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The Practice of Family Mentoring and Advocacy: A Theoretical Investigation of Critical Issues

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ABSTRACT

This paper examines key theoretical underpinnings of an advocacy initiative reaching low-income and African American families in our community. Its practical benefits are proposed to ensue largely from distinct positions on several issues: the scope and location of intervention; the source of intervention (who the primary helpers are); and the nature of intervention (how helping occurs). For each issue, our own specific positions are detailed against a backdrop of competing general stances. Research on similar initiatives is also reviewed in a way that highlights salient and reoccurring themes across the literature. Overall, this inquiry aims to facilitate deliberation among both academics and practitioners regarding the potential of advocacy as a viable supplement to more traditional interventions for struggling families.

The notion that families in the nation are struggling is prevalent enough to be nearly cliché. From ominous abuse statistics to reports of juvenile crime, struggling marriages, and high divorce rates, evidence of wide-ranging distress within homes is well-known. While the existence of such family problems is generally accepted, there is less agreement as to how exactly to approach these problems. On the level of framing and interpretation, in particular, significant disagreement remains.

On one hand, distressed families are seen by some as primarily reflecting individual/group deficiencies or pathology. The potential role of severe psychological disorders or persisting medical conditions, for instance, may be highlighted. Given this view, helping efforts naturally come to emphasize the correction or alleviation of *internal issues*, typically via particular therapies or biological interventions.

On the other hand, families in distress may alternatively be understood as primarily reflecting broader social ills and troubles. Rather than emphasizing internal or inherent deficiency, this view highlights family struggles as intimately interconnected with larger forces and contexts. From broader media influence to widespread economic fluctuations to local neighborhood problems, the potential role of surrounding environmental context is emphasized. From this portrayal, helping efforts naturally come to emphasize the change or alleviation of *external issues*. Without denying meaningful levels of individual responsibility, such a portrayal often expressly underscores the inherent capability and strength of families, even (or especially) those facing difficult circumstances.

While the latter view constitutes a fundamental point of departure for this paper, the former view reflects its inevitable backdrop. Given the sheer prevalence of internally-focused helping approaches for families, any attempt to explore viable alternatives must take seriously their relevance. In our own examination of a more externally-focused intervention for families, we take care to avoid excessively critical or "straw man" portrayals of dominant practice, acknowledging their real benefits at the outset. In this way, the following exploration of family advocacy is offered as a complementary contributor to shared work, rather than as a competitor.

The range of family interventions specifically attuned to *external distress* may be categorized into (a) direct attempts to change external conditions and (b) initiatives to impact the way individuals *relate* to these conditions. One of the most striking alternative interventions combines both aims. Drawing on earlier initiatives with families facing juvenile problems (Davidson, Redner, Blakely, Mitchell, & Emshoff, 1987), Cris Sullivan at Michigan State University created the Community Advocacy Project, with an aim to both (a) expand the access of domestic violence victims to community resources and (b) cultivate the capacity of these individuals to self-advocate in relation to associated institutions (Sullivan & Bybee, 1999; Sullivan, Bybee, & Allen, 2002). Similar advocacy initiatives have subsequently demonstrated success with Hmong refugees (Goodkind, 2005), mothers at risk for poor pregnancy outcomes (Baffour, Jones, & Contreras, 2006), and individuals facing severe emotional problems (Sangster, 2005). Participants in one domestic violence advocacy program, for instance, were documented as having higher quality of life, more effectiveness at accessing needed community resources, greater social support, and, ultimately, less re-abuse by an intimate partner (Allen, Bybee, & Sullivan, 2004; Sullivan & Bybee; see also Barron-McKeagney, Woody, & D'Souza, 2001, 2002). Notably, evidence suggests such effects may endure to a remarkable degree; according to Sullivan and Bybee, "Interestingly, unlike the typical intervention that demonstrates immediate effects, which then soon deteriorate, the experimental and control groups in this study continued to diverge over a 2-year time period on a number of important variables" (1999, p. 51).

