

Communities That Care for Families: The LINC Model for Enhancing Individual, Family, and Community Resilience

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The resilience of families and communities is inextricably linked. Their healthy functioning relies on a balance of stressors and resources. Both can be jeopardized by major challenges such as socioeconomic change or natural and man-made disasters. Such events can cause increased incidences of physical and mental problems such as addiction, posttraumatic stress syndrome, and heart disease. Trauma breeds marginalization, abuse of power, and prejudice. How these stressors are handled is profoundly influenced by the degree of connectedness—attachment—to family and culture of origin. Connectedness can be enhanced by mobilizing support systems, facilitating access to resources, strengthening family, community and cultural ties, and fostering resilience. The LINC Model increases connectedness at the individual, family, and community levels. This article includes methods for designing interventions, studies and clinical vignettes that illustrate the application of the LINC Model, and examples of communities that have overcome major stress.

The family is the integral unit of society. The well-being and resilience of families and communities are inextricably linked. Although inherently competent and resilient, families and communities experiencing three or more transitions in a brief period of time are likely to become stressed to the point of becoming symptomatic if there is imbalance between the stressors and their resources. Individuals and families deal with their own unique traumas and transitions, though not in isolation. The effects ripple outward in the community to friends, neighbors, schools, congregations, health care, and other natural support systems. In addition to internal individual and family transitions and stressors, are the ever-present community-wide threats of socioeconomic change, natural and man-made disasters, migration, and, more recently, climate change and the global financial crisis. These challenges are exacerbated by inequalities of gender, wealth, resources, privilege, and power.

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For families, these stressors may lead to increased incidence of substance abuse and other addictions, posttraumatic stress syndrome (PTSD), sexual risk taking, violence, poor eating and health habits, depression, suicide, and chronic or life-threatening illness. For communities, trauma breeds prejudice, marginalization, and abuse of power.

When the balance of stressors and resources is disrupted by unpredictable or massive loss, individuals, families, and communities develop unconscious adaptive behaviors and coping strategies. One member or subgroup develops symptoms that draw the group's attention away from the loss and toward resolving the new problems. These coping mechanisms serve to shield the family or community from the pain of loss. Because the adaptation is successful, it is transmitted through the generations and across families and communities, despite its being redundant and therefore dysfunctional. When the grief is resolved, typically over three to five generations, someone or several people lead the family and community into healing and recovery. This intrinsic drive toward health and healing within families is *Family Motivation to Change* or to heal (Garrett & Landau, 2007).

As with individual and family loss and trauma, seldom are the consequences of community-wide stressors confined to those most directly affected (Bell, 2004; Garnezy & Rutter, 1983; Landau-Stanton & Clements, 1993; Rutter, 1987; Walsh & McGoldrick, 1991). The ramifications of large-scale trauma can jeopardize entire national economies and geopolitical dynamics. Despite the seeming independence of natural disaster, chronic illness, trauma, addiction, and violence, the meaningful systemic connections among them have been well documented and are described succinctly as *syndemic* (Centers for Disease Control and Prevention, 2001; Milstein, 2002; Singer & Clair, 2003).

Not surprisingly, the most effective strategies for combating syndemics are those that mobilize a broad range of social systems for long-term, systemic, and sustainable healing. This article discusses the application of the LINC Model as a means of extending social support systems to help empower individuals, families, and communities to bind their own wounds by leveraging their collective power to overcome adversity and sustain long-term change with a minimum of time and effort on the part of outside professionals (Landau, 2007; Landau-Stanton, 1986). Following an overview and explanation of the theoretical background and principles of the LINC Model, are the fundamentals of its implementation: (a) the assessment tools that enhance continuity and connectedness and evaluate resources and vulnerabilities and (b) the *Family and Community Links* that serve as natural change agents, facilitating the process. Studies and clinical vignettes of the LINC Model in action at the individual, family, and community levels illustrate its application.

