Methods of Engagement in Family-Based Preventive Intervention

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ABSTRACT: Family-based prevention programs have shown promise in preventing drug use and antisocial behavior in high-risk youth. Multidimensional family prevention (MDFP) is an intensive, family-based counseling program in which a family-specific prevention agenda is crafted with each family. This collaborative, individualized approach to intervention requires a high degree of engagement on the part of families. The main challenges of engagement are discussed, and the main features of an engagement strategy are described: capturing the interest of the family and assessing risk and protective factors within the specific ecological context of the family in order to create a working agenda for preventive intervention.

KEY WORDS: Engagement in Family-Based Prevention.

Introduction

Child and adolescent disruptive behavior problems such as aggression, conduct disorder, delinquency, and drug use are health concerns that compromise developmental achievement and place youths at great risk for poor adjustment and psychological disorder in adulthood (Dishion, French, & Patterson, 1995). In addition, severe antisocial behavior has proven to be extremely resistant to remission and to treatment efforts (Reid, 1993). Family-based prevention has recently shown promise as a means for addressing the multiple influences that

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give rise to antisocial behavior (Hawkins, Catalano, & Miller, 1992; Kumpfer & Alvarado, 1995), and family prevention models have begun to demonstrate some success in preventing drug use and antisocial behavior (Ashery, 1998; Dishion & Andrews, 1995; Kumpfer, Molgaard, & Spoth, 1996; Spoth, Redmond, & Shin, 1998). Prevention programs aimed at strengthening family coping mechanisms offer hope for creating stable gains in problem youth (McMahon, Slough, and the Conduct Problems Prevention Research Group, 1992).

The ideas presented in this paper were developed in a demonstration project funded by the Center for Substance Abuse Prevention (CSAP) designed to evaluate the effectiveness of a drug and alcohol preventive intervention program for at-risk inner-city African-American students aged 11–14, recruited from middle schools located within a nationally recognized Empowerment Zone in North Philadelphia. The project represented a collaborative effort between a community youth organization and a home-based counseling program, Multidimensional Family Prevention (MDFP).

Multidimensional family prevention (Hogue & Liddle, 1999; Liddle & Hogue, 2000) is a family-based prevention model specifically designed to prevent antisocial behavior and drug use in high-risk young adolescents. A randomized demonstration trial has found that MDFP contributes to an increased sense of global self worth, family cohesion, and bonding to school (Hogue, Liddle, Becker, & Johnson-Leckrone, 2002). MDFP combines the features of standard prevention models, which take a curriculum-based and protection-focused intervention approach, with the features of psychosocial treatment models, which take an assessment-based and problem-focused intervention approach. This dual focus is particularly needed for working effectively with adolescents at greatest risk for developing drug use and problem behaviors. Such adolescents require intensive prevention services that address both risk and protective factors, devote considerable energy to the family environment, and coordinate efforts across the multiple social contexts that influence the lives of adolescents (Jessor, 1993; Liddle, 1996). A large body of empirical research points to bonds to family and prosocial institutions as offering important protection to youth from the deleterious effects of antisocial behavior (Hawkins et al., 1992). Research evidence also clearly demonstrates a strong relationship between family cohesion and adolescent competence and well-being (Resnick et al., 1998). The goals of MDFP for high-risk youth and families are twofold: first, to help the teenager to achieve a developmentally appropriate, interdependent attachment

bond with his or her family; second, to support the adolescent in fashioning solid connections with prosocial institutions—educational, recreational, and religious (Liddle & Hogue, 2000).

Many prevention programs used in non-clinical settings have featured family skills training. Because the skills-training model does not traditionally extend much beyond the microsystem of the family into the other ecosystemic contexts which affect both family and individual functioning, it may be limited in its ability to address fully a family's prevention needs (Liddle & Hogue, 2000). In addition, because a typical skills-training curriculum is didactic (and, at minimum, semi-structured), it may not be sufficiently flexible to capture the diversity of family types that exists in a given prevention population. It may thus fail to engender motivation in some families.

