CHAPTER 5
INTERVENTIONS

Adolescence is a time of significant developmental transition that is considered to be second only to infancy in the magnitude of changes that occur (Lerner and Villarruel, 1994). Adolescents experience numerous developmental challenges at varying pace, including increasing need for independence; evolving sexuality; transitioning through education and commencing employment; consolidating advanced cognitive abilities; and negotiating changing relationships with family, peers and broader social connections (Cameron and Kanabarrow, 2003).

The adolescent period is also marked by increased involvement in risk behaviours that may predispose young people to poor long-term outcomes. Many of these risk behaviours are relatively transitory in nature and are resolved by the beginning of adulthood. However, there is increasing evidence of the significant level of emotional and behavioural difficulties such as depression, anxiety, conduct disorder, substance misuse and suicidal thoughts that are experienced by some adolescents (Sawyer, 2001).

Risk factors for maladaptive outcomes in adolescents are found across all domains including individual characteristics, family, peers, school and community. For example, current research indicates the following:

- depressive symptoms in adolescents are strongly related to family factors such as poor family functioning (Bond, Toumbourou, Thomas, Catalano and Patton, 2005)
- self harming behaviours in young people are predicted by family discord including poor communication styles, parental mental health problems, family stress, abuse and neglect (Miller and Glinski, 2000)
- conduct disorder is strongly related to previous anti-social behaviour; involvement with anti-social peers; poor social connectedness such as low popularity and peer rejection; early substance use; and having anti-social parents (Bassarath, 2001).

The current thesis raised research questions pertaining to the cause-effect relationship between perceived parenting, mental health and social maturity. The research also set out to identify the pattern of differences with regards to phases, gender, family structure, birth order of adolescents and adolescents’ mother’s working status. The findings indicated a positive and significant relationship between the variables. The trends discussed in the preceding chapter highlight the need of a thorough intervention plan. A broad spectrum of interventions needs to be planned; and the execution of which is to be carried out in line with the specific needs and goals of the target group. However, it is to be understood that interventions with adolescents are long term and cannot be isolated and targeted to only them. It is imperative that parents, schools and the community also be a part of the process alongside the adolescent individuals.

The work of Ungar (2004) and the International Resiliency Project indicate that families are central to the lives of adolescents. Young people want guidance and support from caring adults and need a balance between autonomy and setting limits. Furthermore, even when young people have experienced physical abuse, several protective factors may buffer such youth ‘at risk’ from anti-social behaviour. These protective factors include a positive peer group, positive school climate, religiosity,
other adult support, family support, positive view of the future and involvement in extra-curricular activities (Perkins and Jones, 2004). These findings point to the important place of peers, school and community as well as family in the lives of adolescents and the need for interventions to address these domains.

Within the literature, studies examining the effectiveness of early intervention strategies predominately target infancy and early childhood, and the importance of intervening in late childhood and early adolescence has been overlooked. Interventions delivered during the transition to adolescence are necessary in order to capture three groups of vulnerable children and young people. These include those who: received an intervention in early childhood but who continue to experience problems, are currently experiencing problems without having had an earlier intervention, are not currently experiencing problems but are at risk for developing problems during adolescence.

Early intervention strategies can be broadly grouped into three categories:

- **Parenting programs**: These are usually short-term programs which target the parent or family and provide parenting education or skills training.

- **Child-focused programs**: These programs target the child or young person directly and involve instructional or skills-based approaches delivered in school settings.

- **Multi-component programs**: These programs involve more than one intervention and may target the entire school, the home and/or the community in addition to the child.