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The purpose of this paper is to systematically examine key theoretical aspects of an additional application of this approach known as "family advocacy." Since 2003, our own Family Advocacy Program (FAP) has been successful in reaching low-income and African American families within our community. This involves a unique 15-week collaboration between supervisory mental health professionals, student advocates, citizen mentors, and the participating individuals themselves, all toward fostering the empowerment of families in achieving the goals that they themselves select. The novel collaboration between student advocates and community "cultural brokers" is particularly crucial to the process (see Key Issue 3 in the "Practice Analysis" section). In a variety of ways, these FAP teams support families in developing their own capacities to overcome challenges, progress in chosen aims, and access needed resources.

Based on experience developing and supervising this initiative, we propose its particular practical benefits as ensuing largely from the distinct theoretical model out of which it operates. To systematically examine this thesis, we identify four issues constituting critical decision points that foreground the distinctive practice of family advocacy. These include the following:

1. The scope of intervention—Individual, family, or system?
2. The place of intervention—Where does a meeting take place?
3. The source of intervention—Who are the primary helpers?
4. The nature of intervention—How does the helping occur?

For each question, competing stances evident in the general academic discourse are compared before turning to descriptions of our own positions. In order to connect with the rich vein of related studies, research on similar initiatives is also reviewed, thus highlighting salient and reoccurring themes across the growing literature. In this way, the paper also aims to contribute to the overall synthesizing of research findings regarding mentoring, home-based and advocacy-related family interventions.

Method

We take a philosophical hermeneutic approach to this theoretical investigation of practice, an increasingly common standpoint within psychology (Martin & Sugarman, 2001). Simply stated, hermeneutic inquiry seeks to supplement objective examination of an intervention (i.e., process and outcomes) with rigorous study of the nature and implications of its implicit theoretical structure (Hess, 2005; Slife & Williams, 1995). Rather than constitute a *contrast* with studies of practice, such an approach is proposed as *another kind* of practice investigation—namely, a systematic investigation into the role of certain assumptions within a particular practice. While some see such inquiry as external to the domain of science, Slife, Reber, and Richardson (2005) recently called on social scientists to embrace such rigorous and freestanding theoretical examination as a more central and regular component of their work.

Empirical illustrations referenced below range from published outcome studies to our own preliminary assessments of FAP (Barr & Hunt, 2007) to a recent report on the same by a local journalist (Wurth, 2004). In spite of data references throughout, however, this particular investigation remains explicitly theoretical (with a comprehensive FAP program evaluation forthcoming in an independent empirical manuscript). Across issues of scope, place, and source of the intervention, to its basic nature, we investigate key stances out of which the distinct practice of family advocacy has arguably emerged. By comparing competing viewpoints in the family intervention literature, broader interpretive patterns may become more explicit and accessible (Slife & Williams, 1995). Consequently, in this realm of family advocacy initiatives, we ultimately aim to facilitate a more thoughtful deliberation of critical issues among both researchers and practitioners (see Schwandt, 1996).

Practice Analysis

Key Issue 1: Scope of Intervention

From individuals to the entire family. As a well-known movement of recent years, mentoring programs typically emphasize establishing supportive relationships with at-risk individuals as a way to facilitate positive development over time (Freedman, 1999; Walker & Freedman, 1996). While demonstrating significant benefits, such programs also reflect evident limitations (Freedman). For instance, even with positive mentoring contacts, youth may return to family and community contexts where negative encounters may tangibly dilute their progress. Like recovered alcoholics going back to unchanged home environments, positive steps inspired by a mentor may be neutralized or overwhelmed in a destructive family atmosphere. For this reason, recent years have seen "child only" interventions (focused on youth independent of their families) receiving some critical attention (Kumpfer & Alvarado, 1998). Alternative approaches have consequently broadened the scope of intervention to include whole families in the mentoring effort.