The multidimensional family prevention model, described in detail elsewhere (Hogue, Liddle, & Becker, in press; Liddle & Hogue, 2000), has two principal features that set it apart from most family prevention models. First, it is a flexibly-delivered intervention that assesses the unique profile of risk and protective factors presented by each family in order to establish an individually tailored prevention agenda. Second, the model takes an ecological approach to prevention (Bronfenbrenner, 1986) that systematically assesses and, when indicated, intervenes into the numerous social contexts in which adolescents participate (e.g., family, school, peer, community). MDFP assesses adolescent, parental, and familial functioning in a number of risk and protection domains that have been linked to the development of antisocial behavior, focusing on both the adolescent's level of functioning within these diverse domains and on parental knowledge about, and direct participation in, the social contexts most salient for the adolescent. By working to help parents become developmentally aware navigators of the adolescent ecosystem, the model endeavors to create a more flexible and resilient family environment to protect against the onset of antisocial behavior. The model operates from a person-in-environment perspective and employs a strengths-based philosophy.

Clinical literature indicates that, for parents of antisocial children, the sense that treatment will be over-demanding can be a major predictor of dropout (Kazdin, 2000). In a voluntary prevention program such as MDFP, whose participants are families of high-risk inner-city teenagers—a population that has classically been difficult to serve—demands made upon parents must be carefully weighed. The program delivery aspects of MDFP are tailored to meet a family's unique needs. Sessions are conducted in a one-to-one (versus group) setting, and the

prevention and case management work occurs in the home, at the clinic, and in various community locations as indicated for each family. Sessions are conducted with individuals, dyads, or entire families, and both in-session and out-of-session behaviors are targeted for intervention. Prevention workers are social workers or other mental health practitioners who have experience working with families.

In a prevention program such as MDFP, strategies for engagement must be attended to with particular care, since participation is voluntary and the majority of families who agree to participate in a prevention program have, at the outset, only a superficial understanding of what such participation will mean for them. Engagement in MDFP has much in common with the process of joining in family therapy that Minuchin and Fishman (1981) have described as facilitating the "building of common ground" (p. 32). We believe that success in engagement requires all of the following elements: (a) engagement of family members' interest in the process of self-exploration and agenda formation; (b) assessment of risk and protective factors; and (c) creation of a collaborative working agenda.

It is during the initial stage of the program that a broad-level assessment of risk and protective factors is made and the unique strands of a family's experience are interwoven with more generic strands of protective content. In this paper we focus on issues specific to the engagement phase of family-based prevention in a model that features customized assessment and intervention planning, and we recommend procedures for creating a collaborative, family-specific prevention agenda with high-risk adolescents and their families.

Engagement: Methods and Goals

Motivation and Interest

Since families generally do not enter prevention counseling with a high level of self-induced or institutionally induced arousal around a problem, strategies for achieving and sustaining the interest of family members must be particularly well thought out. Parents' stated or unstated questions concerning what benefit will accrue to them from talking to a stranger about their teenager and about their parenting practices and attitudes often hang in the air and need to be addressed from the outset. Although parents can be initially engaged around a general concern for the developmental progress of their adolescents,

retaining a family requires collaborating with family members to unfold a practical working agenda and a set of counseling tasks that clearly demonstrates how talking together in a room will help achieve that agenda.

What parents are seeking are some ideas from the worker about what participation in the program entails. The worker's need to provide structure for this enterprise is pressing, and success at this juncture will greatly influence the engagement process. Since the prevention worker's task does not depend upon obtaining family members' agreement to centralize a certain problem or to accept a given systemic/interactional interpretation of a problem, the worker must seek the family's agreement to enter into a specific way of working in collaboration. This means of working will emphasize family relationships and the importance of attachment and communication. It will focus on helping parents implement strategies for remaining effective and influential in the lives of their adolescents through discussing topics in sessions which have meaning for both teenager and parents. Thus, the goal is to engage families in working with interactional processes and with regard to tasks that have significance for both adolescent and family development.