Multi-component interventions that target risk and protective factors appear to have more positive outcomes than single component interventions, especially for high risk children and young people. Factors such as cost and ease of implementation
should be considered prior to delivering a multi-component program. Involving parents in a school-based intervention may enhance the effectiveness of a child-focused intervention. These programs can either be executed at an individual or a group level. While the individual programs offer greater flexibility in terms of pace, content and attention to individual problems of the family, the group programs may be less costly and time-consuming and offer more opportunities for social support. While no studies directly compared the relative effectiveness of group and individual programs, there is some evidence that disadvantaged families may benefit more from individual than group parenting programs. Group programs which aggregate high risk children and young people should be avoided due to the potential negative effects of antisocial peers. With all approaches, progress should be monitored and more intensive interventions offered to those who continue to show problems at the end of the intervention.

The interventions can be categorised into:

- **Universal interventions**: offered to all families
- **Selected interventions**: targeting high risk families, based on a single or multiple risk factors, such as poverty or parental mental illness
- **Indicated interventions**: targeting families where the child or young person is already showing difficulties.

Selected or indicated interventions are also called ‘targeted’ intervention, since those at high risk of future problems are targeted for inclusion in the intervention. The advantages and disadvantages for both universal and targeted interventions should be considered when selecting a program. Universal programs have the benefit of reduced stigma and broader application but are less personalised, associated with smaller individual effects and involve greater expense. Targeted programs provide more
personalised contact, may have greater effectiveness, are less costly but are likely to be associated with greater stigma and limited reach. The most effective strategy may be to introduce a multi-level model of prevention with both universal programs and targeted initiatives for those not helped sufficiently by the universal programs.

Interventions for an all-round healthy and integrated development of adolescents need to target parents as well as the adolescents themselves. Literature review stated through the entire thesis and so also the findings indicates that a healthy parent-adolescent bond and an adaptive parenting style is vital for not only better adolescent mental health and higher social maturity indices but so also for over-wellbeing, identity resolution, personality synthesis and consolidation of academic achievement and consolidation of career goals.

5.1 Parenting programs

‘Parenting program’ is an umbrella term used to encompass parent education, parent training, parent support and family skills training. Parenting programs can be delivered in a number of different formats including individual, group or self-directed programs. They can be delivered in a range of settings and vary in intensity and duration. The general aim of parenting programs is to strengthen protective factors such as positive parent-child communication and to reduce risk factors such as poor monitoring and supervision. Significant changes in the parent-child relationship can occur in the transition from late childhood to adolescence. This can present considerable challenges for parents. Children often disengage and distance themselves from their parents and become more dependent on their relationships with peers. It is generally assumed that parental influence becomes less significant as children grow older. However, evidence shows that parental influence maintains a strong and enduring effect in late childhood and early adolescence.
Parenting programs for parents of adolescents have two broad aims: to modify the risk factors of coercive family interaction and poor parenting which play a role in causing and/or maintaining externalising behaviour problems and delinquency (Dishion and Andrews, 1995; Dishion and Patterson, 1992); and to enhance parent-child communication and connectedness and improve parental supervision and monitoring. Parental supervision, in particular, appears to be of crucial importance in preventing a range of adolescent risk behaviours (Coleman, 1997; DeVore and Ginsburg, 2005).

Parenting programs are particularly important for parents of children and adolescents who are at risk of poor outcomes. Universal parenting programs aim to normalise parenting education and encourage all families to participate. Parental training is vital, in order for the parents to assess their personal styles and then modify to more authoritative techniques, as it is consistently known to have positive outcomes for the adolescent, and has been cited through previous chapters. Parenting programs for parents of adolescents are usually delivered when the off-spring is in the transition to adolescence at around 12 years of age. This is an important period for the decline in parental influence and escalation of risk behaviours and family conflict. Parental programs are efficient if implemented via a school setting. By delivering these programs in the school setting and targeting the transition to secondary school, parents are more likely to see parenting programs as a normal and integral part of this transition. These programs have been found to have long-term positive effects on substance use, behavioural problems, positive parenting and family communication. Behaviourally-based parenting programs are effective interventions for high risk children and adolescents. These parenting programs involve active skills training and aim to modify risk and protective factors such as parental monitoring, psychological
and behaviour control exerted by the parents, the parenting style exercised and the mode and quality of parent-child communication and parent-child relationship quality. Changes in these variables then result in improvements in adolescent outcomes.

