한국심리학회지 : 상담 및 심리치료
The Korean Journal of Counseling and Psychotherapy
2000. Vol. 12. No. 2. pp. 169-184

The Multi-professional Team Counseling System for Adolescent

Myoung-Ja Keum Teck-ho Kim Jin-Ku Kang Hee-jeong An
Korea Youth Counseling Institute

The purpose of this article is to introduce the Multi-professional Team Counseling System for Adolescent (MTCSA), report a case study, and suggest future considerations and issues regarding it. MTCSA has five principles to address factors which are required of the counseling approaches for adolescents; multi-base cooperative intervention, multi-professional team support, outreach approach, mentor relationship, and involvement of the community.

A team constructed of 5 or 6 professionals residing in a local area visited and counseled the clients, their school, family, and friends. The professionals consisted of educators, lawyers, pharmacists, physicians, police officers, and religious figures (i.e., priests, nuns, Buddhist monks). A counselor at a local counseling center supervised the teams and their activities. The team met weekly to discuss the previous week's activities, their individual roles, and the future intervention methods. The team's intensive intervention for one client continued for 6 months, whereupon the team and the client went into mentor relationship.

In September 1998, 4 case studies of the MTCSA took place in a suburb near Seoul. The initial results showed marked change in the adolescents' maladaptive behaviors (i.e., theft, running away from home, frequent absence from school). Since then, there has been 18 teams in 4 cities of 4 provinces in Korea. Now 30 teams in 11 cities were implemented.

An adolescent is in the mist of developing, and should be counseled from an integrated developmental perspective. Since Parsons (1909) promoted vocational guidance for all youths, the field of counseling has long been committed to accommodating development and enhancing mental health for the youth. In this sense, counseling for the youth should differ from the traditional procedures used with the adult, which tend to focus on the client's problems in the clinic, using verbal methods. Nevertheless, the adolescent problems have been addressed with the same theories, techniques, and methods as the adults', although they are fundamentally distinctive.

As the field of youth counseling strives to redefine its original goals and approaches, a more revolutionary theory that addresses the changes in the modern societies are necessary, not an extension of a passive psychotherapy. Burt, Resnick and Novick (1998) summarized three important trends the ecological movement, early and continuous intervention, and overlapping risk factors for problems of adolescence - in adolescent development and prevention theory within the past 15 years that contributed to the current interest in definitions of youth at risk. First, there has been an acceptance and strong empirical support for ecological theories of human development since Bronfenbrenner (1979) published his comprehensive model for portraying the environment's role in child and adolescent development. Empirical evidence continues to substantiate the influence on the individual's development of family processes, the peer group, social supports and community resources, neighborhood safety and quality of life, as well as the larger key social institutions such as the school (Baruch & Stutman, 1994; Wozniak & Fisher, 1993). Second, the findings from early intervention research conducted over the past 10 years have influenced current definitions of risk. Barnett (1995), Yoshikawa (1995) and Ramey & Ramey (1992) suggested that the benefits of continuous educational interventions over the first 5 years of life last at least until early adolescent and in some cases into adulthood. Third, a shift toward viewing specific problems of adolescence delinquency, substance abuse, pregnancy or parenthood, and school failure as having common, rather than distinct, antecedent causes has been seen (Dryfoos, 1990). The co-occurrence of such problem behaviors appears to come from multiple pathways of influence, in which probabilistic interactions of multiple factors now linked to a syndrome of problem behaviors in adolescence.

Four emerging trends in counseling psychology that McAuliffe and Eriksen (1999) defined have similar contents. First is a shifting from major emphasis of client issues to recognition of the social contexts in which all humans are intricately embedded. Second is a shifting from a fixation on pathology to an emphasis on strength and development. Third is a shifting from a focus on empirical evidence to assimilating multiple subjectivities. The last trend is a shifting the dominant reliance on remediation to a focus on education and prevention.

These required approach in counseling the adolescent and their problems cannot be satisfied with the traditional counseling or psychotherapeutic theories and techniques. Dryfoos (1990) reviewed about 100 different successful programs for prevention of delinquency, substance abuse, teen pregnancy, and school failure that appear to have potential for changing behavioral outcomes. He extracted eleven

common components from successful intervention programs, suc as intensive individualized attention, community-wide multi-agency collaborative approaches, early identification and intervention etc. These components are summarized again by the intensive and continued relationship with the client, the commitment of various human resources such as parents, peers, community members, multi-agency collaborated approach, and the arrangements for training. Pittman, O'Brien, & Kimball (1993) and Pittman & Zeidin (1992) underscored the context as well as the content. The promotion of youth development includes not only the content of an intervention but the context in which that intervention or support is given. For service provision, a youth development approach emphasizes providing adolescents with appropriate content within the optimal context. Contexts can include schools that allow education to occur safely, neighborhoods with support and commitment, and communities that have resources to nurture constructive relationships.