Philosophical Underpinnings of the LINC Model: Continuity and Connectedness

The LINC Model evolved out of Transitional Family Therapy, which is grounded in the idea that individuals, families, and communities are intrinsically healthy and competent. With appropriate guidance, they can access their inherent resilience to resolve their own problems (Seaburn, Landau-Stanton, & Horwitz, 1995). The goals are to engage the entire system in the process of change, eliminate blame and reduce shame and guilt, and identify and access naturally available resources for healing. The core philosophy of the LINC approach is that building a sense of continuity from past to future helps people navigate the present with greater awareness of their choices (Landau, 2007; Landau, Cole, et al., 2000; Landau, Mittal, & Wieling, 2008; Landau-Stanton, 1986; Landau-Stanton, Griffiths, & Mason, 1982; Suddaby & Landau, 1998).

Continuity

In times of major upheaval, most people tend to focus only on the immediate crisis and their survival. This results in their becoming disconnected from one another when they most need to be close. It also means that they are disconnected from the *Transitional Pathway*—the hypothetical line connecting the past, present, and future (Landau, 1982; Landau-Stanton, 1990). People adjust to losses or major transitions by moving in different directions and at different rates. This asynchrony (*Transitional Conflict*) between individuals and subsystems or subsystems and the larger system, can trigger symptoms, especially when the upheaval is rapid or severe or when resources are insufficient to balance the stressors (Horwitz, 1997; Seaburn et al., 1995). LINC interventions are designed specifically to resolve Transitional Conflict by creating resolution and synchrony across the system.

Every LINC intervention begins with an assessment process (discussed in more detail later) intended in part to help reestablish the continuity between past, present, and future for a family and/or community. During this process, stories and histories emerge that shed light on the situation's social, cultural,

and historical context and on the way in which families and communities confront their problems. This enables people to gain perspective on the complex systems in which they live and to see their family and/or communities in a fresh light. The process diffuses blame and anger and makes room for more constructive interactions that draw upon a full range of resources and strengths (Landau, 2007; Landau-Stanton, 1986; Watson & McDaniel, 1998).

Connectedness

The LINC Model's assessment tools set the stage for enhancing connectedness within extended family, community, and natural support system, a critical aspect of fostering resilience (Bell, 2001; Bowlby, 1969; Johnson, 2002; Main, 1995). By reestablishing continuity with their forebears, people are reminded how their predecessors weathered difficulties, and they are reassured about their own competence (Landau, 2004; Seaburn et al., 1995). Building connectedness by enlarging and mobilizing natural support systems provides people with resources—tangible and intangible—that enhance their ability to overcome adversity (Hobfoll, 1989, 1998; Melton & Holaday, 2008). Achieving a strong sense of connectedness promotes a feeling of solidarity among family and community members. This eliminates counterproductive we–they dichotomies.

The role of connectedness in protecting against vulnerability is illustrated in two recent research studies: one with women attending a clinic for sexually transmitted diseases compared with women in a community center, and the other with adolescents attending a mental health clinic (Landau, Cole, et al., 2000; Tuttle, Landau, Stanton, King, & Frodi, 2004). All three populations showed that knowing stories about grandparents or great-grandparents and frequent monthly contact with extended family members were strongly associated with lower levels of sexual risk taking. Both measures held up independently and together. In addition, in the second study with adolescent girls, their intergenerational family stories were analyzed for themes of resilience (i.e., overcoming adversity) versus vulnerability (i.e., depression, family violence, addiction). The results indicated that knowing any story, even if it contains themes of vulnerability, is more protective than knowing no story at all. These findings suggest that being able to draw on the resilience of past generations helps people explicate and reconnect their transitional pathways. Then, they can make informed choices about where to go and how to get there.

Assessment Tools for LINC Interventions

LINC interventions rely heavily upon several assessment tools that are designed to evaluate the following: (a) whether connectedness and continuity of the transitional pathway has been disrupted; (b) whether strengths and themes of resilience, rather than vulnerability, are being mobilized in the struggle with hardship; (c) what the overall level of stress is; (d) how stressors and resources are balanced; and (e) whether family and community resources are available, accessed, and utilized. The assessment techniques use a number of geographic, sociological, and therapeutic maps, including the Transitional Genogram, the Transitional Field Map, the Multisystemic Levels Map, and the

Structural Pyramid (Landau, 1982, 2007; Landau et al., 2008; Landau-Stanton & Clements, 1993).