Behavioural parenting programs are effective in improving adolescent outcomes for families with parental depression, multiple risk factors, marital separation or divorce, stepfamilies, parents stressed by adolescent substance use, children and young people who have, oppositional or conduct problems, children and young people who have ADHD and experience family conflict.

Parenting programs can be implemented as an early intervention to prevent the onset of problems or to ameliorate the severity of existing problems in high risk children and youth. Research examining the efficacy of parenting programs for child, parent and family outcomes has overwhelmingly focused on the preschool and early school-age years, and there is a lack of studies that have focused on parenting interventions for adolescents. One of the reasons for the lack of research on parenting programs for youth is the assumption that parental influence becomes less important as children enter adolescence, due the increasing influence of peers, and due to young people spending less time in the home and therefore being less amenable to change through typical parenting strategies (Kazdin, 2005). However, research confirms the strong and enduring influence of parenting practices during the adolescent period (DeVore and Ginsburg, 2005) and it is clear that parents have an important role to play in supporting their adolescent in the transition to adulthood.

However families and children who are at greater risk of poor outcomes are more likely to drop out of parenting programs. Factors such as severity of child behaviour problems, low child IQ, higher parental depression and stress, and low socio-economic status are related to drop out. There may be strategies which can be
used to help prevent families from dropping out of parenting programs. Practitioners should consider implementing brief motivational enhancement programs prior to program participation. Motivational enhancement strategies may include providing information about the importance of attending, eliciting statements about parents’ plans to attend and developing plans for overcoming parents’ barriers to attendance.

5.2 Child-focused and multi-component programs

Child-focused programs generally focus on changing individual risk and protective factors. These programs often involve instructional or skills-based approaches delivered in the classroom to improve social-cognitive problem solving and emotional regulation. In addition to changing individual risk and protective factors, multi-component programs also address risk and protective factors relating to the school climate, the peer group, the home and/or the community. Multi-component programs usually involve a combination of classroom approaches, school-wide approaches, family-based approaches (parent education, family interventions, home-school collaboration), as well as community development strategies. Child-focused and multi-component programs that are delivered in the school setting may be universal or targeted in their approach. The goal of a universal program is to enhance protective factors on a school-wide basis to keep minor problems and difficulties from developing into more serious problems. Targeted programs typically address groups of students who do not respond to universal programs or who are at heightened risk for developing problems in the future.

The school setting is targeted because schools enable access to the majority of children and young people, including those at highest risk of poor outcomes. Outside of the family environment, the school is the primary setting within which the development of children and young people can be directed and shaped. Delivering
interventions in the school has the potential to reduce the recruitment and retention problems commonly experienced when delivering programs in the community.

The results and discussion of the current thesis pointed that another factor, viz. social connectedness mediated the relationship between perceived parenting, mental health and social maturity and warranted further research and therapeutic attention. School connectedness is an important protective factor for behavioural, emotional and school-related problems. Interventions to enhance school connectedness generally involve multiple components that target the classroom, entire school, family and community. These interventions enhance children’s academic achievement and may prevent a number of problem behaviours, such as substance use and antisocial behaviour.

Importantly, in addition to strengthening and evaluating programs that draw on family, school and community resources, it is evident that children and young people who are ‘at risk’ of entering or enter the child protection system may benefit most from multi-component programs. It appears that Parent Management Training may be effective for some families, particularly parents of children and young people experiencing conduct problems. However, for families with multiple problems, Parent Management Training alone is unlikely to modify risk and protective factors, and more intensive, multi-component programs which involve the young person and/or target parental risk factors should be provided. Cameron and Karabanow (2003, p.460) note that for this group of children and young people one shot, uni-dimensional interventions do not suffice. Not only do these adolescents and their families require multi-component strategies but they require it over a period of years. In order to support adolescents at risk, Cameron and Karabanow (2003, p.463) suggest programs need to facilitate the following: pro-social relations with peers, adults and community
institutions, information, coping skills and tangible resources for everyday living, special support for academic progress and social relations at school, direct support for parents coping with the challenges of adolescent difficulties.