We propose six orientations for the adolescent counseling from aforementioned trends in youth counseling and main factors of the successful programs for adolescents. These are developmental, preventive, relationship, multi-based, outreached, and team orientations, which are quite different from traditional counseling or therapy for the adult (see Table 1). Following is a brief description of each.

Developmental: understanding the client within the developmental process, facilitating their developmental tasks and promoting their potential achievements, rather than problem solving.

Relationship: understanding adolescent socio-emotional bond and promoting the client's interpersonal network and social support system, not the client alone.

Preventive: detecting the early signs in those with high-risk factors before the problem behaviors occur, preparing educational services for potential developmental problems before the problem gets severe in degree.

Multi-based: integrated understanding and intervention of the client's overall environmental settings (e.g., family, school, peers, and community), not just the area of client's concerns.

Outreach: gaining first-hand experience by visiting the client in real-life situations, seeing the client and client's circumstances in the actual setting, approaching

Table 1. Changes in counseling Orientation for Adolescent

Traditional Orientations (for adult)	New Orientations (for adolescent)
Problem	Developmental
Individual	Relationship
Treatment	Preventive
Single-based	Multi-based
Clinic	Outreach
One -to-one	Team

them through various modes rather than in the confined and restricted setting of the clinic without time constraints or waiting for an appointment.

Team: achieving the multi-based intervention and outreach counseling, getting the various ideas and resources to facilitate an overall development of the adolescent client, and devising the multidisciplinary collaborative intervention.

Each orientation is familiar one, an extension of the traditionally practiced methods. None of the ingredients from the traditional methods have been disregarded. However, the traditional individual clinic counseling cannot simultaneously satisfy all six aforementioned factors. It is utterly impossible for a single professional to meet these requirements. Therefore, a system rather than a mode is necessary to meet these dimensions. This is the reason why the sixth orientation--team approach--was added. The requirement for system is the basis of development of the Multi-professional Team Counseling System for Adolescent (MTCSA). A team approach involving various professionals and multi-based setting approach are the integral parts of MTCSA. The team delivered integrative services to client in a holistic matter - physical, psychological, social, and spiritual - and to his relevant life settings (i.e., family, school, and community).

An informal consensus about what works best for the troubled youths and their environments has been described as integrating service across different domains. Given the competitiveness of today's professional job market and the responsibilities that follow, it seems almost impossible for different professionals to cooperate, collaborate, or work as a team. But as society and human development become increasingly multifaceted, multi-professional team approach should be regarded imperative. The case studies or program of applied multidisciplinary collaboration among psychologist, counselor, educator, physician, nurse, social worker, or religious figures have been reporting in various fields. Hinshaw and Deleon (1995) listed several successful programs that achieved multidisciplinary professional collaboration on improvement of health care. Edwards, Lim, McMinn, and Dominguez (1999) revealed that collaboration between psychologists and clergy takes place in at least four context: mental health services, parish life, community, and academics. Furthermore, Belar(1999) highlighted the mutual interdependence of disciplines capitated care system with a presentation of a program at the Kaiser Permanente.

Multi-professional Team Counseling System for the Adolescent

Multi-professional Team Counseling System for Adolescent (MTCSA) was developed by Korea Youth Counseling Institute (KYCI) and sponsored by the Ministry of Cultural and Tourism. The system has two goals. The first goal is to provide effective system and mechanism for drastically decreasing the frequency and occurrence of adolescent problem from the source. The second goal is the formation of highly visible community involvement in raising mentally healthy adolescent. A counseling method interested in only the client is not enough to encourage healthy development and wellbeing of the adolescent. The environment surrounding the adolescent can be a major contributor to the problem, at the

