves and on various levels, will extend into the future and empower the youth and their families and networks. When economic prosperity extends to the poorest sectors of our society, the efforts of FIEP will have an even greater chance of contributing to the evolution of a level playing field for underprivileged rural and urban youth.

REFERENCES

- Ackerman, E., Colapinto, J., Scharf, C., Weinshel, M., & Winawer, H. (1991). The reluctant client: Avoiding pretend therapy. *Family Systems Medicine*, 9, 261-266.
- Alexander, J. E., Pugh, C., & Parsons, B. V. (with Barton, C.). (1998). Functional family therapy In D. S. Elliott (Series Ed.), *Blueprints for violence prevention* [Book 3]. Boulder: University of Colorado, Institute of Behavioral Science, Center for the Study and Prevention of Violence.
- Ambert, A. M. (1998). *The web of poverty: Psychosocial perspectives*. New York: Haworth Press.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- Aponte, H. J. (1994). *Bread and spirit: Therapy with the new poor. Diversity of race, culture and values*. New York: Norton.
- Auerswald, E. H. (1968). Interdisciplinary vs. ecological approach. *Family Process*, 7, 202-215.
- Auerswald, E. H. (1983). The Gouverneur Health Services Program: An experiment in ecosystemic community health care delivery. *Family Systems Medicine*, 1(3), 5-24.
- Auerswald, E. H. (1987). Epistemological confusion in family therapy and research. *Family Process*, 26, 1-12.
- Auerswald, E. H. (1990). Toward epistemological transformation in the education and training of family therapists. In M. Pravder Mukin (Ed.), *The social and political contexts of family therapy* (pp. 19-50). Needham Heights, MA: Allyn & Bacon.
- Bateson, G. (1971). *Steps to an ecology of mind*. New York: Ballantine Books.
- Bateson, G. (1979). *Mind and nature*. New York: Dutton.
- Boyd-Franklin, N. (1989). *Black families in therapy: A multi-systems approach*. New York: Guilford Press.
- Boyd-Franklin, N. (1995). Therapy with African American inner-city families. In R. Mikesell, D. D. Lusterman, & S. H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems therapy* (pp. 357-371). Washington, DC: American Psychological Association.
- Boyd-Franklin, N., & Bry, B. H. (2000). *Reaching out in family therapy: Home-based, school, and community interventions*. New York: Guilford Press.
- Boyd-Franklin, N., Franklin, A. L. & Toussaint, P. (2000). *Boys to men: Raising our African American teenage sons*. New York: Dutton.
- Breggin, P. R. (1999). *Reclaiming our children: A healing plan for a nation in crisis*. Cambridge, MA: Perseus Books.
- Broderick, C. B., & Schrader, S. (1991). The history of professional marriage and family therapy. In A. S. Gurman & D.P. Kniskern (Eds.), *Handbook of family therapy* (Vol. 2, pp. 3-40). New York: Brunner/Mazel.
- Brown, D., & Parnell, M. (1990). Mental health services for the urban poor: A systems approach. In M. Pravder Mirkin (Ed.), *The social and political contexts of family therapy* (pp. 215-235). Needham Heights, MA: Allyn & Bacon.
- Capra, F. (1984). *The Tao of physics: An exploration of the parallels between modern physics and Eastern mysticism* (2nd ed.). New York: Bantam Books.
- Carter, B., & McGoldrick, M. (Eds.) (1999). *The expanded family life cycle: Individual, family, and social perspectives* (3rd ed.). Needham Heights, MA: Allyn & Bacon.
- Comas-Diaz, L., & Greene, B. (Eds.). (1994). *Women of color: Integrating ethnic and gender identities in psychotherapy*. New York: Guilford Press.
- Coontz, S. (1992). *The way we never were: American families and the nostalgia trap*. New York: Basic Books.
- Coontz, S. (1997). *The way we really are: Coming to terms with America's changing families*. New York: Basic Books.
- Coontz, S. (Ed.). (with Parson, M., & Raley, G.). (1999). *American families. A multicultural reader*. New York: Routledge.
- Davis, C. (1996). *Levinas: An introduction*. Notre Dame, IN: University of Notre Damp Press.
- Diamond, G. M., Liddle, H. A., Hogue, A., & Dakof, G. A. (1999). Alliance building interventions with adolescents in family therapy: A process study. *Psychotherapy: Theory, Research, Practice, and Training*, 36(4), 355-368.