The Transitional Genogram depicts important family genealogy, themes, scripts, events, relationships, conflicts, and strengths across as many generations as possible. It also maps belief systems in the sociocultural context (Landau, 1982, 2007; Landau-Stanton & Clements, 1993; see Figure 1). The Transitional Field Map provides a schematic representation of a family or community's members, problems, resources, events, themes, and histories that exist within every level of the network, including biological and individual psychosocial systems, natural and ancillary (artificial) support systems, and cultural and ecosystems (Landau-Stanton & Clements, 1993). The Transitional Field Map also underscores that each level within a system (family, community, culture, and context) affects the others. The Multisystemic Levels Map examines in further detail "slices" of the Transitional Field Map that focus on past and current events in the community, sources of resilience, and other features of the community's response to loss or trauma that may guide decisions about intervention (Landau & Saul, 2004) (Table 1).

The Structural Pyramid Map assists in the detailed design of an intervention (Landau, 2007). This map represents all members of the family or community, including target individuals, family members, extended family groups, schools, neighborhoods, local authorities, political leaders, and professionals. It highlights those with special skills and leadership positions as

well as majority and minority populations to help ensure that everyone across the system is informed, there are no secrets, authority is acknowledged, and all potential change makers are included. This detailed process provides insight not only to outside professionals attempting to guide families or communities toward healing but also to the families and communities themselves.

Family and Community Links as Natural Change Agents

A fundamental goal of the assessment process is identifying natural agents who will serve as *Family and Community Links* throughout the LINC intervention. Central to the LINC approach is the recruitment and coaching of individual members of the family or community who can bridge the gap between the professional and the family or community in need (Landau, 1981, 1982, 2007; Landau et al., 2008). Ideally, these Family or Community Links, referred to hereafter simply as *the Link*, should be acceptable to and respected by all members of the group. Because the Link's ability to convene representatives from all levels of the family or community structure is critical to LINC interventions' success, it is important to avoid selecting leaders who cannot garner broad support or who might derail the process for their own aggrandizement or personal gain. The Link should be a person who, still being in transition, is unbiased and able to view the problem from multiple perspectives.