Table 2 Therapeutic factors of five principles of MTCSA

[illegible]	[illegible]
Multi-Professional Team Collaboration	Sufficient number of professionals
	Integrated endeavor
	Availability of resources
Multi-Based Cooperative Intervention	Holistic understanding & intervention
	Comprehensive intervention
	Linkage with other organization
Outreach Approach	Sharing client's life atmosphere
	Revealing of the team's active endeavor
	Early detection potential problem
Mentor relationship	Immediate response
	Response covering all round life area
	Management without disconnection
Involvement of Community	Increasing in concern for adolescent
	Prevention effect
	Change in client environment

same time, a therapeutic agent. Therefore, the environment and the community surrounding the adolescent must cooperate and participate in improvement of the adolescent and change with the adolescent. To meet these needs, MTCSA works on five principles; multi-professional team support, multi-based cooperative intervention, outreach approach, mentor relationship, and community involvement. And each principle has three therapeutic factors. There is Summary for these factors at Table 2.

Multi-professional team collaboration

Various professionals who can facilitate the integrated development of adolescent are invited to the team. They include educators (college professor or secondary school teacher), lawyers, pharmacists, physicians, police officers, religious figures, and social worker. A pharmacist or a physician is knowledgeable in the problems related to adolescent's physical growth and drug abuse. An educator is familiar with problem of school life, study skills, and parent education. A lawyer or a police officer is helpful in delinquency. A religious figure can comfort and guide clients and their family spiritually. A social worker can establish the linkage between client and the community

A team consists of 5 or 6 voluntary professionals that includes any diversity of the professionals. The professionals integrate their perspectives for each client and devised an appropriate intervention. The intervention relates to all aspects of client's life, which can be a comprehensive, integrating, ecologically appropriate intervention. The team is provided with extensive resources and information to approach the adolescent and their issues with integrated and holistic understanding. Each team participates in several discussions and offers individual perspectives on the case. The collaborative team members work together as professionals, share the decision and hold responsibilities of the endeavor. The value of collaborative endeavors lies in the ability to synthesize expertise and resources. This provides a broader, richer base from which to generate ideas and resolve issues, as well as to share knowledge and experience in improving the client. The team is provided with full resourceful network, which allowed for ease of transportation, finances, or organization.

Multi-based cooperative intervention

The team plans and carries out the interventions that can approach client's all life situations - family, school and community. The areas of an adolescent's life are somewhat limited mostly to school, home, and community. Their homes and family are the basis of their lives. They spend much time at school and interact with friends and teachers. The atmosphere of community in which they belong is a critical factor affecting their behaviors and motivations. Dryfoos (1990) recommended that interventions should be aimed at changing institutions rather than at changing individuals.

Most maladapted adolescents are disregarded or overprotected by their family and are regarded troublesome from their teachers and school administrators. Their friends and community must take an important role in decreasing their maladaptive behaviors. Without family education and intervention, the attitudes and behaviors of the adolescent's parents are unlikely to be changed. Furthermore, without modification and awakening of teachers' attitudes in the school setting, the client's running away and frequent absence from school will not decrease. Issues concerning peer pressure and the lack of community acceptance and involvement exacerbate and maintain the problems faced by the adolescent. A family therapy without dealing the school and friends seems to be limited for correction of adolescent problems. The various training programs (i.e., sex education, drug education) which target students at school without contribution of their family members could be to be ineffective. The counseling for adolescent without recognition of their friends won't have any effect.

Therefore, bring a drastic improvement and the low recurring rate at the adolescent counseling area, a comprehensive intervention that provides multi-based cooperative support for the adolescent client is recommended. The programs that Dryfoos (1990) reviewed were loosely categorized by type. Among all models discussed, about 10 percent fell into the category of early child or family intervention, 60 percent were school-based intervention, and 30 percent were community-based or multi-agency programs. The programs for adolescent locate only one site either family, school, or community. He pointed out that the new program must be a package, which is

an integration of these three bases.

Outreach approach

The team members visited where the client is and also his family and school. Outreach counseling is important to establish appropriate interventions and relationship for adolescent client and the people around him.

It is very important for the counselor to first-hand see and understand the client's life situations. The client who has already asked for helping may also have other problems that they haven't brought up yet and even recognize it himself. When the counselor looks around the client's situation with professional perspective, he can correctly assess the client's problems. With only what the client told about himself and his problems, there is a limitation to understand him. Visiting client's home and school and the meetings with his friends make counselor understand him more correctly and objectively. Finn-Stevenson, & Zigler (1999) noticed that rather than inviting the parents and community members to school or center, direct outreach to the place they have lived is more effective in their willingness to commit and cooperate.