- Diamond, G. S. & Liddle, H. A. (1996). Resolving a therapeutic impasse between parents and adolescents in multidimensional family therapy.

- Journal of Consulting and Clinical Psychology*, 64(3), 481-488.
- Diamond, C. S. & Liddle, H. A. (1999). Transforming negative parent-adolescent interactions: From impasse to dialogue. *Family Process*, 38(1),5-26.
- Ellison, R. (1947). *Invisible man*. New York: Random House.
- Falicov, C.J. (Ed.). (1983). *Cultural perspectives in family therapy*. Rockville, MD. Aspen Press.
- Falicov, C. J. (2000). *Latino families in therapy: A guide to multicultural practice*. New York: Guilford Press.
- Fishman, H. C. (1988). *Treating troubled adolescents*. New York: Basic Books.
- Fishman, H. C. (1993). *Intensive structural family therapy. Treating families in their social context*. New York: Basic Books.
- Fishman, H. C, Andes, E, & Knowlton, R. (2001). Enhancing family therapy: The addition of a community resource specialist. *Journal of Marital and Family Therapy*, 27(1), 111-116.
- Fowers, B. J., & Richardson, F. C. (1996). Why is multiculturalism good? *American Psychologist*, 51, 609-621.
- Franklin, A. J. (1993). The invisibility syndrome. *Family Therapy Networker* (17), 33-39.
- Franklin, D. L. (1997). *Ensuring inequality: The structural transformation of the African-American family*. Oxford University Press.
- Galeano, E. (1973). *Open veins of Latin America: Five centuries of the pillage of a continent* (C. Belgrage Trans.). New York: Monthly Review Press.
- Goldner, V. (1985). Feminism and family therapy. *Family Process*, 24, 31-47.
- Goodrich, T. L. Ellman, B., Rampage, C, & Halstead, K. (1990). The lesbian couple. In M. Pravder Mirkin (Ed.). *The social and political contexts of family therapy* (pp. 159-178). Needham Heights, MA: Allyn & Bacon.
- Hare-Mustin, R.T., & Marecek, K. (Eds.). (1990). *Making a difference: Psychology and the construction of gender*. New Haven, CT: Yale University Press.
- Hartman, A., & Laird, J. (1983). *Family centered social work practice*. New York: Free Press.
- Imber-Black, E. (1990). Multiple embedded systems. In M. Pravder Mirkin (Ed.), *The social and political contexts of family therapy* (pp. 3-18). Needham Heights, MA: Allyn & Bacon.
- Inclan, J., & Ferran, E., Jr. (1990). Poverty, politics, and family therapy: A role for systems theory. In M. Pravder Mirkin (Ed.), *The social and political contexts of family therapy* (pp. 193-213). Needham Heights, MA: Allyn & Bacon.
- Ivey, A. E., Ivey, M. B., & Simek-Morgan, L. (1993). *Counseling and psychotherapy: A multicultural perspective* (3rd ed.). Boston: Allyn & Bacon.
- Kaslow, F W. (Ed.). (1996). *Handbook of relational diagnosis and dysfunction family patterns*. New York: Wiley.
- Kaufman, E., & Kaufman, P. (Eds.). (1979). *Family therapy approaches with drug and alcohol problems*. Boston: Allyn & Bacon.
- Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. Berkeley: University of California Press.
- Kliman, J. (1994). The interweaving of sender, class, and race in family therapy, In M. Pravder Mirkin (Ed.), *Women in context: Toward a feminist reconstruction of psychotherapy* (pp. 25-47). New York: Guilford Press.
- Krestan, J. A. (Ed.). (2000). *Bridges to recovery: Addiction, family therapy, and multicultural treatment*. New York: Free Press.
- Kristeva, J. (1991). *Strangers to ourselves*. New York: Columbia University Press.
- Kumpfer, K. (1994). *Implementation manual for the Strengthening Families Program*. Unpublished manuscript, Salt Lake City, University of Utah, Department of Health Sciences.
- Laird, J. (1994). Lesbian families: A cultural perspective. In M. Pravder Mirkin (Ed.), *Women in context: Toward a feminist reconstruction of psychotherapy* (pp. 118-148). New York: Guilford Press.
- Landau-Stanton, J., & Clements, C. D. (1993). *AIDS, health, and mental health: A Primary sourcebook*. New York: Brunner/Mazel.