In order to gain the family's cooperation, workers must take the time to learn about individual and collective goals, motivations, and relevant history. They must introduce important content and themes into the counseling that will have resonance for the family—content derived, in part, from predetermined knowledge of family psychology and risk and protective factors in adolescent development and, in part, from the idiosyncratic situation and motivations of the given family as they have understood them. Tailoring the prevention interventions to the particulars of each individual family relies on an active use of developmental knowledge to assess the functioning of the family.

The Initial Stage: Understanding the Program

It is only natural for families to want to know what they are going to do in a prevention program. In MDFP it is necessary but not sufficient to introduce families to the content domains into which the worker will lead them: the school context, the world of peers, and the like. The larger task for the worker is to engage family members' interest in the work ahead and to help family members get comfortable with an initial period during the course of which the agenda will be formulated through getting to know the family.

In this enterprise, the worker has much to learn from the successful journalist or documentarian about how these professionals come to know their subjects and engage their subjects' interest in being known. The worker who can interest the family in *itself* (i.e., interest family members in themselves and how they respond to each other) is likely to be successful in engaging them in prevention work. Questions need to be sufficiently compelling in order to cause family members just entering the program to leave a session considering that they have never really talked about family life in such a way. In a context that does not give workers their customary mandate for the work—that is, the existence of a "problem"—workers may be hampered by a sense that they are being intrusive because the family has not asked to be known, and by a feeling of ineptitude because, in the absence of an immediate agenda they are not certain where to go. To the extent that workers feel both intrusive and inept, they will find themselves inhibited in their efforts to establish a sound working relationship with family members.

Creating a relationship with family members in the absence of a clear mandate is a daunting task. The worker who fears that there is nothing to hold the family to its initial agreement to enter a prevention program will behave quite differently from one who believes that, for the family, the process of becoming known is intrinsically compelling. Initially, the most useful antidote to these concerns is a careful conceptualization of what the first sessions will look like and the ability to articulate to the family, in concrete terms, the underlying philosophy of the program and the process whereby the objective of "prevention" will be achieved. Here is an example of such an initial anchoring "mission statement":

> As you know, this program is about teenagers and their families—helping teens develop in a good way and helping their parents to guide them as they grow. You are the best bet your son/daughter has for turning out well; your influence and values are what are going to protect him/her against what is out there. You already know that, I imagine. But how does that work? How can you really protect him/her? These days, we believe that the real protection you offer is in the relationship between you [parent(s)] and your son/daughter. You can't offer that protection by following him/her around, because s/he's getting older. You can offer rules, and rules are important, but even rules are not everything. So a lot of it comes down to the relationship between you—how effectively you and s/he are getting through to each other, so that each of you gets taken seriously. I know you want your son/daughter to come to

> you when there are things to work out or decide. It's only when s/he lets you into his/her life that you have influence. And, at this point in his/her life, [name] has a choice about whether to come to you or not.
> I'm interested in how you are with one another, what you consider important in parenting, what kind of person you [teenager] are and how you want things to go for yourself. It may seem a little strange at first, talking about yourselves with someone you don't know. But parents and kids tell us that they don't get much time to look at what's going on in the family, and that it can be interesting to get to know each other a little differently. So some of what we'll do here is to look together at what is working and what could be going better as you go into this period where things are changing.
> We'll decide together what we want to spend the most time getting into. There are certain things that may be high on your list, and then there are other things that haven't come up yet, but that you can get ready to deal with together as you [teenager] get older. Does this sound O.K. to you?