Furthermore, outreach counseling makes easy develop a deeper relationship between the member and the client. The adolescent client watches and hears about the members' visit with his parents, teachers, and friends. After their visit, the client realizes the change in his environment. This accelerates their relationship.

It is necessary to recognize that the potential clients is larger than those not seeking help. It seems to be hard for client himself to seek professional help. Ironically counseling require client be active and motivated to get help even though most clients show withdraw behaviors and become passive during counseling. The counselor for adolescent need go out to client, rather not waiting the client to come to clinic.

Mentor relationship

Mentor' was a name of a sincere man who took on the care of his friend's son, whose father went to a war. Mentor' took care of the child as his own. Although they lived in a different houses, Mentor immediately responded with love to the child's needs, such as emotional encouragement, financial helping, guidance about the career choice, etc. Mentor' is beyond a counselor, beyond a teacher, beyond a charitable person, and beyond a role model.

Mentoring assumes a one-to-one relationship between mentor and mentee, but even this is often described as having differing roles and functions for the mentor. Malderez & Bodoczky (1999) classified majority of these five roles and functions. First, as a model, mentor inspires and demonstrates mentee to do something. Second, mentor becomes an acculturator so that he shows mentee the ropes and helps mentee get used to the particular professional culture. Third, as a sponsor, he opens doors, introduces mentee to the right people', and use his power (ability to make things happen) in the service to the mentee. Fourth, as a support, he is always there, providing safe opportunities for the mentee to let off steam. The last, as an educator, he acts as a sounding board for articulation of ideas, consciously creating appropriate opportunities for mentee, and providing professional learning objectives.

While any one or combination of the roles above would seem to us to justify the term mentor', most mentor will be involved to a greater or lesser degree in all five roles. The volunteer professionals participated in MTCSA had the qualifications to be a model, an acculturator, a sponsor, a support, and an educator. They had the successful persons in each field. Most of them were middle aged parents themselves with mature character, who managed their own household, and were devoted to their professional jobs with confidence. The adolescent client needed the various supports, economic as well as emotional. The volunteer professional immediately responded to the client's any kind of needs as if he was a father or a mother living with him. In addition, the volunteer professional-adolescent client relationship can continue until the client enters a college or gets a job. In other words, the client becomes a healthy autonomous person.

Mentor relationship provides social support to adolescent client. Social support given from the smallest social unit like family is a necessary factor to the well-being. House (1981) showed that there were four factors in social support; emotional, evaluative, informational, and instrumental. The emotional factor involves in trust, affection, empathy, or intimacy. The evaluative factor is acceptance, positive feedback, or positive self-evaluation. Informative factor is information-giving source for self-help or applying to social service. Instrumental factor is giving money, material, or time. These factors correspond to mentor's roles and functions.

Involvement of Community

Professionals living a district participated in MTCSA and worked with the adolescent living in a same region. Their work contributed to making their community healthy, and healthy community in return will protect their own children. An extensive body of research has substantiated a host of influences on individual development (Baruch & Stutman, 1994; Kreppner & Lerner, 1989; Lerner, 1993; Pence, 1988; Wozniak & Fischer, 1993). These influences include family processes, the peer group, social support, community resources, neighborhood safety, and quality of life. The ecological perspective suggests that high risk youth are more likely to come from those environments that heighten their vulnerability, communities with scarce social resources, high levels of stress, and inadequate institutional support. Furthermore, an ecological perspective on risk also considers the strengths and competencies of the individual and the protective factors in the environment that mitigate against potential difficulties.

As respectable figures in the community, their involvement with the adolescent are enough to raise interest and concern for the adolescent and bring about social support for the adolescent at risk from the community. The potential individual problem is mitigated by a healthy society. Also, their own children can be raised in a better community. Their voluntary work for the community is at least in part, for their own children.

Case report

Procedure of team establishment

Area selection: N city, suburb Seoul, which had several advantages to put MTCSA in practice was

selected for validating it. First of all, local counseling center and administrative department was concerned about the adolescent delinquency problems and showed their interest in the MTCSA. They were eager to help professional activities of the team members. Because it was a small agriculture-industrial city whose populations were about 200,000, various professionals residing in the city were easily contacted. The participation was voluntary. It was easy to make a human network and to get help from the various resources in the city.