A mentoring focus on the entire family constitutes a central thrust of our own Family Advocacy Program (FAP). At the outset of the intervention, a mentor drawn from the local community works with the family to generate a list of goals for each member. These goals subsequently become emphasized in joint efforts between family members and the mentor (see further elaboration in the following sections). Goals vary from family to family, with common examples including finding affordable housing, enrolling in postsecondary education, and locating employment. Adolescent goals have included improving grades, obtaining counseling services, and resolving problems with the law. Importantly, this discussion of goals and needs aims to be explicitly strength-based in its highlighting of implicit family capacities and assets, as well as the wisdom and expertise housed in their own lives and community.

Recent years have seen similar family-oriented mentoring efforts emerging across multiple settings (Family Strengthening Policy Center, 2004), from families within a faith community (Harrison, 1997) to those coping with severe accidents (Blosser & De Pompei, 1995) to others struggling with juvenile crime (Heard, 1990). Some have even proposed family mentoring as an inherent aspect of natural extended families (Kalbfleisch, Anderson, & Noor Al-Deen, 1997). Just as "one good relationship" has been shown to have a dramatic influence on youth in difficult circumstances (Freedman, 1999), these efforts are united in illustrating the exciting potential impact of *one relationship* for a family in distress (Barron-McKeagney et al., 2001, 2002). Indeed, research suggests that, compared to programs targeting youth or parents alone, more comprehensive "family-focused" prevention efforts may have a greater impact on family risk and protective factors (Kumpfer & Alvarado, 1998).

From families to the surrounding system. As noted earlier, in addition to facilitating family capacities and skills in relation to surrounding institutions, family advocacy also generally emphasizes direct change to surrounding conditions as well. In our own case, FAP has aimed to influence the larger "system of care" locally (Stroul & Friedman, 1994) to better meet the needs of those who have historically been disenfranchised within social services (Snowden, 1999). Evidence continues to suggest that families with the greatest need for formal help are not receiving it

at the same proportion as other families (Shallcross, 2002; U.S. Department of Health and Human Services, 2001). To address such problems in our community, FAP encourages its family mentors, as seasoned community paraprofessionals, to sit on task force committees, consult with human service agencies, and attend community meetings. In this way, FAP seeks to advocate for families more broadly and to ensure their voices are heard where important policies are being developed.

Key Issue 2: Place of Intervention

In traditional models of practice, the site of professional intervention is typically a place external to community settings, such as an office, clinic, or treatment center. Leaving more familiar settings for these independent helping sites can clearly be, at times, more comfortable—even *essential*—for clients. Challenges also exist, however, with such treatment settings. On a most basic level, this arrangement may contribute to a natural disconnect between families and outside services—if only for something like a lack of transportation, which is an ongoing barrier for many communities (Baffour et al., 2006). As one FAP client stated, "It's hard especially without transportation….There are no flexible schedules, and [clinics are] hard to reach."

Another problem with external helping sites is the significant financial cost of related professional services, which remains an obvious challenge for many. On a more subtle level, families who eventually connect with formal services may find themselves in a place uncomfortably foreign to their natural settings. Similar to the constraining effect of removing individuals from family connections as part of an intervention (see Key Issue 1), assisting families *outside of natural settings* may also contribute to diluted or temporary effects in a significant way. Henggeler and Schoenwald (1994) corroborate this concern in their explorations of the "shortfalls in time-limited residential treatment programs…which may affect behavior change in a controlled environment, but are not likely to maintain their effectiveness when the individual reenters his/her unchanged family, peer, and neighborhood environment" (as paraphrased in Cervenka, Dembo, & Brown, 1996, p. 207). The relevance of this critique has been documented across contexts of residential drug abuse treatment programs (Henggeler & Schoenwald, 1994), hospitalizations of youth with emotional problems (Henggeler et al., 1999), and the incarceration of juvenile offenders (Henggeler, Melton, & Smith, 1992).