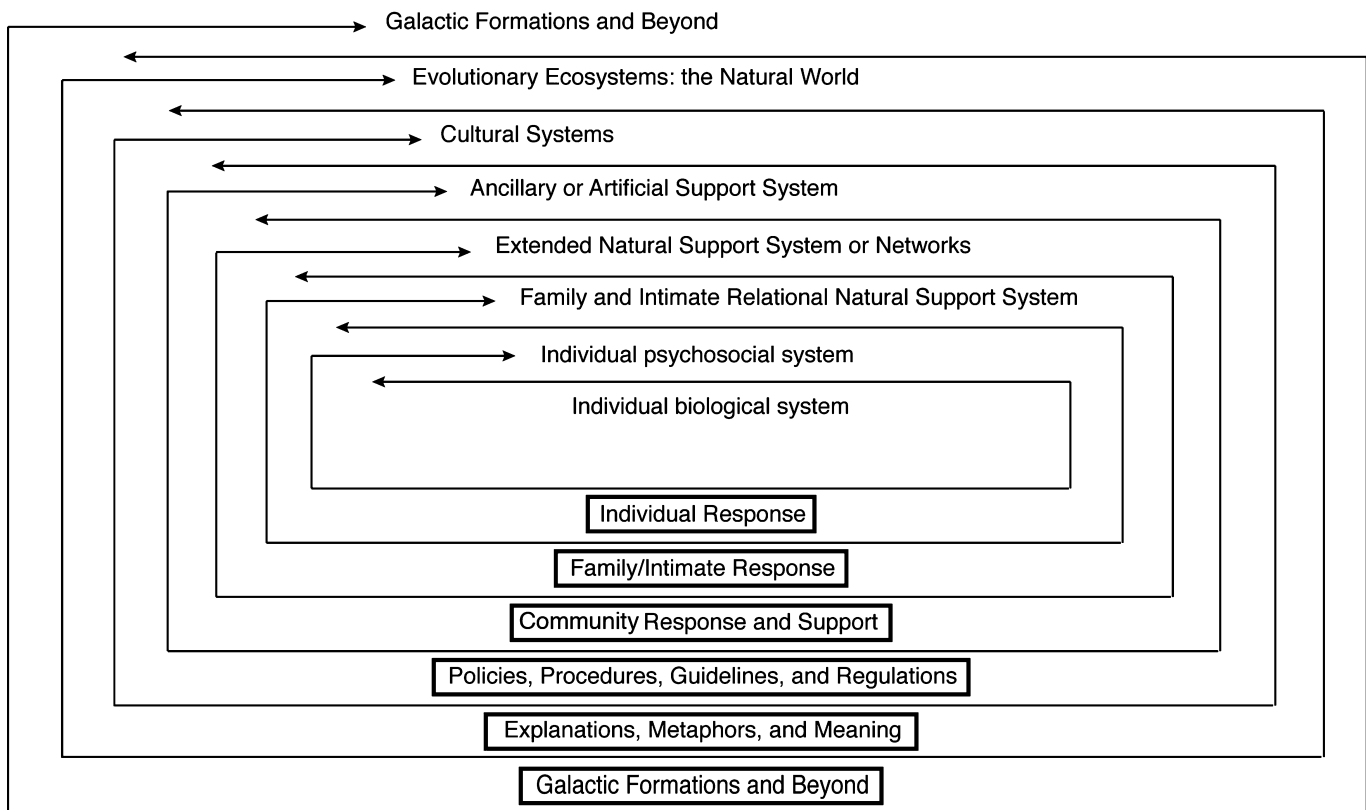


Figure 1. The Transitional Field Map (Landau-Stanton & Clements, 1993) depicts the entire biopsychosocial system, enabling one to assess structure, function, organization, and process at each level.

Table 1. *The Multisystemic Levels Map (Landau & Saul, 2004) Used in New York City Community Intervention Following September 11, 2001, Terrorist Attacks: The Map Provides a Detailed Template for Understanding Traumatic Events and Their Sequelae, Sources of Resilience, and Potential Intervention Strategies*

Systemic level	Traumatic event(s) impact (severity and duration)	Protective factors resources and resiliency	Symbolization and narrative system	Problematic reactions to event(s) and long-term sequelae	Interventions and prevention
Biological system Physical Nervous system Endocrine	Death, injury, CNS response, respiratory problems from debris	Levels of physical fitness, and health, youth, stress inoculation, mind-body-spirit practices	Somatic expression, dreams	Somatic symptoms, respiratory and health problems	Pharmacological agents, mind-body-spirit regulatory practices and intervention, physical self-care
Individual psychological system Cognition Emotions Behavior Relations	Loss, insecurity, disruption of routine and role, fear and anxiety, dissociation, altered time	Personality and coping skills, identity, self-image, cognitive skills, relational behavior, affect regulation	Recall and constructions of dreams and intrusive memories, and multiple personal meanings	Anxiety, depression, acute stress symptoms, PTSD, grief reactions, aggression and suicidality, alcohol and substance abuse	Individual counseling and therapy, stress-relieving interventions, psycho-education, enhancing intrinsic strengths, facilitation posttraumatic growth
Social systems Family and intimate relations Natural support system (local community): church, neighborhood, school, work, other groups Ethnic/national/global Ancillary support system: emergency, hospital, welfare	Separation and loss, change in relational behavior and bonding, stress on family and other social groups, displacement, disruption of role and routine, increased connectedness and bonding, communication breakdown, media response Activation of ancillary support system	Family support, competence of natural supports, community organization and support, history of family and community, community self-mobilization, organization and support, national and international support Ancillary support	Collective narration with family friends, neighborhood and community National and global narratives	Disruption of family life cycle, neighborhood relations Flight from city and severing of social attachments Displacement of families and work organizations Stress due to loss of income, housing, employment Intrusion of ancillary support systems	Family, group, and network counseling and therapy, mobilization, and facilitation of natural support systems by ancillary support systems, peer support networks Building on long-term preventative groups and methods Organizing community forums; enhancing social connectedness for communication, problem solving, and resource accessing
Cultural systems Meaning systems Knowledge systems Language and symbols Identity Rituals and practices	Shattered world assumptions, sense of invulnerability and safety	Creation of rituals, religious and spiritual solace, patriotism, sources of coherent world view, arts and literature, communication	Interpretation of collective narration, of old and new rituals, contextualizing and memorializing, creation of new symbols, 9/11 as a temporal marker Impact of environmental, economic and political change on symbolic systems	Increasing rigidity and resort to primitive belief systems, discriminatory responses to Arab and Moslem minorities	Changing cultural belief systems from vulnerability to resilience, facilitation of new rituals and practices focused on communal grieving, revitalization, and conciliation, cultural legacy and mission
Eco-systemic environment Physical and natural world Economic and political context	Environmental destruction and hazard, mobilization of rhetoric	Economic and political resources, physical		Disruption of utilities, transportation and communication, exaggerated political responses (curtailment of civil rights)	Clean up of environment, plan for reconstruction, war on terrorism, preemptive strikes