Multi-systemic Therapy provides an example of a rigorously designed program that has multiple components. Multi-systemic Therapy works directly with the family to improving family emotional bonding and parental discipline strategies, together with opportunities for increasing parent-teacher communication and support for academic performance, as well as promoting involvement in extracurricular activities, structured sports or volunteer organisations. However, successful outcomes from programs such as Multi-systemic Therapy rely on the training and commitment of staff, adherence to principles underlying the program/s, commitment to the strategy by young people and their families, co-operation within and between school staff, positive involvement with peers and community or neighbourhood and effective interagency work.

One of the most consistent findings in this review is that parents and family members are keys to the success of most interventions with adolescents. Brosnan and Carr (2000) note in their review of Functional Family Therapy that while the skills base of interventions is important to their success, the capacity of workers to make and maintain collaborative relationships with family members is a particularly important determinant of positive outcomes. Similarly Carr and Semel (2004) note that positive outcomes of interventions for adolescent substance misuse are associated with parental involvement. When parents are involved, young people are more likely to reduce their drug use. It is also important to consider the feasibility and likelihood of family participation. A family’s capacity to enter and remain connected to a program or treatment over time may be limited (Carr and Semel, 2004). Rarely are all
family members enthusiastic about attending programs when only one family member may appear to them to be experiencing the problem (Santisteban 2006). For example, a number of authors note that most families where children require mental health outpatient services do not use these services for very long (Santisteban and Szapocznik, 1994; Hoagwood, Burns, Kiser, Ringelsen and Schoenwald, 2001; Stanton and Heath, 2004).

In particular, vulnerable populations such as children of single mothers, children living in poverty, children with serious problems and those from minority groups are less likely to stay in a program beyond one session and are more likely to discontinue therapy prematurely (Hoagwood et al., 2001). To achieve family participation it is important to identify and address the barriers to participation. For many families, attendance may be limited by practical reasons such as needing to care for other children (Brody, McBride Murry, Chen, Kegan and Brown, 2006). Santisteban et al. (2006) also indicate that the presence of marital conflict or parental substance misuse may influence parent’s decision to participate, and alternatively the young person who is misusing substances may have a powerful role within the family which is limiting their involvement in programs, or other family members may be trying to maintain the status quo.

5.3 Adolescent focused interventions

As the parental and community programs only work to modify the external environment within which the adolescents operate, it is equally imperative to work with the adolescent, as it is primarily that only the adolescent can bring about the desired changes in their individual psycho-social structure, mental health and social maturity indices and identity resolution, quality of life and overall well-being.
5.3.1 Individual therapeutic approaches

- **Cognitive Behavioural Therapy (CBT)** has been found to be the most ‘efficacious’ intervention for anxiety in adolescents (Butler, Chaman and Beck, 2006; Barrett, et al., 2004) and is considered to be ‘probably efficacious’ or promising for depression in adolescents (Ollendick and King, 2004; Butler, et al., 2006). Cognitive-Behavioural Therapy (CBT) can be broadly defined as a combination of cognitive and behavioural therapeutic approaches used to modify maladaptive thoughts and behaviours (Beck, Rush, Shaw, and Emery, 1979). CBT is often considered a ‘short-term’ therapy, which generally consists of approximately 8 to 12 sessions where the client and therapist work collaboratively to identify problem thoughts and behaviours, in order to enable the therapist to provide the client with tools and techniques to alter the way in which they think, feel and behave in a given situation. There are a variety of CBT based techniques used for different populations and different presenting issues; however, the underlying principle of therapy remains the same.

