

Strengthening America's Families:  
Exemplary Parenting and Family Strategies  
For Delinquency Prevention

by

Karol L. Kumpfer, Ph.D.,  
University of Utah  
(April, 1999)

*This User's Guide was prepared under Grant No. 95-JN-FX-K010 from the Office of Juvenile Justice and Delinquency Prevention, Office of Juvenile Programs, U.S. Department of Justice. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.*

**TABLE OF CONTENTS**

**OVERVIEW .....4**

**PART I: FAMILY INFLUENCE ON JUVENILE DELINQUENCY ..... 5**

INTRODUCTION ..... 5

JUVENILE CRIME STATISTICS ..... 7

DEVELOPMENTAL PATHWAYS TO DELINQUENCY.....10

*Family Risk Factors* ..... 12

        Family History ..... 12

        Family Management Problems..... 14

        Family Conflicts..... 15

        Family Poverty ..... 15

*Family Dynamics and Violence* ..... 16

        Cycle of Violence..... 17

        Exposure to Violence in the Home ..... 18

        Child Abuse & Domestic Violence..... 18

        Victimization from Neglect, Physical Abuse, and Sexual Abuse ..... 19

*Family Protective and Resilience Factors* ..... 20

JUVENILE CRIME CONTROL AND DELINQUENCY PREVENTION ACT 1997..... 21

*Information Program Dissemination* ..... 22

**PART II: REVIEW OF FAMILY STRENGTHENING APPROACHES..... 23**

DEFINITION OF FAMILY..... 23

*Family Strengthening* ..... 24

FAMILY PREVENTION APPROACHES ..... 29

*Family Skills Training Program* ..... 30

*Family Education Programs*..... 31

*Family Therapy* ..... 31

*Family Services* ..... 33

*Family Preservation Programs*..... 33

*Surrogate Family Approaches* ..... 34

PARENTING APPROACHES..... 34

*Behavioral Parent Training Programs* ..... 34

*Parent Education Programs* ..... 35

*Parent Support Groups*..... 36

*Parent Aid or In-home Parent Education* ..... 36

*Parent Involvement in Youth Groups*..... 37

*Adlerian Parenting Programs* ..... 37

PREVENTION IS COST-EFFECTIVE..... 38

**PART III: PRINCIPLES OF EFFECTIVE FAMILY PROGRAMS ..... 41**

COMPREHENSIVE INTERVENTIONS ..... 41

FAMILY-FOCUSED ..... 41

LONG-TERM AND ENDURING..... 42

SUFFICIENT DOSAGE OR INTENSITY ..... 42

CULTURALLY SENSITIVE ..... 43

DEVELOPMENTALLY-APPROPRIATE..... 44

CHANGE ONGOING FAMILY DYNAMICS ..... 45

EARLY START..... 45

FAMILY RELATIONS, COMMUNICATION, AND PARENTAL MONITORING ..... 45

RECRUITMENT AND RETENTION ..... 46

VIDEOTAPING OF EFFECTIVE PARENTING SKILLS ..... 46

TRAINER'S PERSONAL EFFICACY ..... 46

**PART IV: OJJDP FAMILY STRENGTHENING PROJECT ..... 48**

HISTORY OF FAMILY STRENGTHENING PROJECT .....	
NATIONAL SEARCH FOR MODEL PROGRAMS .....	
PROGRAM MATRIX .....	
UNIVERSAL PREVENTION INTERVENTIONS.....	48
SELECTIVE PREVENTION INTERVENTIONS.....	48
INDICATED PREVENTION INTERVENTIONS.....	48
EXEMPLARY PROGRAM DESCRIPTIONS	
<i>FUNCTIONAL FAMILY THERAPY (6-18 YEARS; FAMILY THERAPY) .....</i>	<i>53</i>
<i>HELPING THE NONCOMPLIANT CHILD (3-7 YEARS; PARENT TRAINING).....</i>	<i>53</i>
<i>IOWA STRENGTHENING FAMILIES PROGRAM WITH PRE &amp; EARLY TEENS (10-14; FAMILY SKILLS).....</i>	<i>54</i>
<i>MULTI-SYSTEMIC FAMILY THERAPY PROGRAM (10-18 YEARS; COMPREHENSIVE).....</i>	<i>56</i>
<i>PARENTS, TEACHERS, AND CHILDREN=S SERIES (3-8 YEARS; COMPREHENSIVE).....</i>	<i>57</i>
<i>PRENATAL &amp; EARLY CHILDHOOD NURSE HOME VISITATION (0-5; FAMILY IN-HOME SUPPORT).....</i>	<i>58</i>
<i>PREPARING FOR THE DRUG-FREE YEARS (8-14 YEARS; PARENT TRAINING) .....</i>	<i>58</i>
<i>RAISING A THINKING CHILD: I CAN PROBLEM SOLVE PROGRAM FOR FAMILIES (4-7; PARENT TRAINING).....</i>	<i>60</i>
<i>STRENGTHENING FAMILIES PROGRAM (6-10 YEARS; FAMILY SKILLS TRAINING).....</i>	<i>61</i>
<i>STRUCTURAL FAMILY THERAPY (0-18 YEARS; FAMILY THERAPY).....</i>	<i>62</i>
<i>TREATMENT FOSTER CARE (12-18 YEARS; PARENT TRAINING).....</i>	<i>63</i>
<b>REFERENCES.....</b>	<b>66</b>