- Levinas, E. (1992) *Otherwise than being or beyond essence* (A. Lingis, Trans.). The Hague: Martinus Nijhoff. (Original work published 1974)
- Levinas, E. (1992). *Totality and infinity: An essay on exteriority* (A. Lingis, Trans.). Pittsburgh, PA: Duquesne University Press. (Original work published 1961)
- Liddle, H. A. (1995) Conceptual and clinical dimensions of a multidimensional, multi-systems engagement strategy in family-based adolescent. *Psychotherapy*, 32, 39-58.

- Liddle, H. A. (2000). A family-based, developmental-ecological preventive intervention for high-risk adolescents. *Journal of Marital and Family Therapy*, 26(3), 265-279.
- Liddle, H. A., Henderson, C E., Rowe, C. L., & Dakof, G. A. (2001). *Multidimensional family therapy for adolescent substance abuse: Major findings from a clinical research program*. Miami, FL: Center for Treatment Research on Adolescent Drug Abuse.
- Lindblad-Goldberg, M., Dorc, M., & Stern, L (1996). *Creating competence from chaos: A comprehensive guide to home-based services*. New York: Norton.
- Lindblad-Goldberg, M., & Dukes, J. (1965). Social support in Black, low-income, single-parent families: Normative and dysfunctional patterns. *American Journal of Orthopsychiatry*, 35, 42-58.
- Madsen, W. C (1999). *Collaborative therapy with multi-stressed families: From old problems to new futures*. New York: Guilford Press.
- McDaniel, S., Hepworth, J., & Doherty, W. (1995). Medical family therapy with somatizing patients: The co-creation of therapeutic stories. In R. Mikesell, D.D. Lusterman, & S.H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory* (pp. 377-388). Washington, DC: American Psychological Association.
- McDonald, L., & Frey, H. E. (1999). Families and schools together: Building relationships. *Juvenile Justice Bulletin* (pp. 1-19). Washington, DC: U. S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.
- McGoldrick, M. (Ed.). (1998). *Re-visioning family therapy: Race, culture and gender in clinical practice*. New York: Guilford Press. .
- McGoldrick, M., Giordano, J., & Pearce, J. (1996). *Ethnicity and family therapy (2nd ed.)*. New York: Guilford Press.
- Mikesell, R., Lusterman, D. D., & McDaniel, S. H. (Eds.), (1995). *Integrating family therapy: Handbook of family psychology and systems theory*. Washington, DC: American Psychological Association.
- Minuchin, P. (1995). Children and family therapy: Mainstream approaches and the special case of the multicrisis poor. In R. Mikesell, D. D. Lusterman, & S. H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory* (pp. 113-124). Washington, DC: American Psychological Association.
- Minuchin, P., Colapinto, J., & Minuchin, S. (1998). *Working with families of the poor*. New York: Guilford Press.
- Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.
- Minuchin, S., & Fishman, H. C. (1981). *Family therapy techniques*. Cambridge, MA: Harvard University Press.
- Minuchin, S., Guerney, B. G., Montalvo, B., Rosman, B., & Schumer, F. (1967). *Families of the slums: An exploration of their structure and treatment*. New York: Basic Books.
- Moore Hines, P. (1988). The family life cycle of poor Black families. In B. Carter & M. McGoldrick (Eds.), *The changing family life cycle* (pp. 513-514). New York: Gardner Press.
- Parnell, M., & Vanderkloot, J. (1994). Poor women: Making a difference. In M. Pravder Mirkin (Ed), *Women in context: Toward a feminist reconstruction of psychotherapy* (pp. 390-407). New York: Guilford Press.
- Philpot, C, & Brooks, G. (1995). Intergender communication and gender-sensitive family therapy. In R. Mikesell, D.D. Lusterman, & S. H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory* (pp. 303-325). Washington, DC: American Psychological Association.
- Pinderhughes, E. (1989). *Understanding race, ethnicity, and power: The key to efficacy in clinical practice*. New York: Free Press.
- Pinderhughes, E (1990). Legacy of slavery: The experience of Black families in America. In M. Pravder Mirkin (Ed.), *The social and political contexts of family therapy* (pp. 289-305). Needham Heights, MA: Allyn & Bacon.
- Pravder Mirkin, M. (Ed.). (1990). *The social and political contexts of family therapy*. Needham Heights, MA: Allyn & Bacon.
- Pravder Mirkin, M. (Ed.). (1994). *Women in context: Toward a feminist reconstruction of psychotherapy*. New York: Guilford Press.