Volunteer Professional Recruitment: We took three-stepwise procedures to seek out the volunteer professionals. First, to identify the community recognition of the adolescent problem and voluntary commitment from the community activity and to prompt to lead their involvement, general survey was made for various professionals (i.e., secondary teachers, lawyer, pharmacist, physician, and religious figures). Second, to obtain recommendation and provoke from the professional groups, we invited the presidents of various local professional associations to the city hall and introduced about the MTCSA. And we asked them to inform their members about MTCSA. Third, we sent an applying sheet with a brochure to all professionals with a recommendation from presidents. We only admitted volunteers who were eager to participate in our counseling system. Finally, 23 professionals 7 teachers and educators, 4 lawyers, 4 physicians, 4 pharmacist, and 5 priests were selected. Eleven among them are females. Their age ranged from 36 to 65.

Team formation (organization): we attempted to compose each team of 5 different professionals. Generally a team constituted of a lawyer, a pharmacist, a physician, a priest, and a teacher. Members of the team lived in close area allowing for frequent meeting. Each team appointed a leader and a recorder. A counselor of local counseling center participated as a supervisor with a team. A director of local counseling center and researchers also supervised the counselors.

Orientation and small education program: Before the clients were assigned to, the team participated in 8 hours of counseling education program. The contents of education program consisted of orientation session', the characteristics of adolescent', the process of juvenile delinquent', the roles and activities of local counseling center', the applying and activity of community resources on adolescent problem', and the exercise of applying MTCSA'.

Case Referring: Usually the cases of local counseling center were referred from the parents, school, or the police department. The cases assigned to the teams for the current study was referred from the police department, who worked closely with the counseling center.

A case report applied MTCSA

Client: 15-year-old, male, He was arrested for stealing a bag from the parking car. He was put to trial and referred to counseling center. He had not attended school for one year, but recently enrolled it. However, his attendance was very irregular. He ran away from home three times and was bulling students at school. He wandered the streets with his friends who had similar problems like him. The client himself complained lack of communication at home and insufficient weekly allowance. He wanted

to gain attraction from his family and school teachers.

Family condition: he lived with his father, grandmother, and two elder sisters. His father divorced the client' mother when the client was three-years old and did not remarry. The relationship between him and his father was very weak and had limited communication. His grandmother cared of her grandchildren since her son's divorce. The client felt comfortable with her. His sisters were not involved with the family nor the client. The client's socioeconomic status was poor.

Team members: The team consisted of six professionals priest(M), pharmacist(F), oriental physician(F), teacher(F), lawyer(M), and president of private institute association(M).

The process of activities: The intensive counseling activities, 10 team meetings and 10 interventions, were implemented for 4 months. During that period, the client showed marked improvement in behavior and attitude changes in his all life situations. After that, the team changed from intensive team approach to mentor relationship. The processes are as followed:

1st meeting: six team members received the case from the counseling center with intake interview recording. They had intensive discussion session for one and half hour, and then planned the interventions for each life bases and took on different role. They arrived at a conclusion that what is necessary for him is a steady emotional relationship with significant people in his life, such as his family and teachers. To start the intervention, they decided that the physician would visit his house because she volunteered.

1st intervention: before visiting client's home, the physician called his family and obtained consents to visit. She met and interviewed his grandmother. The client and other family members were presat although it was almost 9 p.m. The client's house was very small and he did not have his own room. His grandmother discussed his negative behaviors and financial difficulty. The physician obtained much information from direct observation and the grandmother's reports.

2nd meeting: The physician reported her visit home. And they planned the interventions in each aspects of life. Three members took each role of visiting the client, his grandmother, and his school teacher.

2nd intervention: The physician visited his home again and medically examined his grandmother. The teacher, a member of the team, called his teacher and obtained the information about the client at school. She asked for his academic records, and his teacher sent the report about the client's academic progress and attitude at the school and the class to the team.

3rd meeting: The team shared the interventions and discussed next interventions. They discussed commitment from his sister by finding her a job and allowing her tutor the academic subjects for her brother. They also planned to visit the school and the teacher. Prior to such, they all needed to meet with the client.

3rd intervention: the physician visited his teacher and shared information about the client's school life. The priest visited the client's home and waited for the client. Finally the priest met and interviewed him very late time in the evening. The priest

received feedback from the earlier intervention. The client expressed that he felt comfortable with the professionals.