## Overview

Years of program development and research have provided effective strategies for strengthening America's families to prevent juvenile delinquency. This document has been written to help program planners, policy makers and service providers determine the most effective family-focused and parenting intervention strategies for the high-risk youth and families they serve. This guide will review what is currently known in the research literature about the impact of family characteristics on risk for delinquency as well as the most promising family change interventions. Providers using the guide will be better able to choose or modify existing programs or create new interventions for high-risk youth in their communities. The guide contains four major sections:

### Part I: Family Influence on Juvenile Delinquency

This section will help service providers understand the factors that influence juvenile delinquency and why certain family strengthening approaches reduce delinquency among youth. Additionally, research literature on the types of family characteristics that impact juvenile delinquency, statistics reporting juvenile delinquency rates, and family protective and resilience facts are reported in this section

### Part II: Review of Family Strengthening Programs

This section reviews program strategies shown to be effective in preventing problems that often lead to delinquency. Various approaches including family and parenting approaches are described. Issues of cost-effectiveness of prevention programs are also addressed.

### Part III: Principles of Effective Family-Based Programs

This section suggests that there is no single best family-based program. Rather, effective programs tend to have several principles that guide their implementation activities. It is recommended that service providers review these principles and incorporate them in selecting and planning family-based programs. Critical issues such as recruitment, attrition, staff training, and program evaluation are also discussed.

### Part IV: Family Strengthening Project

This section describes a national search to find the highest quality family-based prevention programs and outlines the strategy designed to disseminate this information. The programs selected are identified and additional instruction is provided on how to utilize the information provided. The final section presents brief one-page descriptions and contact information for the eleven "exemplary" parenting/family programs and provides information on how to access further program information.

## Introduction

Delinquency, youth violence, gangs, early sexual involvement, alcohol and drug abuse and other problem behaviors in our young people are causes for grave concern in this country. Although recent publicity indicates a general decline in overall violent crime in the United States, there are dramatic and disproportionate increases in rates of violent crime from 1980 to 1995 in the young adult and adolescent population (Snyder & Sickmund, 1995). Since 1991 the number of violent crimes in this country has dropped by 6%--over 100,000 fewer crimes each year. Although fewer crimes are being committed, the juvenile arrest rate has grown by 20% since 1991. According to the FBI about 2.7 million juveniles were arrested in 1995, which is 18% of all arrests. Additionally, in 1994 more than 1.5 million delinquency cases were processed in juvenile courts in the United States representing a 41% increase in cases since 1985 (Butts, 1996). The Violent Crime Indexes Offenses further supports this dismal view by reporting that in 1995 violent crime arrests were 67% higher than the 1986 level (Snyder, 1996). On a more hopeful note, for the first time in a decade, in 1995 there was a small decline of 3% in juvenile arrests for Violent Crime Index Offenses which includes murder, forcible rape, robbery, and aggravated assault.