As workers proceed to discuss how families may experience this "getting to know you" process, they should attempt to uncover what family members' imagined the program might be like as well as reactions to and reservations about this initial plan. The importance of holding this discussion should not be underestimated. Not only does it help define the family's expectations, but the worker may need to refer to it more than once during the first several sessions in order to help families tolerate what may seem to them a less structured experience than they had anticipated when they agreed to enter a prevention program.

Some parents' initial response to the worker's questions may be to insist that everything in a particular domain is "fine." This type of response may indicate a lack of understanding of how to describe family processes, and the worker may need to assist family members in focusing on how things go in the family (e.g., how individuals perceive each other and how they respond in given situations). From other parents, a response of "fine" may indicate a fear that the worker is looking for (or, indeed, may find) something "wrong" or "bad" in their management of family relationships and/or decisions. The worker will need to explore these possibilities with family members and help them discuss their feelings about the process before proceeding. The worker seeks to achieve a certain level of detail about a given topic of interest—family interactions around homework, for example, or how the adolescent makes friends, or how the parent utilizes resources. The ability of family members to provide this level of detail depends, first, upon how

salient the subject under discussion is for them and, secondly, on how effectively the worker can engage them in this topic as an area of work.

The worker, in trying to establish a mandate for examining interactional processes and unique values/judgments, must listen for topics that are salient for the family—generally, content that is of current interest and/or importance or that represents important values. In coming to understand the idiosyncratic interests, values and beliefs of a family, the worker can, in tandem with the family, formulate a working agenda that will have resonance.

Setting the Collaborative Prevention Agenda: Engaging Questions and Engaging Themes

Questions that provoke discussions among family members and between family members and the worker provide a compelling experience for families. Although answers to these questions may prove extremely informative to the worker, the questions are also an engagement strategy.

The worker who asks questions in a hit-or-miss fashion will fail to define the structure of the work ahead; the worker who insists on taking a complete history will fail to introduce the family to the process of collaborative dialogue. Families themselves may be eager to "help" workers by offering pertinent information that they assume is needed. However, a vital opportunity for engagement will be lost if the worker accepts such assistance, because the information volunteered is generally "old news" to family members, and overfocusing on it prevents the worker from interesting family members in the process of prevention work.

The worker's questions at this stage must be carefully selected not only to capture the interest of family members, but also to reinforce the themes that inform the work ahead. Questions will frequently target patterns of interaction and the nature of relationships within the family from the perspective of various family members, as in circular questioning (for techniques of circular questioning, see Fleuridas, Nelson, & Rosenthal, 1986). Questions are multidimensional, eliciting multiple varieties of human experience. Many of them are designed to encourage recall of family history, and these narratives naturally evoke emotion and create a climate of empathy (Diamond & Liddle, 1996; Diamond & Liddle, 1999). An example is: "When you think back

to when your daughter was born, what do you remember? How did you feel when you held her in your arms for the first time? Do you recall any dreams you had for her future then? Tell me about them." Typically, questions are framed in such a way as to discourage defensive responding (Wachtel, 1993). For example, "What do you think you learned about being a parent from your own parents? What do you do that they used to do? Are there things that they did that you have tried especially hard to repeat with your children? If so, what are they?" These questions leave it entirely to the parent(s) to determine whether they choose to talk about any of their own parents' poor parenting practices. A series of questions (to parents) like: "We're interested in what makes families work. Why do you think some families work while others don't? Think of a family you know that works really well and one that doesn't. What's different about these two families? How would you compare your family to each of these two families?" (see Gottman, 1997, for prototypes of these questions used with couples) enables a worker to obtain a good deal of information about both positive and negative aspects of the family as seen from the parental point of view. It also pulls for the articulation of overarching values about what constitutes optimal family functioning, and does so in a way that may prove both more interesting and easier to respond to than direct questions about general family values and perceptions of family functioning.