The Link should avoid affiliating with only one position or faction and artificially driving the decision-making process and subsequent action.

Soon after the assessment in which the Link is selected, the professional begins coaching the Link to assist the family or community in resolving its problems. This reinforces the Link's confidence in his or her expertise about the family or community. A central advantage of utilizing Links is that they permit access to social systems that might otherwise resist outside "interference" in their concerns or invite intervention during a crisis but quickly discontinue their participation once the crisis is resolved. Working with Links is particularly useful for professionals attempting to intervene within "closed" social systems, such as traditional extended families and clans, or highly educated and sophisticated communities. Harnessing the power of a Link maintains respect for a family or community's traditions, strength, pride, and privacy and capitalizes on the group's capacity for healthy change and survival.

Principles of the LINC Approach

Whether executed at the level of individuals, families, or communities, the LINC approach is guided by the following principles:

- Involve all components of the extended social system.
- Ensure representation of each layer of the Transitional Field Map.
- Ensure invitation, authority, permission, and commitment from family or community members or leaders who are widely accepted by the larger system.
- Ensure access to biological, psychological, and spiritual resources.
- Directly relate the program to the group's goals, future directions, and best interests.
- Develop and prioritize realistic tasks from the goals and then devise practical projects.
- Build on existing resources, assigning projects to appropriate resources.
- Provide the process; remain peripheral; and encourage the group to take responsibility for the content, goals, and actions.
- Attribute success of the program where it belongs—with the individual, family, or community.

LINC Interventions in Action

The following examples illustrate the wide array of circumstances in which natural change agents serving as Family and/or Community Links can implement prevention and intervention at the individual, family, and community level.

Individual Level: A Relational Invitational Sequence for Engagement

The A Relational Invitational Sequence for Engagement (ARISE) Intervention is a three-phase, gradually escalating

intervention process designed to engage a problem individual and his or her family in treatment for a minimum of 1 year. The person with a problem is invited to participate in the process, and the goal is long-term individual and family healing and recovery (Landau & Garrett, 2006, 2008). The ARISE Intervention is applicable to such self-destructive behaviors as substance abuse, addiction, and other process or behavioral compulsions including gambling, gaming, overspending, Internet addiction, sexual acting out, cybersex, and eating disorders. It can also be used for those struggling with emotional illness or chronic and/or life-threatening physical illness.

The first phase of an ARISE Intervention is initiated by a concerned family member who contacts a Certified ARISE Interventionist. This *First Caller* serves as the Family Link and is coached by the Interventionist about strategies for mobilization of the family and support system as an Intervention Network, who, along with the individual of concern, is invited to a family meeting. There are three escalating levels of this first phase, which are intended to motivate the problem person into treatment or self-help by using a loving, compassionate, and transparent approach and capitalizing on the strengths and resources of the entire Intervention Network. Phase B begins at the time of treatment entry and continues for 6 months. During that time, the Intervention Network and problem person, along with their treatment team, continue to meet with a goal of reinforcing the lifestyle changes essential for recovery of all participants (Fernandez, Begley, & Marlatt, 2006; Landau & Garrett, 2008). Phase C focuses on the entire family living in recovery and typically lasts 6–12 months.