These statistics provide strong evidence that that these problems be addressed immediately. The authors believe that without high quality prevention efforts, even higher percentages of our youth are likely to become aggressive and violent. Despite vocal skeptics who say nothing works in prevention, the research literature (Bilchik, 1995; Falco, 1992; Kumpfer, 1997; Sloboda & David, 1997; Tobler & Stratton, 1997; Wright & Wright, 1995) contains numerous examples of effective programs that target these problems. Many of these programs are family interventions for the prevention of delinquency and drug abuse (Bry, Catalano, Kumpfer, Lochman, & Szapocznik, in press; Kumpfer, 1993, 1997; Kumpfer & Alvarado, 1995; Kumpfer, Olds, Alexander, Zucker, & Gary, in press). Like other family intervention researchers (Bry, Greene, Schutte, & Fishman, 1991; Szapocznik, et al., 1988; Szapocznik, 1997), the authors believe that improving parenting practices and the family environment is the most effective and enduring strategy for reducing juvenile delinquency and associated behavioral and emotional problems. It appears that strengthening families is a key strategy to the effort to significantly reduce delinquency. We believe that strengthening the ability of families to raise children to be law abiding and productive citizens should be one of the most critical public policy and social issues in the United States.

In both the delinquency and substance abuse prevention or intervention fields, most programs are aimed at working with problem youth, rather than the whole family. Historically, earlier approaches to rehabilitation and therapy assumed that it was the youth who had the problem, not the family. Additionally, working with children and youth is also much easier than working with parents and other family members. Children and adolescents are generally more accessible through schools or community groups for participation in delinquency prevention activities than are entire families. Garnering a commitment from parents who may face numerous obstacles to participation, can be a challenge but well worth the investment in terms of not only individual parent/child changes but also the overall impact on the family. Although efforts focusing on youth should be continued, mounting evidence demonstrates that strengthening the family has a more enduring impact on the child. In a review of both family and child-focused approaches to the reduction of conduct disorders, McMahan (1987) concludes that children's "skills training

approaches have failed to demonstrate a favorable outcome or evidence of generalization in more naturalistic settings (p. 149)". Conversely, McMahon (1987) concludes that family-focused approaches have demonstrated outcomes that are both positive and enduring.

Unfortunately, more children are being raised in highly stressed families. Consequently child abuse and neglect is increasing dramatically (Kumpfer & Bayes, 1995). Personal victimization and children witnessing acts of violence, hopelessness, and depression are just some examples associated with the use of violence. Youth living with family conflict, community disorganization, and economic disadvantages are at particularly high risk for becoming both perpetrators and victims of violence. Because they are exposed to violence in their neighborhoods and homes, they face bleak prospects for the future, and are often drawn into violent activity (DuRant, Cadenhead, Pendergrast, Slavens, & Linder, 1994).

Recent research has demonstrated this clear link between a child's level of exposure to violence and the propensity to commit violent acts later in life (Thornberry, et. al., 1994). Parents must help protect children from seeing violent acts at home, school, neighborhood, or on the television or movies. Social learning theory (Bandura, 1986) predicts that children learn ways of behaving vicariously through observation. If children identify with perpetrators of violence, children are likely to adopt these violent behaviors.

Hence, it is necessary to understand the family dynamics that influence the behavior of the child since the family provides the first level of social contact for the child. More importantly it is essential that families understand their role in their child's development and are armed with the information and skills necessary to raise healthy and well-adapted children. It is incumbent upon our society to promote these learning opportunities for families in this country.

Critically important to understanding delinquent behavior of youth outside the context of family is an understanding of the social environment in which children function. The following document provides information on the prevalence of violence in our communities as well as effective strategies to reduce this trend with family based programs. Hopefully this research-based information on the causes and solutions to delinquency will provide a positive direction for the future.