Among other things, such difficulties serve to justify increasing attention to the way natural settings—such as community centers, churches, and individual homes—may also serve as viable sites of intervention. Several decades ago, Rappaport and Chinsky (1974) distinguished "seeking" and "waiting" modes of helping, suggesting that professionals move beyond the exclusive "come to us" mentality and consider going out *to the community* to visit families in their natural environments. Consistent with this, our FAP interventions frequently occur on community "turf." As clients are given the choice of where to meet (see Key Issue 4), they often naturally select locations most accessible and familiar to them, ranging from their own homes, workplaces, and churches to other comfortable community settings.

Recent decades have seen the proliferation of "home-based" or "in-home" service programs for high-risk youth and families, such as Intensive Family Preservation Services (IFPS), Multisystemic Therapy (MST), and Family Empowerment Intervention (FEI) (Cox, 2005; Dembo & Schmeidler, 2002). Similar to FAP, these programs all reflect serious attempts to help homes become more legitimate sites of healing and support, including between family members themselves (see Key Issue 3). As noted previously, when not within individual homes, advocacy programs often seek other locations more accessible to the majority of participants, such as something within walking distance of individual homes (Baffour et al., 2006). This may range from family resource centers in a public housing complex to classes within fellowship halls of area churches to food pantries, schools, day care centers, and senior centers (Maurana & Rodney, 2000).

More frequent use of natural settings as sites of intervention may have particular implications for reaching those who need it the most. In one health advocacy program, after being provided with names of individuals at high risk for negative pregnancy outcomes, indigenous community advocates used creative outreach strategies and extensive community connections to reach many previously isolated individuals (Baffour et al., 2006). Because African American citizens are consistently less likely than those who are White to access formal services (Snowden, 1999), they have been a particular target for our own program. During one year alone, introductory presentations by our family mentors across 23 community settings prompted contacts with over 350 members of the low-income and African American community.

Beyond the success of simply reaching individuals, interventions on-site in community settings may also contribute to greater "staying power" with family changes than would be the case otherwise. In their work with domestic violence survivors, Bybee and Sullivan (2002) advocate for working in natural contexts to "maximize the likelihood of creating lasting change" (p. 104). One possible reason for this is that, ironically, community-based intervention may be uniquely effective in helping families authentically connect with essential support *external to the community*. For instance, following the broad-based assessment of family needs and capacities mentioned earlier, FAP service teams subsequently work with and on behalf of families in the direct mobilization of community resources to address unmet needs. This includes confronting external barriers, connecting families with pertinent systems, and helping individual members gain greater capacity to act for themselves (see Key Issue 4).

Key Issue 3: Source of Intervention

Expanding an intervention's reach to an entire family (Key Issue 1) within their own natural contexts (Key Issue 2) leads naturally to a third key question: Who plays the roles of primary helpers in family advocacy? To what degree might local citizens or family members themselves participate in helping? While a traditional reliance on professionals as the primary source of helping permits the unique capacities of doctors, social workers, psychologists, etc., to be leveraged on behalf of families, challenges remain. Most basically, as outlined in an early report on "mental health manpower trends" (Albee, 1959), the number of trained professional workers may never be sufficient to "put a dent" in broad societal problems. At a deeper level, in his provocative treatise *The Careless Society*, McKnight (1995) raises hard questions about the potential of professional services to unintentionally undermine and co-opt the natural capacity of citizens to support one another. Thus, even if it were possible to dramatically expand the number of expert-level helpers, critical challenges to a professionally centered approach remain.

Among possible recourses, one promising alternative resituates professional and citizen roles to a significant degree, with members of the natural community highlighted as ultimately most capable of helping one another, rather than merely being adjuncts or secondary helpers. Professionals, in turn, may function as the secondary helpers as they find meaningful ways to enable and empower citizens in their own caretaking capacities. This alternative approach is evident in three related "waves" of innovation relevant to our own program: commissioning

paraprofessional support, tapping citizen wisdom, and mobilizing family members as helpers.