A clinical study was conducted through the National Institute on Drug Abuse (NIDA) on the cost effectiveness of the ARISE Intervention for engaging resistant substance abusers in treatment or self-help. The primary outcome variable was dichotomous: Did the substance abuser, within 6 months from the first call, engage in treatment or self-help by physically either (a) showing up and enrolling in treatment or (b) attending self-help meetings? Results showed an 82.7% success rate: $n = 110$ —86 engaged in treatment, 5 in self-help (Landau et al., 2004). Half of those who entered treatment did so within 1 week of the initial call, 76% within 2 weeks, and 84% within 3 weeks. The engagement rate did not differ across preferred substance of abuse, the level at which engagement occurred, or demographic variables such as age, gender, or race. The outcome/effort scale refined the above-mentioned dichotomous outcome score (engaged vs. nonengaged) on the premise that a successful engagement, achieved with less clinician time and effort, should be viewed as a more positive outcome than a successful engagement that entailed greater clinician time/effort. Conversely, an unsuccessful engagement in which the First Caller refused even to attempt ARISE should be viewed as more negative than an unsuccessful case in which at least some effort was made. A score was thus assigned to each case according to the following 5-point, ordinal scale: First Caller refused ARISE (–2), ARISE was attempted but failed (–1), engagement success at Level III (1), engagement success at Level II (2), and engagement success at Level I (3). On average, professionals spent less than 90 min of coaching concerned friends and family members to mobilize their networks to motivate addicted subjects to enter treatment.

The mean amount of time required was 88 min with a median of 75 min.

A recent “real-world” study on ARISE conducted by Stanley Street Treatment and Resources (SSTAR) replicated the results from the NIDA study with an 80% engagement rate (see Table 2). Their 1-year follow-up study demonstrated a 61% sobriety rate with an additional 10% improved (see Table 3) (Landau & Garrett, 2008). SSTAR recently conducted a pilot study wherein the ARISE Intervention was initiated by the addicted individual themselves while in detox. The goal was to determine how effective the ARISE Intervention is at ensuring that after detox these patients engaged in secondary and tertiary care. The sample, of which 55% was homeless, ranged from 5 to 12 prior admissions, averaging 10. The study found that 82% went on to a secondary level of care; of those, 100% went on to a tertiary level of care. Ninety-one percent reported that they were active in NA or AA. At the time of last contact at 12 months, 55% had not relapsed. Of those who had, 80% were back in treatment (P. Emsellem, personal communication, October, 21, 2009).

Family Level: Link Individual Family Empowerment

The Link Individual Family Empowerment (LIFE) intervention grew from studies on connectedness and self-protective

Table 2. Outcome Comparison Between NIDA Study and Real-World Data From Stanley Street Treatment and Resources (SSTAR)

Variable	NIDA (<i>n</i> = 110)		SSTAR (<i>n</i> = 39)	
	No.	%	No.	%
Engaged in treatment or self-help	91	83	31	80
Relationship of first caller				
Parents	44	40	18	46
Spouse/partner	34	31	7	18
Offspring	4	4	2	5
Other relatives	21	19	12	31
Nonrelatives	7	6	0	0
Gender of first caller				
Female	76	69	30	77
Male	34	31	9	23
Average intervention network size	3	—	2.5	—

Table 3. Data From Real-World Study at Stanley Street Treatment and Resources (SSTAR) of Sobriety Status at the 1-Year Mark

Variable (<i>n</i> = 90)	No.	%
Engaged in treatment	68	76
Engaged in secondary care	36	53
Sobriety status		
Sober at last contact	41	45.5
Period of sobriety w/relapse	14	15.5
Reduced use	9	10
No change	11	12
No information	15	17

behavior (Landau, 2007; Landau, Cole, Clements, & Tuttle, 1995; Landau et al., 1996). It is a formal, eight-session intervention that focuses on enhancing positive connectedness to family and culture of origin, which is in line with the findings that frequency of visits to extended family and knowledge of intergenerational stories of family resilience is correlated with reduced risk taking. Six of the sessions focus specifically on creating positive connectedness by working with the Links to explore their intergenerational family stories of vulnerability and resilience. Because the work in these sessions help recreate ritual and celebration, the perspective is positive (Imber-Black & Roberts, 1992; Landau, Cole, et al., 2000; Tuttle et al., 2004; White & Epston, 1990). Two of the sessions, typically the final ones, focus on the specific need or problem and goals of that particular family.