- Rabinow, P. (Ed.). (1984). *The Foucault reader*. New York: Pantheon Books.
- Saba, G. W., Karrer, B. M., & Hardy, K. V. (Eds.). (1990). *Minorities and family therapy*. New York: Haworth Press.

- Savin-Williams, R. C. (1998). " ... and then I became gay": *Young men's stories*. New York: Routledge.
- Schefflen, A. (1981). *Levels of schizophrenia*. New York: Brunner/Mazel.
- Schorr, L. B. (1997). *Common purpose: Strengthening families and neighborhoods to rebuild America*. New York: Anchor Books.
- Scrivner, R., & Eldridge, N. (1995). Lesbian and gay family psychology. In R. Mikesell, D. D. Lusterman, & S. H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory* (pp. 327-344). Washington, DC: American Psychological Association.
- Seaburn, D. B., Lorenz, A. D., Gunn, W. B., Jr., Gawinski, B. A., & Mauksch, L. A. (1996). *Models of collaboration: A guide for mental health professionals working with health care practitioners*. New York: Basic Books.
- Simon, R. (1986). Across the great divide: A mental health center opens doors in the South Bronx. *Family Therapy Networker*, 10(1), 20-10, 74.
- Sluzki, C. E., & Ransom, D. C. (Eds.). (1976) *Double bind: The foundation of the communicational approach to the family*. New York: Grune & Stratton.
- Stanton, M. D., & Todd, T. C. (1982). *The family therapy of drug abuse and addiction*, New York: Guilford Press.
- Steinglass, P., Bennett, L., Wolin, S., & Reiss, D. (1987). *The alcoholic family*. New York: Basic Books.
- Szapocznik, J., & Kurtinca, W. (1969). *Breakthroughs in family therapy with drug-abusing and problem youth*. New York: Springer.
- Szapocznik, J. & Kurtines, W. (1993). Family psychology and cultural diversity: Opportunities for theory, research, and application. *American Psychologist*, 48, 400-407.
- Thomas, A., & Sillen, S. (1979). *Racism and psychiatry*. Secaucus, NJ; Citadel Press.
- Walsh, F. (Ed.). (1999). *Spiritual resources in family therapy*. New York: Guilford Press.
- Weingarten, K. (1994). *The mother's voice: Strengthening intimacy in families*. New York: Guilford Press.
- Wetzel, N. A. (1994a). Beyond the therapy room: Therapy and politics in the global village. *Peace Psychology Bulletin*, 5, 23-27.
- Wetzel, N. A. (1994b). Beyond the therapy room: Therapy and politics in the nuclear age. In B. Gould & D. H. DeMuth (Eds.), *The global family therapist: Integrating the personal, professional, and political* (pp. 22-40). Needham Heights, MA: Allyn & Bacon.
- Wetzel, N. A. (1998a). Contextual dimensions of inner-city healthcare: Integrating family systems and community approaches: Reflections on the work of the St. Martin's Center for Health Services in Trenton, NJ. *Families, Systems, and Health*, 16(1/2), 85-102.
- Wetzel, N. A. (1998b). The Family Intervention Program: A context oriented intervention model for adolescents at risk *New Jersey Psychologist*, 48(1), 24-27.
- Wilson, W. J. (1997). *When work disappears: The world of the new urban poor*. New York: Vintage Books.
- Wilson, W. J. (1999). *The bridge over the racial divide; Rising inequality and coalition politics*. Berkeley: University of California Press.
- Winawer, H., & Wetzel, N. (1999). Youth in the inner cities: School-based and community-oriented family therapy. *Newsletter, American Family Therapy Academy*, 78, 37-38.
- Winawer-Steiner, H. (1979). Getting started in family therapy: A preliminary guide for therapist, supervisor and administrator. In M. Dinoff & D. Jacobson (Eds.), *Neglected problems in community mental health* (pp. 154-174). Huntsville: University of Alabama Press.
- Wistow, F. (1986). A safe harbor: A client constructs a new life on the mean streets of the Bronx. *Family Therapy Networker*, 10(1), 33-36, 75.
- Wright, L. M., Watson, W. L., & Bell, J. M. (1996). *Beliefs and families: A model for healing illness*. New York: Basic Books.
- Wynne, L. C. (Ed.). (1988). *The state of the art in family therapy research*: New York: Family Process Press.