Engagement questions fall into several categories that represent prominent themes in the counseling:

- *Family Life*. Examples: The happiest/hardest times in the family; recent good times; current activities family members have shared; significant family memories; the evaluation of family life. *Goals: Encourage recognition of the shared past and present interrelationship among individuals which constitutes a family legacy; gain information about the degree of unity and the perceived degree of unity in the family.*
- *Parenting*. Examples: Parents' ideas about differences in parenting children versus adolescents; contributions that others have made to parenting their children; notions about discipline and monitoring; the story of how parents themselves were parented; how parents experienced the transition to parenthood; sacrifices parents have made in order to raise their children. *Goals: Generate, on the part of the adolescent, a new under-*

standing of the self of parent(s); gain information related to positive and negative attributions parents make about parenting as well as self-evaluation of parental effectiveness.

- *The Adolescent's World; Parental Hopes.* Examples: Parents' dreams for their adolescents; parental understanding of teenager and his/her world. *Goals: Create opportunities for teenagers to hear of their parents' hopes for, and connection to, them in positive ways; expand and enhance parental knowledge of their adolescents' dreams, values, friends, pursuits, worries; assist parents in retaining optimal, protective influence with their teenagers by keeping a current mental map of their adolescents' feelings, minds, and worlds.*

As the worker opens up a dialogue between parent(s) and adolescent, she helps to forge stronger attachment bonds by increasing the size of the territory in which discussion can occur and, thereby, the amount of potential influence available to each. The topography of the relationship can begin to shift. If "engaging" questions succeed in their goal, families will have a template for the relational aspects of the work ahead. In addition, entrance into each of the assessment domains that forms the core content of the prevention program is eased when there is an established dialogic process among family members as well as between worker and family members.

Assessment

As workers begin to learn more about a family in the process of engaging their interest, and to assess factors such as the family's level of motivation as well as family members' capacity to articulate positions and needs, they are also assessing individual and family risk and protective factors in these domains: school, peers and peer influence, drug use, adolescent autonomy and parenting practices, self-concept and sexuality, race and culture, and bonding to prosocial institutions. Each of these content domains must be entered with every family in order to make an assessment of risk and protective factors, and the sum of these assessments constitutes a family profile which is used in the formation of a collaborative working agenda that targets specific content areas for discussion. For some families, only one area may be focused upon; for others, many may be targeted. Assessment, then, leads to interventions which are tailored to the needs of each family in two ways. First, the decision about content emphasis depends on

the family profile that is achieved with the assessment; second, discussions within the domain or domains targeted are made relevant to the family in question, given its history, style, and patterns of communicating, among other variables.

Challenges for the Worker

For the worker, some unique challenges are posed in the engagement phase of family-based prevention work. As in all work with families, a successful alliance depends upon the development of an agenda which has resonance for the individuals involved. In family prevention counseling, prevention of both drug use and antisocial behavior are the "treatment" and the goals. Without an identified problem, the worker may begin to feel that there is no "hook"—that there is no real reason for the family to return. In the absence of any other engagement strategy except a problem focus, the worker may feel there are only two alternatives. One of these is to find a problem which the family has not previously identified; the other is to take an aggressive approach to "selling" the program vigorously. Each of these approaches can be detrimental to the process of engagement with families.

Joining with a family around a problem is itself problematic for the prevention worker, given that the family has not necessarily agreed to enter prevention counseling because it has problems. A problem focus potentially creates a framework of pathology for what is intended to be a preventive intervention. Parents who have agreed to participate out of care and concern for their children may reasonably be concerned when a worker starts "microbe-hunting." The worker who, having no other means at his/her disposal for creating an agenda, persists in looking for problems will inevitably feel frustrated, and may actually become angry with the family for failing to help sufficiently in the creation of an agenda.

An approach that overfocuses on problems compromises engagement in two principal ways. On the one hand, if the search for problems is successful, the adolescent (his or her behavior, attitude, school performance, etc.) will undoubtedly be offered up to the worker as the "problem" and will thereby become the target of criticism by his/her parents at a time when s/he does not yet have an alliance with the worker. The worker will then be perceived as an ally of blaming parents, and the alliance will be jeopardized forthwith. On the other

hand, if no problems are found, parents and adolescents may well begin to wonder why they agreed to embark on this journey in the first place if it is only with the object of being criticized.