The original LIFE study was a qualitative, developmental study conducted in Rochester, New York, and Taipei, Taiwan (Landau et al., 1996). Its focus was to prevent the spread of HIV/AIDS in the immediate and extended family and in the neighborhood. Links in this case were HIV-positive family members who were best connected to other family members and neighbors. Single-family or multifamily LIFE interventions have since been applied in a number of contexts: child abuse and domestic violence (the Bronx, New York), addiction (Argentina and Kosovo), and cultural transition (refugee families in Kosovo and the United States).

Community Level: LINC Community Resilience

LINC Community Resilience interventions involve the entire community or representatives of the community in assessing their situation and designing their own intervention (Landau, 2007). These interventions can be used within a community or by governments and organizations as a means of preparing for and/or resolving the consequences of mass disasters (Landau, 2004, 2007; Landau & Saul, 2004; Landau & Weaver, 2006; Landau et al., 2008). They use a series of maps to assess demographics, attitudes, customs, family structures, and important events in the communities. Following this assessment, community forums are organized, each representing a comprehensive cross section of the population. In larger communities (more than 6,000 people), LINC Community Resilience interventions begin with consultants who train local professionals to assist in facilitating the intervention so that the entire community may be reached.

Following LINC protocol guidelines, members of the community divide into small discussion groups, each representing a cross-section of the community. The groups identify strengths, themes, scripts, and resources that are available within the community and discuss what the concept of resilience means to them individually, and to their families and community. Each group then develops overarching goals for the future. Groups usually embrace the goals set by the collective, but they also usually add several of their own. The groups discuss ways in which their available resources can be applied to each small and easily achievable task that is derived from one of the goals.

Groups then work as collaborative teams to select their Community Links who are people from within their own group whom they trust and with whom they can easily communicate. Links are identified as people who would make good leaders

and who are able to bridge the gap between the community and outside professionals. Members of the collaborative teams then identify practical tasks from their goals and arrange work groups to achieve them. The number of Links depends in part on the size of the community. Medium-sized communities (i.e., those with a population of 6,000–50,000 people) select, on average, 3–5 Links, whereas larger cities (i.e., with a population of up to one million people) select 8–10 Links, each of whom coordinate multiple projects.

Case Example 1: 10,000 Leaders for a Change (Buenos Aires Province, Argentina). After a lengthy period of severe political unrest and upheaval in Argentina from the late 1970s that culminated with a serious economic crisis in 1990, the author was invited to perform a wide-scale survey to assess the problems in the community. The survey showed that there was an increase in the prevalence of addiction and HIV/AIDS as well as violence in Buenos Aires Province (with an urban and rural population of 12 million). To combat these problems, health officials requested the development of a province-wide, community-based program focused on prevention and intervention.

Some of the activities and groups that developed in different communities in Buenos Aires Province—all catalyzed by Community Links—included: a partnership of police, school personnel, parents, and community residents to expel drug dealers from the neighborhood; support of a preexisting formal organization, *Padre a Padre*, designed to serve parents of children struggling with issues of substance abuse or addiction (this organization grew into a nationwide initiative that continues to flourish); a program for evening education for literacy, business skills, and handicrafts; and a social group for children and families of the military to become integrated into the communities in which they were stationed. In one example of the many indicators of positive system change, within 2 years, there was a 400% increase in the admission to treatment of young people struggling with alcohol or drug abuse, most of whom were brought to and supported in their treatment by family members. A 15-year follow-up found that in one of the cities of 2 million people, more than 90% of the original 47 community projects were still functioning. The current mayor, in office only 5 years, took credit for his community. This is as it should be; because LINC Community Resilience interventionists “tread lightly and hope to leave no footprints,” the success of the work is attributable to the community.