4th meeting: Sharing the interventions and their results, further discussing about next interventions. They decided to have the priest regularly visit and interviewed him. Another agreement was that the pharmacist would visit his friend's mother because the emotional support from her to the client could strengthen the self-esteem of the client as well as build up the relation with the friend. Through the last interview the team gathered that the client frequently visited the friend's home and had close bond with the friend's mother.

4th intervention: The pharmacist visited the client's friend's home and met with the friend's mother. They discussed about the client's relationship with his friends. As a counseling team member, the pharmacist asked for her consistent emotional support. The priest interviewed the client's father and sister as well as the client. They expressed positive attitude toward the team's counseling activity. The priest informed them of the behaviors and attitudes of the adolescent and asked for sincere commitment and concern.

5th meeting: Sharing the intervention and the results and a discussing about next interventions. The client needed a pair of glasses. He could not read blackboard without glasses. But the lack of concern from his family and their poor status didn't allow them to be attentive to his needs. The team decided to donate the pair of the glasses. Also, there were very few playing areas and extra activity programs for the client and his friends in the local area. One member of the team, the president of the Association of Private Institution (API) was in charge of change to this special limitation. And the client had been in training for Tae-kwan-Do, so The president planned a visit to client's Tae-kwan-do master with the client.

5th intervention: The priest also met and interviewed the client and his father. The father thanked him for the team efforts. The team received a donation for client's glasses from a Catholic church organization. The president of API found a small sport center with table tennis, where a missionary for adolescent stationed and supervised. He also found a Sunday school program and adolescent volunteer activity from a social service. He met the Tae-Kwan-Do master and shared about the client. He got the information about upcoming Tae-Kwan-Do competition.

6th meeting: Sharing the intervention and the results, and discussing about next interventions. The team member would give the glasses and provide the client with information about the extra activities.

6th intervention: while the pharmacist was bringing the client to order the glasses, they had a conversation. The client gave same feedback about the activities of volunteer team. The important report was the changes of teacher's and family's attitude. They became concerned, interested, and was kind to the client. Especially he reported that his sister regularly taught about academic subjects.

7th meeting: Sharing the intervention and the results, and discussing about next interventions. The matter of his theft remained unresolved at the district public prosecutors office. The lawyer, a member of team was in charge of resolving this issue. The team planned a dinner with the client

Table 3. The Summary of the Interventions

Session	Team member	Client part	Intervention	Changes
1st	Physician	Family	Fam. Education	
2nd	Physician, Teacher	Family, School	Support Fam., Collect Inf.	
3rd	Physician, Priest	Individual, School	Rel. w/ CL. & Team	
4th	Pharmacist, Priest	Individual, Community, Family	Social Support, Fam. Education	CL.'s positive Atti. For team
5th	Priest, Education fig.	Individual, Family, Community	Rel.	
6th	Pharmacist	Individual	Mat. Support Rel.	CL. family's Positive atti. For team
7th	Lawyer, all	Community, Peer	Social support, Rel.	Fami. & Tea. Atti. Change For CL.
8th	Some member	Individual, Community	Social support, Rel.	CL.'s behav. Change @ S.
9th	Priest, Educator fig.	Individual, Community	Social support, CL.'s behav. Change @ C.	
10th	Some member	School	Social support	

Note. Fam.= family; Rel.= relationship; CL. = client; Atti.= attitude;
Tea.= teacher; Behav. = behavior; @ = at; S = school; C = community

and his friends. Through this the team expected to understand his peer relationship and show social support.

7th intervention: The lawyer identified the process of the events at the police office and the district public prosecutors office. And he and the team stood surety in the future for the client and could keep from recording on crime. Five team members had dinner with the client and his 5 friends. The relationship of the team and the client became more closely.

8th meeting: Sharing the intervention and the results, and discussing about next interventions. The improvements of client's behaviors and attitudes at school and home were reported by his teacher and grandmother. His teacher reported that his attention span in the class was increased. His grandmother reported that he asked her to pick him up after school to avoid bullies. The president of API informed about the Tae-Kwan-Do Competition and the team planned to attend competition to cheer him on.

to experience the voluntary social service activity with the client and the friends.

8th intervention: Three team members cheered him on the competition and the client placed 3rd. After the competition, they got together to celebrate his achievement.

9th meeting: Sharing the intervention and the results, and discussing the next interventions. The team discussed the client's extra curricular activity and the plan for the winter vacation. They thought he needed an experience involving social services disability and poverty. For winter vacation he needed to prepare for high school entrance exam.