- **Interpersonal Psychotherapy (IPT)** has also been found to be effective in reducing symptoms of depression in adolescents (Mufson et al., 2004; Hazell, 2003) and is possibly more effective than CBT. However, to date IPT does not appear to be effective for young people with anxiety. Interpersonal Psychotherapy (IPT) is described as a time-limited therapy which focuses on the individual’s current difficulties in functioning (Mufson et al., 2004). The aim of IPT is to reduce depressive symptoms by improving the individual’s interpersonal functioning and is based on the premise that a deficit in interpersonal functioning is the cause of the depression. Interpersonal Psychotherapy has its roots in
attachment theory (Bowlby, 1980), where the focus is on interpersonal relationships. Attachment theory states that infants’ early attachments with their caregivers form the basis for future relationships. These attachment styles can be modified throughout the lifespan, meaning that an individual who has poor attachments early in life is still able to form secure attachments later in life. Secure attachments (a balance between exploring the world and attachment to one’s caregiver) are thought to lead to improved mental health; insecure attachments make the individual less adaptable to stress and can lead to unsatisfactory relationships (Durkin, 1995). Based on this notion, IPT focuses its attention on relationships that are either secure or insecure for the individual.

When working with adults, a therapist using IPT focuses on four main areas where interpersonal difficulties may be leading to depressive symptoms: grief, interpersonal disputes, role transitions, and interpersonal sensitivities (Mufson and Pollack Dorta, 2003). The aim is to identify the specific interpersonal relationship difficulties within one of these four key areas in order to effectively treat the symptoms of ensuing depression.

- **Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)** is a model of psychotherapy that focuses on the unique needs of adolescents who are experiencing post traumatic stress disorder (PTSD) or other problems related to traumatic life experiences, particularly sexual abuse. There is strong evidence that TF-CBT is the most appropriate intervention for PTSD, anxiety and depression in sexually abused children and likely to be effective for children exposed to other traumas as well (Saunders, et al., 2003; Chorpita, 2002; Cohen, et al., 2000; Berliner, 2005). The goal of Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT) is to help address the unique bio-psycho-social needs of adolescents.
who are experiencing Post Traumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences, particularly sexual abuse. TF-CBT is a model of psychotherapy based on social learning and cognitive theories and combines trauma-based interventions with CBT. Non-offending parents are included in the treatment process to enhance support for the child, reduce parental distress, and teach appropriate strategies to manage child behavioural reactions. In the latter stages of therapy, family sessions that include siblings may also be conducted to enhance communication (Cohen and Deblinger, 2004). TF-CBT is a clinic-based, individual short-term intervention that involves separate sessions with the child and parent as well as joint parent-child sessions. Children and parents are provided with knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviours; emotional regulation skills; stress management skills; enhancing safety; re-education about healthy interpersonal relationships; parenting skills; and family communication (Cohen and Deblinger, 2004; National Child Traumatic Stress Network). TF-CBT also places sexual abuse and other traumatic experiences into a broader context of children’s and young people’s lives so that their primary identity is not that of a victim (Cohen and Deblinger, 2004).

5.3.2 Group interventions

Group interventions, using approaches such as CBT, have also been developed and tested with adolescents. Most commonly, group therapy has been used for adolescents who have experienced sexual abuse. For these young people, research demonstrates improvements in levels of anxiety, fear, depression, self-esteem, and feelings of competence after attending group interventions (Gagliano, 1987; Kitchur, 1989; Rice-Smith, 1993; Reeker et al., 1997; Stevenson, 1999; Nurcombe, Wooding,
Marrington, Bickman and Roberts, 2000; Dufour and Chamberland, 2004). There are several reasons that group work is considered to be successful with adolescents, for example: adolescents accept comments more readily from peers than from adults, groups offer the advantage of peer interactions and emphasise importance of relationships, members can benefit vicariously from the work done by others; and, groups give opportunities for listening without demands.