Commissioning paraprofessional support. As a long-established finding in psychology, trained nonprofessional or paraprofessional helpers are known to be effective change agents, with outcomes comparable in some cases to professional treatment (Bright, Baker, & Neimeyer, 1999; Durlak, 1979). In spite of this, many home-based, family-focused interventions, such as Intensive Family Preservation Services (IFPS) and Multisystemic Therapy (MST), rely primarily on professional workers for direct service. In contrast, our advocacy initiative applies available professional expertise primarily in supervising the direct work of family mentors and "student advocates"—two kinds of paraprofessionals involved in FAP. Other projects, such as the Family Empowerment Intervention (FEI) (Dembo & Schmeidler, 2002), likewise reflect the indirect investment of human service professionals in helping families.

Each year, 10 to 12 undergraduate students are selected to work as student advocates alongside family mentors in our FAP program. After initial training in the strength-based, individualized, and family-centered approach described in this paper, students subsequently receive ongoing group supervision within a psychology service-learning course. Family mentors drawn from the community also receive annual training in this same approach, alongside their own ongoing supervision from the FAP director of outreach services.

Mirroring the classic argument in favor of "consultation" as a professional role, the involvement of paraprofessional advocates also promises to significantly address persisting "manpower" concerns noted previously. As Cervenka and colleagues (1996) suggest:

> Although home-based structural and strategic family systems approaches have been tested when delivered by therapists, our view is that only when such interventions are delivered by staff who have received less than a master's level training can interventions be applied on the scale that is needed to respond to the overwhelming problems of juvenile crime, drug use, family abuse, and related conditions. (p. 215)

In addition to reaching more individuals, a significant decrease in cost has been associated with advocacy programs (Maurana & Rodney, 2000); this advantage ensues from both a reallocation of professional time and a greater reliance on community and student efforts. (Although students receive course credit and mentors receive a stipend, the cost remains well below what a professional-centric intervention would require.)

Tapping into community wisdom. While a general trend toward paraprofessional support may extend the (quantitative) scope of family interventions in a cost-effective way, a second, related wave of innovation improves the more nuanced (qualitative) aspects of helping efforts. In their own community health advocate program, Maurana and Rodney (2000) cite interest among families for helpers who "look like" and "talk like" them—someone with whom they can generally relate (p. 40).

In our own program, we have specifically relied on trusted citizens from *within* the African American community to become our paraprofessional "family mentors." In other programs, these special outreach workers are also referred to as "field consultants" or "peer health advocates" (Cervenka et al., 1996), "family health advocates" (FHAs) (Baffour et al., 2006), or "community health advocates" (CHAs) (Maurana & Rodney, 2000). In both FAP and the FEI noted earlier, these citizens had typically already been "doing the work" within their community as literal "indigenous helpers" prior to becoming mentors—in services ranging from roles in area churches or local government boards (Cervenka et al.) to the dynamic "neighborhood mothers" in our own community.

Beyond their own paraprofessional training, this community background uniquely positions family mentors to reach local individuals facing difficult problems. As one FAP participant said of her mentor:

> She is like a role model to me, because she has come so far. She basically has been in the same predicament I'm in, and she's come out so successful and able to use her experience to help other people like me. (Wurth, 2004, p. A2)

In addition to advantages in actually locating individuals (see Key Issue 2), mentors possess an intuitive sense and capacity in overcoming *nonphysical* barriers, including perceived discrimination and fears of having children removed from homes (Baffour et al., 2006) and negative past experiences in the system (Maurana & Rodney, 2000). Referring to families involved in our own program, one family mentor noted:

> These are people who've had things embedded in them, ingrained in them for years and years. They're afraid of failing and afraid of trusting people. It's about building relationships and a rapport with people. You just don't become friends overnight. (Wurth, 2004, p. A2)

In response to such barriers, family mentors may offer support tailored to unique family context, demonstrating confidence in a family's potential and helping them discover new growth and opportunities. Specifically, these mentors can become intermediaries who help bridge gaps between families and external institutions, a practice known as "cultural mediation" (Baffour et al., 2006) or "cultural brokering." The latter term, "cultural broker," was classically used to describe someone assisting a foreign-born, nonnative speaker in navigating and adapting to a new locale. More recently, the practice of cultural brokering is being leveraged where any significant cultural divide exists, including between minority families and traditional treatment systems (Singh, McKay, & Singh, 1999). In such a situation, the mentor may fill a role as cultural broker by "translating" between, for instance, the language of a government bureaucracy and the language indigenous to a family. In addition to an intuitive grasp of cultural issues, mentors drawn from the community may also leverage a more informal engagement style, such as "sister friend" or "woman to woman" relationships (Baffour et al.) or a "neighbor helping neighbor" approach (Maurana & Rodney, 2000).