Case Example 2: Public health in postwar Kosovo. Since the end of the 1999 war in Kosovo, the Kosovar Family Professional Education Collaborative has been consulting to the newly emerging government on building health and mental health systems that are closely tied to the culture and draw upon the strengths of family, community, and culture (Agani, 2000; Pulleyblank-Coffey, Griffith, & Ulaj, 2006; Weine et al., 2005). The initial goal was to develop a services-based training initiative directed toward establishing a collaborative group of Kosovar professionals trained in family and systems approaches. Our work has prepared these professionals to work with Kosovar families and their communities to establish sustainable systems for prevention and intervention. Because the

culture stresses the importance of the extended family and the community, the overall strengths-based design views families as the most important unit of change and communities as the primary units of both prevention and care (Landau, 1982; Landau, Garrett, et al., 2000; Landau-Stanton, 1986; Walsh, 2003). If the LINC Model’s underlying principle of inherent community resilience is followed, all services would be embedded in the communities, and the communities would participate in designing the systems of delivery and prevention, not unlike what Argentinian leaders accomplished in their communities. The inherent competence and resilience of the individuals, families, and communities and their cultural heritage are mobilized, and, as a result, we are seeing the emergence of a truly resilience-based health and mental health care system poised to develop effective mechanisms for dealing with trauma, grief and loss, violence, addiction, HIV/AIDS, and other serious and chronic illness and mental illness (Agani, Landau, & Agani, 2010).

Case Example 3: Child welfare, Romania. A primary care physician in Romania mobilized the community to deal with major problems in a village on the border of Romania and Hungary—children were being injured or killed as they tried to cross a railway line to get to their school, and gang warfare and drug dealing had increased dramatically. In a community meeting, the villagers realized that their new railway line divided the wealthy from the poor, leaving all the resources on one side of the tracks, creating enmity across the new boundary. The Community Links worked with a task force to petition the government for a bridge. Other community groups took responsibility for bringing the two disparate communities together for the safety and future of all their children. After a year, there were no more deaths of children on the railway line.

Conclusion

The LINC Model reinforces the inextricable connections among the many forces that govern a healthy family or community. LINC not only recognizes the association among different problems, but values relationships among the people, agencies, and strategies that we as a society turn to for healing and protection (Milstein, 2002). During the stresses of modern-day living, we are seeing the dissolution of the traditional family and community. People are far more isolated, and social support is often perceived as unavailable or inaccessible. Mobilizing family, neighbors, and community resources (e.g., schools, churches, athletic groups, public service professionals, and educators) can prevent this isolation and strengthen our families and communities (Melton, 2010). As human beings, we need to rely on our family and community connections to survive both normal stressors and unexpected traumatic events. With the support of family and community, people can grow stronger through adversity, rather than being overwhelmed by it (Hobfoll, 1989, 1998). Individuals and families have survived through time because of the natural helpers or change agents who have emerged during trouble or crisis. When these natural change agents do not appear spontaneously, outside facilitators can be recruited to help the community identify and mobilize them to serve as Family and Community Links. The LINC Model is designed especially for these times.

Working from this perspective allows us to understand community systems in larger, more dynamic, and democratic terms. The focus becomes a constant navigational challenge to move ourselves, our families, and our world away from positions of vulnerability and affliction to positions that are safer and healthier. The LINC Model brings these principles to life through its pragmatic commitment to find and to activate sources of resilience in society, not as an add-on but from the outset and throughout the process.

Keywords: communities; families; extended families; substance abuse; PTSD; STDs; sexual risk taking; heart disease; resilience; depression; impulsive behavior; grief; family support; trauma; LINC; Family Links; Community Links; connectedness; family therapy; transitional pathways; natural helpers; community change; Romania; genograms; change agents; assessment; ARISE; HIV/AIDS; gambling; Argentina; Kosovo; political violence; family violence; isolation

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