Various group interventions have been developed and tested with adolescents, including groups for social skills, cognitive-behavioural groups, psychoanalytic and psycho-educational groups, and other specialised groups, for example, groups for chronically ill and disabled young people, those with a mental illness and those who have been sexually and physically abused (Kymissis, 1993; Reeker, Ensing and Elliot, 1997; Stevenson, 1999; Nurcombe et al., 2000; MacMillan, 2000; Berliner and Kolco, 2000; Dufour and Chamberland, 2004). Glodich and Allen (1998) note that an extensive literature endorses group therapy as an appropriate mode for the delivery of interventions for adolescents and some of the therapeutic approaches described above have also been used and tested in group situations. According to Chaffin, Bonner, Worley, and Lawson (1996), there are a number of reasons why group work is considered to be successful with adolescents, for example: adolescents accept comments more readily from peers than from adults, groups offer the advantage of peer interactions and emphasise the importance of relationships, group norms can be a powerfully socialising influence, members can benefit vicariously from the work done by others, groups provide opportunities for listening without demands.

It is believed that group work is more successful in gaining the immediate participation of young people and alleviating the early resistance that can characterise individual therapy with adolescents (Glodich and Allen, 1998). Furthermore, peer
relationships are viewed as central in helping adolescents with the process of separation-individuation and identity development. Groups can support a positive connection between young people and interpersonal styles and social skills can be observed (Chaffin et al., 1996). Importantly, participation in groups can reduce a young person’s isolation and feelings of ‘differentness’ by engaging with others who have similar experiences (Chaffin et al., 1996; Gagliano, 1987; Kymissis, 1993; MacLennan, 1991; Schamess, 1993; Grayston and De Luca, 1995). In addition to the value of connecting with peers, Eder (2006) draws attention to the important role of the group facilitator or therapist who forms a therapeutic relationship or alliance with individual young people. This relationship is important in facilitating positive outcomes for adolescents (Eder, 2006).

Most commonly group therapy has been used for adolescents who have experienced sexual abuse. Research indicates improvements in levels of anxiety, fear, depression, self esteem, feelings of competence for one to two years after attending group interventions in young people who have been sexually abused (Gagliano, 1987; Kitchur, 1989; Stevenson, 1999; Nurcombe et al., 2000; Dufour and Chamberland, 2004). For children and young people who have experienced other forms of abuse there is less evidence of the value of group interventions (Dufour and Chamberland, 2004). Group interventions with young people have been effective in managing social phobia in female adolescents (Hayward, Varady, Albano, Thienemann, Henderson and Schatzberg, 2000) and anger in adolescents (Snyder, Kymissis & Kessler 1999). Adolescent depression has also been shown to be responsive to cognitive-behavioural group therapy, especially when combined with booster sessions when full recovery was not attained at the end of the initial therapy. This finding is important as it highlights the value of booster sessions with adolescents. While group interventions
are effective for a range of problems, it is unclear as to whether individual or group CBT is more effective (Eder, 2006). Some meta-analyses have shown a slightly increased effect size for individual therapy in comparison to group therapy (Weisz et al. 1995) but the differences in outcomes have not reached significance.

### 5.3.3 Family focused interventions

Family focused interventions are based on social-ecological models and hold that family functioning and interactions may cause, maintain or worsen adolescent conduct disorder or problem behaviour such as substance misuse. Family interventions, including Functional Family Therapy (FFT; Barrett Waldron et al., 2001), Brief Strategic Family Therapy (BSFT; Santistiban et al., 2003), Multidimensional Family Therapy (MDFT) and Multi-systemic Therapy (MST), are all significantly better at reducing adolescent substance abuse than ‘treatment as usual’, and most are promising or effective in reducing conduct problems. While components of these forms of family therapy differ, the underlying principles are the same and include: enhancing positive family relationships by improving communication and conflict resolution, tackling problems within the family which are maintaining the adolescent’s problem behaviour, increasing the level of support provided from parent to child, shifting the focus of the problem from something within the adolescent to something within the family system.