## Juvenile Crime Statistics

The growing juvenile crime problem is one of the most important issues facing our nation. Juvenile crime stems from a complex array of causes including a lack of adult supervision for our youth, a lack of strong role models, and limited opportunities in addition to negative conditions associated with poverty, abusive backgrounds, and a host of other reasons. Juvenile crime often varies depending on the region, community, and neighborhood, statistics provide evidence that it is a serious problem nationwide. Although small percentages (approximately 16% to 23%) of delinquents are serious, chronic offenders (Shannon, 1991; Snyder, 1988), they account for about 50% to 60% of all juvenile offenses and about 75% of all violent juvenile offenses (Huizinga, Loeber, & Thornberry, 1995).

According to data gathered by the Center for the Study and Prevention of Violence (Elliot, 1994), researchers project that by the year 2010, juvenile arrest rates for violent crimes will more than double. This forecast is based on currently escalating trends in juvenile arrests and increases in the numbers of youth in the 10 to 17 year age range. Juvenile arrest rates began increasing dramatically in 1988 and are continuing at a faster rate than the numbers of adolescents (**Snyder, Sickmund & Poe-Yamagata, 1996**). In less than ten years between 1984 to 1993, juvenile delinquency arrests for violent crimes rose by 68 percent. Homicide arrests for very young offenders, under 15 years of age, increased 24 percent in a single year between 1992 and 1993 along with a 12 percent increase in arrests for weapons violations (Department of Justice, 1995). Between 1990 and 1994, the number of juvenile drug arrests rose from 60,000 to over 130,000, an increase of 117%. In addition, juvenile drug overdoses are increasing at staggering rates in many areas of the country. This may be due to the availability of smoke-able heroin and adulterated drugs.

Additionally, Elliot's (1994) research indicated that about 5% of each age cohort from ages 12 to 17 years were classified as serious violent offenders who had engaged in three or more major offenses; however, 84% of these chronic offenders had no official arrests or delinquency records. Chronic offenders are characterized by early onset of conduct disorders and crimes before the age of 12 that doubles in frequency between 13 and 14 years and reaches a peak at ages 16 to 19 years, but then begins to decline (Elliott, 1994). The earlier the onset of offending (before age 9 years), the greater the likelihood of becoming a chronic violent offender (Huizinga, Loeber & Thornberry, 1995).

Gang violence is also rising rapidly and becoming a way of life for more and more youth. About two-thirds of these serious chronic offenders are gang members and most associate with anti-social peers (Huizinga, Loeber, & Thornberry, 1994). Within the 79 largest U.S. cities there, was an estimated 3,875 juvenile gangs involving more than 200,000 youth (Spergel, 1995). Many of these youth were involved in drug activities and carry guns (American Psychological Association, 1993). Huizinga and associates (1994) report a strong relationship between illegal gun possession by juveniles, delinquency and drug use. They found that three-quarters of youth who carry guns have committed street crimes; one-quarter have committed a gun-related crime; and 40 percent used drugs. Youth are not just the perpetrators of violence, but also are the victims of violence at rates twice as high as for adults over 25 years of age (Moore, 1994). As a result, non-violent youth become fearful and also obtain guns for their own protection. Not only are guns more available, but youth are also showing an increasing tendency to use guns to settle disputes. Though often portrayed as resulting from criminal activity, the bulk of firearm deaths that occur as a result of arguments exceeds the number of deaths associated with robberies, fights, and rapes combined (Tolan & Guerra, 1994).

Fear of juveniles and crime has resulted in many Americans curtailing their activities and living in fear. Politicians have responded quickly, but typically with less effective, short-term solutions, such as increased funding for policing, supply reduction strategies, and incarceration. According to a poll of police chiefs, 85 percent of chiefs want major changes in current policies related to this area and 47 percent want to see more efforts in education, prevention, and treatment (Fox, 1996). Only 21 percent gave a higher priority to law enforcement strategies. Many prominent

correctional specialists agree with prevention specialists that longer-term solutions are required to prevent the problems of delinquency.