It is this collaboration between community-drawn mentors and student advocates that is especially unique to FAP. Alongside the unique role of mentors described previously, students provide energy and "legs" to help get things done in support of the families. While both mentors and student advocates meet individually with families, students thus play a special role in making more frequent follow-up visits. Regular meetings between mentors and advocates consequently provide a forum for updating each other and discussing their ongoing collaboration in the support of families with their unique needs and goals.

Mobilizing friends and family. While family mentors and student advocates may address both physical and emotional barriers, a significant gap may persist. Whether from a professional or paraprofessional stance, the implicit helping emphasis of these intervention approaches can remain centered on individuals *outside the family* as primary support. A final innovative trend is reflected in the further empowerment of family members themselves—a "mobilization" that may awaken their inherent capacity to help. Kalbfleisch and colleagues (1997), for instance, highlight the family itself as a naturally rich source of potential mentoring relationships. In a medical context, Watson (2003) asserts that "families provide the bulk of health and social care. If we do not support and

engage with them, we have not only lost an opportunity but also may find treatment and care plans inadvertently undermined" (p. 494).

In addition to investing precious time and energy in supporting paraprofessionals, professionals may thus also consider ways to directly consult with and facilitate family helpers. As natural support systems grow in assurance of their own capacity to address problems, social workers, psychologists, and other health professionals may direct their efforts toward enabling and empowering this to happen more successfully. Relevant social support interventions such as "network facilitation" and "network enhancement" are receiving growing attention (Cox, 2005).

As families further awaken to this sense of capacity to support one another, communities may come to realize a power to address pervasive problems far beyond what could be achieved from outside help alone. In most cases, family members know and love one another more than a professional ever will—even in an extended therapy relationship. On this note, Cox (2005) points out that natural support systems reflect a "long-range commitment…that is unmatched by formal service providers" (p. 4), with the longest of "long-term" professional relationships rarely comparing to the duration of relationships within an intact network of family or friends. A citizen in our own community commented:

> It's *the little things* that can help…that I don't think the system can really *effectively provide…*because it's not in that position.… You know, the system can't find a friend who's been a friend for someone's whole life and will be a friend forever, no matter what. They just can't do that.…Well, they can assign a case worker.…But they've got *20 other people to help…*You know, a case worker is not going to be in the office at three in the morning when you need to talk to someone like a friend would be.

Like family relationships, of course, mentoring relationships may also be lifelong. A number of FAP parents reported they had "gained a friend," with one mother stating, "[My mentor] is like a long lost sister!" This combination of enduring mentoring support and the awakened mutual support within families may likewise have an exciting long-term potential in the future. As with previously discussed issues of intervention scope and site, the source of intervention may have particular consequences for the durability or "staying power" of family change. In this case, benefits may ensue from the naturally more expansive reach and enduring stability of citizen and family helpers.

Key Issue 4: Nature of the Intervention

Beyond choices about the specific scope, site, and source of intervention, the most fundamental decision underlying family advocacy concerns the basic nature of the helping effort itself. In this final section, we explore the fundamental dynamics of advocacy practice itself (as reflected in the overlapping work of both family mentors and student advocates in our own program).