Based on the social-ecological theory proposed by Bronfenbrenner (1979) many theorists and practitioners have recognised the need to tailor interventions towards not only the individual adolescent but also towards the significant others in the adolescents’ lives including school and peers, the local community. Family based interventions hold that family functioning may cause, maintain or worsen adolescent conduct disorder or risk behaviours such as substance misuse. If family relationships
are appropriately modified, these approaches can be effective in reducing the problem behaviours (Woolfenden, Williams, and Peat, 2001). For example, research into adolescent substance misuse has found that family factors (such as poor communication, parental criticism, ineffective discipline, emotional disengagement) can negatively impact on the adolescent and increase their risk of substance abuse. Consequently, family focused interventions that target negative patterns of interaction have been found to be the most effective approaches to adolescent substance abuse when compared with individual supportive interventions or skills training (Carr, 2003). Other research, such as that by Ogden and Halliday-Boykins (2004) found, with a sample of young people presenting with anti-social behaviours, that improving family functioning by working with them within their own social context decreased anti-social behaviours.

5.4 New directions in meeting the needs of marginalised young people

Ungar (2005) highlights the need to consider the role of systems in providing care and support for adolescents that offer a seamless transition across agencies and services. Ungar (2005) has identified a number of specific principles that have the potential to make systems (such as child welfare, mental health, corrections and education) more responsive to the needs of young people. These include:

- Community reach: systems and resources that meet the needs of young people must be, readily available and accessible. This principle emphasizes rethinking the access that young people have to services. For example, can the young person identify and access the service without a professional having to refer or direct them to the service?

- One stop shop: adolescents find it much easier to navigate their way to services when those services are clustered or co-exist. In order to facilitate
successful reintegration into the family and community, adolescents and young people require access to services that form a link or ‘stop gap’ service to provide support to a young person moving from an in-patient facility, correctional placement or out-of-home care, and their subsequent reintegration into the family home and community.

- **Continuity of carer and care**: if young people are to be well supported and successfully moving around in the system they are best served by a few workers who get to know them and their needs well. Emphasis needs to be placed on staff training and skill development particularly in relation to cultural sensitivity and an openness to appreciate differences in other world views.

There is a need for future research to evaluate both casework practice and therapeutic approaches and interventions for adolescents to identify what works, what does not work, with whom and in what situations (Evans and Seligman, 2005; Kazdin, 2003; Dufour and Chamberland, 2004). As Ollendick and King (2004) note, currently there are only a limited number of empirically-supported interventions for children and young people. Many approaches used with adolescents have been tested only with adults or young children and there is limited research conducted with adolescents. Further, most of the ‘well established’ or ‘probably efficacious’ interventions reviewed in this paper are based on behavioural and cognitive-behavioural principles. As Ollendick and King (2004) note, the most frequently used interventions such as CBT tend to be the ones that are evaluated and other approaches used in practice are not sufficiently evaluated. Dufour and Chamberland (2004) have identified there are virtually no studies that evaluate the effectiveness of social work or casework
interventions for children, young people and families that enter the child protection system.

In conclusion, as individuals grow, they closely observe their parents and the familial interactions. They feel inclined to imbibie parental attributes or in some cases, to even rebel against them. Parental acceptance, rejection, and encouragement shape the individual’s view of the world, his attitudes toward society, conflicts and resolution. There can be no ideal circumstances. Demographic variables like age, gender, socio-economic status, cultural and racial identity etc intervene to challenge an individual’s personality coherence and the development of a healthy, balanced emotional, social fully functioning individual. An individual’s attitude, emotionality and coping will enable him to turn adversity to opportunity. The individual will have to optimistically strive to preserve and maintain the integrity of his social environment, his equation with parents and significant others, choice of adequate conflict resolution techniques, and the sustenance of his mental health. There can be no one else initiating the change than the individual himself.