## Developmental Pathways to Delinquency

There are many pathways to delinquency (Huizinga, Esbensen, & Weiher, 1991) and a variety of family circumstances contribute to negative behavior in children (Wright & Wright, 1992). Studies of family risk factors for delinquency conclude that the probability of a child becoming a delinquent increases rapidly as the number of family problems or risk factors increases (Rutter, 1987). Children and youth generally appear to be able to withstand the stress of one or two family problems. When they are continually bombarded by family problems, however, their normal development is impeded.

Three developmental pathways to delinquency have been described in longitudinal studies of delinquency (Huizinga, Loeber, & Thornberry, 1995):

Authority Conflict Pathway which begins with stubborn behavior, then defiant behavior, and developing later into avoidance of authority figures (e.g., truancy, running away, staying out late),

Covert Pathway which begins with minor covert problem behaviors (i.e., shoplifting, frequent lying, stealing), moving to damaging property, and later to delinquent acts (i.e., fraud, theft, burglary), and

Overt Pathway which begins with minor aggression (bullying, teasing), followed by physical fighting and later violent acts (physical attack, rape, assault and battery).

Youth in more than one pathway report more crimes. Two family characteristics were found to impact these developmental pathways to delinquency, namely poor family attachment and poor parenting behavior. Higher levels of delinquency and drug use were associated with both of these family risk factors.

Patterson and associates (Patterson & Joerger, 1993) posit that there are two groups of youth involved in delinquent behaviors:

the early starters who follow the previously described developmental pathway and

the late starters who are more influenced by peers.

While the increases in problem behaviors are correlated with immediate precursors of decreased individual and peer perceptions of harmfulness and disapproval of violent, aggressive or delinquent acts, research studies suggest that parents have an early influence on the developmental pathways towards delinquency and drug use (Kumpfer & Turner, 1990/1991). While many tested theories of problem behaviors (Oetting, 1992; Oetting & Beauvais, 1987; Newcomb, 1992; 1995) find peer cluster influence as the major reason to initiate drug use or delinquent behaviors, parental disapproval has also been shown to be a major reason **not to engage in delinquent acts or to use drugs** (Coombs, Paulson, & Richardson, 1991). Family variables are a consistently strong predictor

of antisocial and delinquent behaviors (Loeber & Stouthamer-Loeber, 1986; McCord, 1991; Tolan & Loeber, 1993; Tolan, Guerra, & Kendall, 1995 a & b). According to Bry and associates (in press): "The critical role of family factors is acknowledged in virtually every psychological theory of substance abuse (Brook et al., 1990; Bry, 1983; Catalano & Hawkins, 1996; Dembo et al., 1979; Dishion et al., 1988; Elliott et al., 1989; Hawkins et al., 1992; Jessor, 1993; Kandel & Davis, 1992; Kaplan & Johnson, 1992; Kellam et al., 1983; Kumpfer, 1987; Newcomb & Bentler, 1989; Oetting & Lynch, 1993; Wills et al., 1992).

### *Family Risk Factors*

There is no gene for violence. Violence is a learned behavior, and it is often learned in the home from parents and family members or the community, friends, peers, or neighbors (American Psychological Association, 1996). The level of exposure to violence in the home and community also plays a part in persons who engage in violent acts. Children in these situations are more aggressive and grow up more likely to become involved in violence either as a victimizer or as a victim especially if they witness violent acts.

The home is the most fertile breeding ground for violent behavior. Children, who see a parent or other family members abused, or abusing another, are more likely to view violence as a way to solve problems. Children who are exposed to domestic violence are more likely to abuse others, as they grow older (American Psychological Association, 1996).

### **Family History**

Depending on the level of functioning, families can negatively impact a child's development. While there is no single cause of delinquency and violence, family variables are a consistently strong predictor of antisocial behaviors (McCord, 1991; Tolan & Loeber, 1993; Tolan, Guerra, & Kendall, 1995 a & b). Parents and peers are the strongest risk factors for delinquency according to the study of Causes and Correlates of Delinquency (Thornberry, Huizinga, & Loeber, 1995). Several empirically tested models of delinquency and substance abuse have found that parent/child relationships or processes such as support and supervision are the precursors of peer influences--the final pathway to delinquency (Duncan, Ary, Hops, & Bigland, in press; Kumpfer & Turner, 1990/1991). In other words, youth who like and respect their traditional parents are less likely to become involved with antisocial peers and delinquency. From this and other reviews (including Hawkins, Catalano, et al., 1992; Kumpfer & Alvarado, 1995; Wright & Wright, 1995) as well as other primary sources, a list of family correlates of delinquency based on functional family risk theory can be assembled:

Family history of the behavior problem, including parent's or sibling's role modeling of antisocial values and behaviors and favorable attitudes about antisocial behaviors (Hawkins & Catalano, 1992), and parental criminality, psychopathology (Offord, 1982; Robins, 1981), and antisocial personality disorder and substance abuse (Faraone, et al., 1991; Frick, et al., 1992).

Poor socialization practices, including failure to promote positive moral development, and neglect in teaching life, social, and academic skills to the child or providing opportunities to learn these competencies.

Poor supervision of the child, including failure to monitor the child's activities (Ary, Duncan, Hops, **submitted**), neglect, latch-key conditions, sibling supervision, and too few adults to care for the number of children.

Poor discipline skills, including lax, inconsistent, or excessive discipline, expectations which are unrealistic for the developmental level of the child (which creates a failure syndrome), and excessive, unrealistic demands or harsh physical punishment;

Poor parent/child relationships, including lack of parental bonding and early insecure attachment (Baumrind, 1985), repeated loss of caretakers (Loeber, 1990), negativity and rejection of the child by the parents (Cole & Kahn- Waxler, 1992; Brook, Whiteman, Gordon, Brook & Cohen, 1990), including cold and unsupportive maternal behavior (Shedler & Block, 1990), lack of involvement and time together (Kumpfer & DeMarsh, 1986) resulting in rejection of the parents by the child, and maladaptive parent/child interactions;

Excessive family conflict and marital discord (Katz & Gottman, 1993) with verbal, physical or sexual abuse;

Family disorganization, chaos and stress often because of poor family management skills, life skills or poverty (Tolan, Gorman-Smith, Zelli & Huesmann, 1993);

Poor parental mental health, including depression and irritability that cause negative views of the child's behaviors;

Family isolation, lack of supportive extended family networks (Dilworth-Anderson, 1992), family social insularity (Dumas, 1986), and lack of community support resources, and;

Differential family acculturation and role reversal or loss of parental control over adolescents by parents who are less acculturated than their children (Szapocznik & Kurtines, 1993).

Research reviews concur that the final pathway in which family factors influence delinquency is the way that the family functions, rather than external demographic variables. According to Zill (**in press**): "It is important to look at the realities of how families are actually functioning, rather than labeling some types of families as inevitably bad and others as invariably good ", for instance "many single parents do manage to provide stable, secure, stimulating and supportive homes for their youngsters (p.22)."

However, many structural factors tend to be positively correlated with family dysfunction. Some of these structural factors include:

Poverty, which is the overarching cause of many of the other structural and functional family factors. Parents who are poor do not have the money to provide the same

opportunities for their children as more prosperous families. Many of the poor are single working mothers who do not have enough money to provide adequate child care, health care, or educational opportunities (Zill, **in press**).

Neighborhood disorganization, which is related to increased crime. There are two possible reasons for this relationship. First, in disorganized neighborhoods, youth do not have close bonds with neighbors, and second, informal monitoring of youth in such neighborhoods is limited (Zill, **in press**).

High density housing, which is related to juvenile crime and family dysfunction. Families are often socially isolated in public housing projects and live under a great deal of stress (Zill, **in press**).

Reduced educational, cultural, and job opportunities, the economic robustness of neighborhood often determines the quality of the schools, access to community cultural resources, and number of jobs available for youth (Zill, **in press**).

Discrimination, which is also related to poor growth outcomes, whether caused by religious, ethnic, cultural, gender or family background factors. Youth who are not accepted by the mainstream youth in their school, church, or neighborhood are not likely to bond to these social institutions (Zill, **in press**).