9th intervention: the president tried to find an institute to improve his academic skills. The priest discussed the possibility of involvement in the social service experience with the client.

10th meeting: the team evaluated the process of their activities and the changes of the client during the last four months. The team planned a regular visit to the client, family, and school. The priest planned to meet the client once every two weeks, the physician planned to visit his family once every month, and the teacher would check his school life once every two weeks. Also they decided to have monthly meeting.

10th intervention: the team had a dinner with his school teacher. The school teacher thanked the team for their involvement and wanted

Future Considerations

MTCSA was developed based on realistic requirements for the adolescent. To facilitate the balanced development, the adolescent needed responsible social support resources as well as the family support. Through the case study, we could make the following future considerations for counseling field.

The process of evaluation: We tried to show the effects of MTCSA through a case study and found marked improvement in the client. But it is difficult to explain the exact change because of many variables involved in the MTCSA. For example, the appropriate intervention of the team, the prestige attached to the team, and the simple caring of

adults. With the support from his family and teachers, client's improvement may have been accelerated. If we pinpoint the main factor influencing the change, we can recommend it to another multi professional team, which will be the next step.

The economy of MTCSA: When we developed the MTCSA, there was a criticism about the economics. Five or six professionals were to deal with one client for a long time. However, our goal was a thorough management of adolescent's life without relapse of the problem. The professional team's continued intervention for a certain period was sufficiently necessary.

The participation of each professional area: There was another criticism that professionals did not fully contribute one's expertise. In such case, physician visited the client's home only because she managed her own clinic and could make time freely. Since the client had no drug problems, the pharmacist didn't have to display her own expertise. She brought him to an optician in order to receive his eye glasses. MTCSA team is not a meeting of representatives from each profession. Rather, it is a flexibly integrated team.

The reward for professionals: How to recruit and involve them in MTCSA is really important. MTCSA run by very busy professionals. MTCSA requires time commitment for long time. Materialistic incentive such as money does not work for them. They evaluated themselves as motivated by volunteerism for the community's adolescents at the beginning, and later on the client's improvement and team membership was the important rewarding factors. For the former, the easy case to handle had better be referred to the new team. The professionals who were similar in age and living in the same district easily got along with each other than others. It is a good strategy to collect information about the human resources which are interested in the adolescent from the local professional organizations. For the latter, we are trying the volunteer professionals to register in the organization in the governmental branches.

The commitment from the local government office: For the integrative and comprehensive interventions in the MTCSA, the cooperation of various organizations and facilities is required. To activate MTCSA at a district level, many kind of preparations are needed, such as local government's and counseling center's acceptance of MTCSA, recruitment of the professionals, and educational program for them. The local government has a sufficient power to mobilize and lead their participation, especially that of the Korean government. Furthermore, the government is more able to prepare the funds for the MTCSA because it has already secured of fiscal year budget for the Youths. The government's interests in MTCSA is important for its nationwide recognition and development.

References

Barnett, W. S. (1995). Long-term effects of early childhood programs on cognitive and school outcomes. *The Future of Children, 5(3)*, 25-30.

Baruch, R., & Stutman, S. (1994). *Strategies for Fostering Resilience.* Washington, DC: Institute for Mental Health Initiatives.

Belar, C. D. (1999). Collaboration in capitated care:

Challenges for psychology. *Professional Psychology: Research and Practice, 26(2),* 139-146

Burt, M. R., Resnick, G., & Novick, E. R. (1998). *Building Supportive Communities for At-Risk Adolescents: It Takes More Than Services.* American Psychological Association, Washington, D.C.

Bronfenbrenner, U. (1979). *The Ecology of Human Development: Experiments by Nature and Design.* Cambridge, MA: Harvard University Press.

Dryfoos, J. G. (1990). *Adolescents at Risk.* New York: Oxford University Press Edwards, L. C., Lim, B. K. B., McMinn, M. R., & Dominguez, A. W. (1999). Example of collaboration between psychologist and clergy. *Professional Psychology: Research and Practice, 30(6),* 547-551.

Finn-Stevenson, M., & Zigler, E. (1999). *Schools of the 21st Century: Linking Child care and Education.* Westview Press

Hinshaw, A. S., & Deleon, P. H. (1995). Toward achieving multidisciplinary professional collaboration. *Professional Psychology: Research and Practice, 26(2),* 115-116.