In order to avoid rooting around for problems as a means of engagement, it is useful to discuss with parents the goal of helping them help their teenagers to "stay on the right track." Families find the goal of planning for the transitions ahead as their adolescents move into a period of great developmental change and social and academic challenge very attractive, and it is not difficult for worker and parent(s) to come to agreement here. Once agreement has been reached on this general goal, however, the question arises as to how it will be accomplished. Workers involved with families that are doing reasonably well may find themselves with the unenviable job of trying to create an agenda without any cues from the family as to which areas of functioning, if any, need to be shored up. At this point it may prove tempting for the worker to continue to "sell" the program through an emphasis on the bumpy road the family faces ahead. Paradoxically, however, attempts to get the family on board via concern about the impending difficulties of later adolescent development may only serve to diminish their enthusiasm and commitment.

Painting a foreboding picture of the future for parents in order to energize their protective mechanisms betrays a lack of trust in parents' own ideas about family strengths and creates a negative valence around the early counseling situation, especially with families who report few difficulties—those families for whom the immediate reality of a serious problem does not exist. If parents are not feeling anxious in the present, they will naturally feel disinclined to have anxieties about the future aroused by an insistent worker. It is considerably more effective for the worker to reinforce parents' original impetus for engaging in a prevention program: their desire to shore up their adolescent's strengths.

Tailoring Program Specifics to Family Differences

Families at each end of the "problem" continuum require different types of attention in order to help them arrive at the same prevention goals. MDFP offers the possibility of shaping content and process differentially in order to accommodate diverse family structures with a variety of communication styles and varying perceptions of need. In order to achieve the same level of "prevention," some families will not need as much assistance in a particular domain or domains as others.

Likewise, some families will require more vigorous efforts to sustain their interest and engage their ongoing participation than will others. Within given families, one or more members may require additional support from the worker if prevention goals are to be achieved. In MDFP, the heterogeneity of the prevention population is taken into account and translated into program methods and goals that are sufficiently flexible to serve families ranging along a continuum, from those who appear relatively "problem-free" to those who more closely resemble clinical families.

The Program and the "Problem." In the case of a family in which parents report few, if any, difficulties, the challenge is to engage their interest and collaboration in an enterprise which is absolutely voluntary, in the absence of any obvious motivation which might impel them to seek out a relationship with a helping professional. A family that reports obvious difficulties presents an entirely different set of challenges for the prevention worker.

The portrait of such a family is one that clinicians easily recognize: the teenager may be performing poorly and/or exhibiting incipient behavior problems in school or at home; parent or parents will typically view the child as a "problem" and view the relationship between parent and child as unsatisfactory or unsatisfying in some way. Parents may feel that they are not effective in maintaining limits and may tend to use the language of ineffectiveness and/or blame ("I don't know what to do that I haven't done," "Cheryl just wants to do what Cheryl wants to do," "She's just lazy, that's all"). When conversations between these parents and teenagers do occur, they are often initiated by parents eager to lecture or reprimand. Parent(s) and children do not report a sense of closeness.

With these families, the process of asking "engaging" questions may not be workable. Parents in such families may, in fact, feel that their concerns have been overlooked if workers begin to ask them questions that appear removed from the present dilemma. They need little coaxing to enter into a conversation with the worker; however, they often assume that the bulk of the work will consist in "solving" the presenting problem, and the conversation in which they seek to engage, full of blame and reproach, may not provide the worker with a reasonable vantage point from which to engage the adolescent or help the family define a workable prevention agenda. With these families, the challenge is to address areas of concern to them without losing sight of the need to enter domains of work other than those presented in the

obvious complaint or problem, so that the overall protective function of the prevention work is preserved.