### **Family Management Problems**

As mentioned earlier, family management problems increase children's risk for health and behavior problems including an increased risk for crime and violence (Yoshikawa, 1994). Poor family management is particularly important in the case of a difficult child, (Patterson, Debaryshe, & Ramsey, 1989). In the case of a difficult child, the cycles are thought to begin with hyperactivity or other conditions that produce irritability on the part of the child, to which the parent responds adversely, but ineffectively. This, in turn, rewards and reinforces the child's aggressive and adverse behavior, and a stable pattern of mutually coercive style of relating is built up from regular daily interactions during childhood. Increased aggressiveness by the child and increasing ineffectiveness of the parent lead to escalation of destructive behavior. In later childhood, according to research, the child spends more time unsupervised by parents, and parents tend to know less about the child's relationships with peers and teachers. Failure in school and contact with deviant peers are likely outcomes.

Lack of supervision and monitoring appears to be particularly salient as a cause of violent offenses. Violent crimes peak just after the close of school at about 3:00 pm (Snyder & Sickmund, 1995) suggesting lack of parental supervision and latch key status. The Carnegie Council on Adolescent Development (1994) study found that about 40 percent of adolescent's non-sleeping time is spent alone, with peers without adult supervision, or with adults who might negatively influence their behavior.

### **Family Conflicts**

Conflicts among family members may increase the risk for both domestic violence and violence against others. Again, it is emphasized that family conflict increases the risk for crime and violence. Children learn by example; hence, it comes as no surprise that children learn to be aggressive through observing aggression in their families and the surrounding society.

### **Family Poverty**

Jones and DeMaree (1975) in their research on high-risk families concluded that structural or demographic characteristics such as race, socioeconomic status, poverty, frequent family moves, low educational level, and unemployment are intricately interrelated with family functioning. These structural factors, often out of the control of family members, may contribute to family disruption, overcrowding and stress, depression and other interrelated factors.

Recent research and theory has focused on the processes by which family poverty leads to violence and delinquency in individuals who live in public housing and lower-income neighborhoods (Aber, Seidman, Allen, Mitchell, & Garfinkel, 1992; Gonzales, Cauce, Friedman, and Mason, 1996). It is argued that poverty, structural disadvantage, and economic loss diminish parental capacity for consistent and involved parenting, exacerbates conflict, undermines the quality of the family's interactions, and reduces parents capacity to exert informal social control. Beyond this level of analysis, economic factors may play a slightly different role in violence. Economists have suggested that family outcomes such as place of residence, health care, and job opportunities are affected by family income (Tauchen, Witte, & Griesinger, 1994). This increases or reduces exposure to violence. Gonzales, Cauce, and Friedman (1996) examined family, peer, and neighborhood influences on academic achievement among African American adolescents. Academic drop-out is a risk factor for later delinquent behavior as reported throughout this report. These researchers found that family status variables were not predictive of adolescent school performance as indexed by self-reported grade point average. However, neighborhood risk was related to lower grades, while peer support predicted better grades (Gonzales, Cauce, and Friedam, 1996).

One other interesting risk factor deals with the source of income as well as who within the family is earning the income. Increases in female income can have quite different effects on violence than increases in male income. Violence in the family is lower when the male is employed for a significant proportion of the time, while changes in female employment generally have an insignificant effect on violence, no matter what the level of income. Additionally, studies have found that children from families without an adult male in the home rely on the influence of peers and other socializing agents as their primary reference (instead of the family) at an earlier age (by age 8) than other children. This reality calls attention to the limits of the family's influence on delinquency and violence (Hawkins & Weis, 1985).

Unfortunately, family risk factors often tend to cluster. For example, children of poverty typically contend with multiple problems. Multiple problems are compounded by parental absence because parents must work or because fathers unable to support their family have left; irritable and depressed parents or caretakers; lack of money for social or educational opportunities; and in severe cases, lack of adequate food and clothing, and even homelessness.