Backdrop for family advocacy. Traditional professional helping efforts are typically fairly unilateral and instrumental, sometimes in spite of sincere intentions to the contrary (Hess, 2005). Formal alternatives have attempted to move in varying degrees toward a more bilateral, collaborative intervention model. While evident across disciplines, this shift is especially apparent in the movement toward "partnering," "patient-centered," and "concordant" medical practice (Conway et al., 2006; Enegaug, 2000):

> It has been suggested that interactions with patients should not be viewed simply as opportunities to reinforce instructions around treatment; rather, they should be seen as a space where the expertise of patients and health professionals can be pooled to arrive at mutually agreed goals. (Bissell, May, & Noyce, 2004, p. 851)

Watson (2003) notes, "The message about what patients and their [families] want is clear. They want to be respected and fully involved in discussing, agreeing and providing their treatment and care plan" (p. 494). The beneficial effects of this approach for medical patients are becoming increasingly evident (Conway et al., 2006).

In the case of interventions for social and emotional problems, similar shifts toward collaboration are also occurring—reflected in both recent counseling innovations (Friedman, 1993) and the ongoing popularity of paraprofessional and nonprofessional mutual help groups (Katz, 1981; Kurtz, 1997). In both cases, greater trust is placed in the capacity of distressed individuals to collaborate in their own healing and progress.

The heart of family advocacy. Advocacy initiatives reflect an especially vivid reflection of this impulse toward more bilateral, collaborative helping. Relative to other innovations, advocacy takes partnership and empowerment to a new level. Sullivan and Keefe (1999) note a consistent theoretical position underlying their own advocacy program:

> 1. First, the project was based on the belief that [individuals] were competent adults capable of knowing what was best for them and what they needed from their communities.
> 2. [Second], following this logic, the [individual], not the advocate, guided the direction of the intervention.
> 3. Third, activities focused on making the community more responsive to needs, not on changing the [individual]'s thinking or belief system. (p. 3)

As reflected here, an advocacy model first enjoins helpers to go beyond a general surface awareness of strengths, toward recognition of profound competencies and insight within distressed families (Bybee & Sullivan, 2002; Iscoe, 1974). Shpungin (2002) highlights such a showing of respect, allowance of autonomy, and recognition of unique individuality as critical ways of recognizing another's "human dignity."

Beyond acknowledging strength and competence in families, an advocacy approach next emphasizes the practical demonstration of this acknowledgment by insisting that decisions remain in the hands of individual families themselves. Just as domestic violence advocacy efforts are guided by survivors (Bybee & Sullivan, 2002; Davies, Lyon, & Monti-Catania, 1998), the process of family advocacy "puts the family in the driver's seat"—an emphasis also reflective of wraparound treatment approaches (Burchard, 2000; VanDenBerg & Grealish, 1997). Most basically, this entails a family's own active participation in "identifying their needs and how they wish to prioritize them" (Allen et al., 2004, p. 1030), as mentioned earlier. Given this, successful advocacy efforts demonstrate great variability in the resulting treatment goals, reflecting how such efforts do "not impose a predetermined intervention on families but provide a framework and a set of skills that advocates [can] employ to meet women's and children's unique needs" (Sullivan et al., 2002, p. 932). Consistent with an emphasis that "each individual is entitled to make choices related to his or her own health problems and that each person should be actively involved in [their] resolution," one health advocacy program emphasized "doing with" instead of "doing for" or "doing to" (Maurana & Rodney, 2000, pp. 41, 43). Similar to other advocacy initiatives, this program's goal was for citizens to become "active participants in their own health and the health development of their communities" (Maurana & Rodney, p. 43). In this way, advocates across contexts not only ensure that family needs drive the process, but also that the process itself becomes owned and adopted by individuals. In light of this, advocacy efforts may be understood as family/community-based in three distinct senses: (a) taking place within

community settings, (b) relying on helpers from within the community, and (c) partnering with family members themselves in a collaborative intervention process.