Prevention workers must, therefore, work to contextualize the "problem" within the set of nested structures that forms the adolescent's ecological environment (Bronfenbrenner, 1979). In this way, they can address the presenting difficulty while simultaneously connecting assessment and intervention at this level to the necessary exploration of related content domains that lie outside it. For example, as is often the case, if a parent or parents indicate a primary concern with a son's/daughter's poor school performance, the worker may centralize this concern, but also explore the "problem" within the context of the family, within the context of school and peer group, in relation to the parents' connection to school and community, and with regard to any culturally-derived beliefs on parent's and teenager's parts about the meaning of school performance. These contexts should be explored, not in checklist fashion, but rather, in a manner which emphasizes the organic interconnections among them. In this way, assessment of, and intervention into, the problem area leads naturally to assessment of, and intervention into, related domains. Parents do not feel unheard in their concerns about the immediate problem, as they are not coerced into leaving the field of concern in some artificial way in order for other prevention-related topics to be addressed. Adolescents in these families will be relieved of the burden of excessive parental and worker pathologizing as exploration of domains moves conversations beyond parental concern about specific behaviors. In addition, access to all the domains that are due to be assessed can be readily achieved through this approach to the "problem."

Conclusion

The prevention worker is challenged to conduct early-phase work in a substantially different manner than typically occurs in treatment. Engagement strategies with prevention families do contain many elements basic to good therapy with clinical families: alliance-building with each member, developing a systemic understanding of and formulating systemic hypotheses about key areas of family functioning, integrating prior information into the content of the session, and giving the family multiple opportunities to practice new relational skills within the session. However, prevention workers work carefully to *avoid* anchoring the counseling to a specific problem or even a specific

problem context. Workers are not interested in formulating a systemic understanding of the *problem* foremost, but are looking to formulate a systemic understanding of the *family* foremost. As such, workers must decide how much (if any) attention should be allocated to *any* problem identified at any point during counseling. Naturally, clinical-level problems receive immediate and extensive attention, insofar as these problems represent destructive risk factors that compromise several areas of functioning and development. Even in this case, however, work with a given family cannot be restricted to such problems.

Rather than adopting the position "There is something in it for the family if I can help fix a problem," prevention workers must adopt the philosophy that "There is something in this process that will strengthen the family for having experienced it, and we can also address any problems that exist along the way." Family preventionists look to investigate together with the family how important processes work in (and on) the family, and they must bring their expertise to bear on issues which come to light as a result of this process. They assist members in talking in some detail about what is working well in the family. Family members who are more aware of what they are doing well are more inclined to repeat these behaviors.

This strengths-based strategy is part of the engagement process as well as a mainstay over the course of counseling, serving to reinforce and enhance adaptive functioning. In a few families, it will quickly become evident that a solid foundation exists and adaptive mechanisms are in place for handling near and future challenges, and such families will spend a relatively brief time in prevention counseling, drawing from it a valuable sense of validation for their specific strengths as well as a sense of preparedness that further fortifies that foundation. With all families, presenting the counseling as a means of bolstering existing strengths in order to help the family meet future challenges, creates an environment of mutual energy and collaboration—a secure base from which the worker can challenge the family, question ingrained habits and belief systems, and act as a catalyst for change.

Even in the case of more troubled families, counseling will inevitably shift its focus from the problems the family has now or may have in the future, toward a focus on: (1) whether/how family processes will hold up over time (so that the values they support can be sustained), and (2) whether these processes work optimally now or can be modified to some degree in order to ease the stress or anxiety identified by a family member or members. This work would not be possible were

it not for the success of initial engagement strategies and engagement questions. Solid engagement around salient content leads to the fleshing out of a collaborative prevention agenda tailored to meet the interests of a given family as well as their present and future needs. The discussions among family members that arise in the creation of that agenda provide new content for, and a new exposure to, a way of relating that enlarges the shareable space between the worlds of parents and adolescents.

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