Kreppner, K., & Lerner, R. M. (1989). *Family Systems and life span development* Hilllsdale, NJ: Erlbaum.

Lerner, R. M.(Ed.). (1993). *Early Adolescence: Perspectives on Research, Policy, and Intervention.* Hillsdale, NJ: Erlbaum.

Malderez, A. & Bodoczky, C. (1999). *Mentor Course: A resource book for trainer trainers.*_Cambridge Teacher Training and Development, Cambridge University Press.

McAuliffe, G. L., & Eriksen, K. P. (1999). Toward a constructivist and developmental identity for the counseling profession: The context-phase-stage-style model. *Journal of Counseling and Development, 77,* 267-280

Parsons, F. (1909)._*Choosing a Vocation.* Boston: Houghton Mifflin.

Pence, A. R. (1988). *Ecological Research with Children and Families: from Concepts to Methodology.* New York: Teachers College Press.

Pittman, K., O'brien, R., & Kimball, M. (1993). *Youth Development and Resiliency Research: Making Connections to Substance Abuse Prevention.* Washington, DC: Academy for Educational Development, Center for Youth Development and Policy Research.

Pittman, K., & Zeidin, S. (1992). *Evaluating Youth Development in Programs and Communities: The Need for an Integrated Framework and Collaborative Strategy.* Washington, DC: Academy for Educational Development, Center for Youth Development and Policy Research.

Ramey, C. T., & Ramey, S. L. (1992). Effective early intervention. *Mental Retardation, 30,* 337-345.

Wozniak, R. H., & Fischer, K. W. (Ed.). (1993). *Development in context: Acting and thinking in specific environments.* Hillsdale, NJ: Erlbaum.

Yoshikawa, H. (1995). Long-term outcomes of early childhood program on social outcomes and delinquency. *The future of children, 5(3),* 51-75.

한국심리학회지 : 상담 및 심리치료
The Korean Journal of Counseling and Psychotherapy
2000. Vol. 12. No. 2. pp. 169-184

청소년을 위한 다중-전문가 팀접근 상담 체제

금명자 김택호 강진구 안희정
한국청소년상담원

본고는 한국청소년상담원에서 청소년상담의 혁신적 접근방법으로 개발된 다중-전문가 팀접근 상담 체계(MTCSA; Multi-professional Team Counseling System for Adolescent)와 이 체계를 적용한 사례를 소개하고, 몇 가지 제한점들을 논한다. MTCSA는 5가지 원리에 입각한 체계로서, 성인상담과는 차별하여 청소년상담에서 요구되고 있는 요소들로 구성되어있다. 이 원리들은 다중-기지 종합적 개입, 다중-전문가 팀 접근, 찾아가는 상담, 멘토-관계, 지역사회공동체의 관여들이다.

일정 지역에 살고 있는 전문직종 종사자 5-6명이 한 팀을 이루어, 의뢰된 청소년 내담자와 그의 가정, 학교, 친구 및 지역사회로 직접 찾아가 상담 개입을 한다. 전문직종 종사자들에는 중고등학교 교사를 비롯한 교육인, 변호사를 비롯한 법조인, 의사와 약사를 주축으로 하는 의료인, 목사와 스님과 같은 종교인들이 포함되며, 지역 청소년상담실의 전문 상담자의 지도・감독 아래 의뢰된 청소년 내담자와 그의 환경에 찾아가서 상담을 한다. 팀원들은 대개 1주일에 한번씩 만나 상담활동을 의논, 결정하고 그 다음 주에는 각자 혹은 팀으로 활동을 실행하고 다시 논의하는 식으로 팀이 운영되며, 적어도 6개월 이상 그 상담 사례를 지속한다. 청소년내담자의 문제가 호전되어 더 이상의 적극적 개입이 필요 없다고 하더라도 팀과 내담자의 관계는 그가 고등학교를 졸업할 때까지 멘토링 관계로 유지된다.

보고된 사례는 서울 근처의 중소 도농복합도시에서 실시된 MTCSA의 적용 사례이다. 1년여 이상의 가출과 절도로 현장에서 잡혀 지역상담실에 의뢰된 사례였지만 MTCSA의 1개 팀이 상담을 실시하여 4개월 안에 급진적 진전을 보였다. 현재 MTCSA는 7개 시・도의 11개 도시에서 약 30개의 팀이 운영되고 있다.