As goals are settled upon, advocates subsequently work proactively with the family to accomplish both group and individual aspirations. As noted earlier, such support sometimes entails engagement with or confrontation of an external system on behalf of a family. For instance, in one program focused on health issues, an advocate was successful in obtaining health care for some children after an official told the parents their family was not eligible (Maurana & Rodney, 2000). In other instances, advocates may simply provide emotional and social support to families as they work to achieve their goals. One FAP participant described her family mentor as a "neutral sounding board," and spoke of ways the mentor would proactively combat negative messages and tell her, "You're doing the right thing. You've got a good head on your shoulders. You're not crazy." She went on to point out how the mentor had "tried to get me to realize that I did need to stick to my guns and stand firm on things like child support, things that I was very passive about" (Wurth, 2004, p. A2).

The ultimate aim of advocacy. While the direct support of family goal-striving by advocates may prompt meaningful family change, even greater shifts may occur via a second, more indirect emphasis: the *transfer of self-advocacy skills* to families. Rather than merely leading in helpful directions, advocates ideally seek ways to reinforce a family's own agency and capacity for self-direction. One FAP participant reflected, "I learned a lot about myself. [My mentor] showed me how to get up and do things for myself." While ever willing to "go to battle" in directly mobilizing community resources for families, advocates thus remain focused on the larger vision of family empowerment: cultivating family capacity to gain control over circumstances of their own lives (Rappaport, 1981), including in the access of resources (Sullivan & Bybee, 1999; Sullivan et al., 2002).

The ultimate goal thus becomes promoting family self-determination, "not only to connect women to the resources they needed but also to teach them the model that the paraprofessional was using" (Sullivan et al., 2002, p. 931). In this way, good advocates thus continually work to "put themselves out of a job." The time-limited nature of our own program has provided a helpful endpoint at which "training wheels" come off, requiring participants to proceed on their own. Prior to this happening, advocates intensify efforts to ensure a sufficient transfer of skills and knowledge so the family may be successful in their "solo" efforts.

When effective, the overall process reflects a gradual growth in confidence and self-efficacy, even if only in the smallest of steps. One family mentor in FAP spoke of the impact of finishing several job applications for one person unemployed for a long period:

> That's progress, compared to where she was when we first started working with her. If you can get a person to just change a little bit, then you are successful. The goals sometimes may be small, but they're still big deals for some people.…Change doesn't come overnight. (Wurth, 2004, p. A2)

Preliminary pre- and post-evaluations have confirmed that families in our own program experience associated increases in quality of life, social support, and self-advocacy efforts (Reid, Barr, & Hunt, 2005). Over time, these changes may nurture a growing quality of life that can "set in motion" more significant long-term effects in a spiral of upward progress (see Bybee & Sullivan, 2002).

Conclusion

In the foregoing examination of family advocacy, we have sought to examine key theoretical dimensions of our own initiative alongside similar programs across the nation. Alongside the growing confirmatory empirical evidence of traditional outcome research (Allen et al., 2004; Barron-McKeagney et al., 2001, 2002), we offer this examination as something of a theoretical warrant for claims of advocacy effectiveness (and for family advocacy, in particular). Among other things, the foregoing exploration underscores our contention that benefits of advocacy programs stem not simply from logistics or technique, but from an innovative theoretical foregrounding for its practice. Against a backdrop of competing stances on several critical issues, we have explored the particular benefits of a specific approach that, in summary:

1. Reaches out to the entire family;
2. Is enacted within places of residence or other natural settings;
3. Mobilizes student volunteers, family mentors, and family members themselves in the helping process; and
4. Prioritizes the ultimate capacity of families to meet their own self-chosen goals.

In the context of struggling families, there appears to be a significant power in being not only helped to find *one's own* goals, but then trusted to pursue those goals *as fast as one is ready.* In place of being forced, pressured, or co-opted, this paper's inquiry illustrates how this kind of a helping relationship may ultimately foster greater empowerment and well-being for individual families. By attending to salient themes across the growing advocacy literature, we pay tribute to parallel initiatives and highlight the fact that we are not alone in our excitement! Ultimately, we offer this theoretical investigation of practice as our own contribution to the expansion of advocacy as an established helping practice, with specific hopes that our paper may further facilitate a more productive and rigorous deliberation about struggling families and how best to awaken their natural capacities and intrinsic strengths.

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