## *Family Dynamics and Violence*

Although family problems are not always directly related to troublesome or violent behavior, they are important factors to consider. Over the last few years many studies have looked at the issue of family dynamics as it relates to violent behavior and the increased rates of delinquency of children raised in certain types of dysfunctional families (Snyder, Sickmund, & Poe-Yamagata, 1996). Understanding the type and extent of interaction between a child and his or her extended family members is important to understanding the relationship between the child's family structure and his or her delinquent behavior. Attributes directly relating family dynamics and delinquent behavior include (Snyder, Sickmund, & Poe-Yamagata, 1996):

Ineffective Parenting Style

Inefficient Parental Authority

Contradictory Parenting Styles

While much is known about parenting styles generally and their outcomes, further research needs to be conducted to understand parental practices and differences among the various types of households. Three aspects of household structure should be considered in developing family-based programs to prevent delinquency according to Snyder, Sickmund, & Poe-Yamagata (1996):

### **Household Environment**

With whom does the child live?

How well do the family and household members get along?

How often do individuals in the household change?

### **Care Providers**

Who takes care of the child by providing nurturance, supervision, and intellectual stimulation?

Does the care provider live in the household?

Is the primary care provider a relative or someone outside the extended family?

### **Other Key Figures**

Who else beyond household members and child care providers is important to the child?

Does the child have access to other members of the extended family such as grandparents, cousins, aunts, or uncles?

Does a nonresident father influence the child --perhaps serving as a role model?

## Cycle of Violence

The idea that violence begets violence has emerged from studies on abuse and family assaults over the past 25 years. Called the "cycle of violence," this hard to test theory suggests that abused children become abusers themselves and that child victims of violence become violent adults (Tolan & Guerra, 1994).

### "Cycle of Violence" suggests:

physically-abused boys are more likely to grow into physically abusive and violent men than their non-abused counterparts;

physically abused girls are more likely to become victims of abuse as adults.

Despite its theoretical appeal, the transmission of violence across generations is difficult to prove (Sells & Blum, 1996). While childhood abuse or violence can definitely point a child towards criminal or violent activity, these events do not cause an individual to maintain that lifestyle. Using psychiatric, neurological, physiological, and cognitive tests, Synder and Sickmund (1995) identified the "intrinsic vulnerabilities" that predisposed juvenile males to engage in antisocial behavior. Those with a combination of an abusive family and two or more vulnerabilities were more likely to commit crimes as adults. The intrinsic vulnerabilities are:

paranoia	below-normal reading level
hallucinations	impaired memory
seizures and limbic dysfunction	anti-social personality

Family violence and intrinsic vulnerabilities interact to produce violent behavior within the family that is perceived as **a-normal** (abnormal??) models of behavior. Healthy, resilient children resist these models and adopt more socially appropriate behaviors they see in the community or at school, but those with neurological or psychiatric impairments may be more likely to follow the patterns of their early home life (Synder & Sickmund, 1995). Children with neurological or psychiatric impairments may have more difficulty controlling the rage that abuse often kindles. Hyperactive or impulsive children may encourage abuse from parents who have difficulty controlling their own impulses and anger (Synder & Sickmund, 1995). According to these researchers, the relationship between childhood abuse and later adult crimes may be less clear in females than in males.

## Exposure to Violence in the Home

As discussed earlier, research by Thornbery & associates (1994) suggests that children who witness violence frequently are more likely to adopt violent behaviors. Each year more than 10 million American children witness a physical assault between their parents. In 2/3 of these cases, there is repeated violence between the parents. The childhood prevalence of

witnessing violence is at least triple these annual rates (Bureau of Justice Statistics, 1992). The vast majority of children whose mothers are abused actually witness the violence and its aftermath in their family, in contrast to many parents' estimates that they have protected their children from this experience (Durant, Pendercrast, & Cadenhead, 1994). Children who witness their mother's victimization suffer from both short-term and long-term adjustment problems (Cellini, 1995). Children whose parents are aggressive are more likely to be aggressive and violent themselves in adolescence and young adulthood (Durrant et al., 1994). According to the Bureau of Justice Statistics: Executive Summary (1996) subtle symptoms of children who witness violence include the following:

- learn that violence is an acceptable way to resolve interpersonal conflict;
- learn various rationalizations for the use of violence in order to maintain power and control in relationships;
- feel some degree of responsibility for the violence;
- may have conflicts and skill deficits regarding how to handle emergencies.

### **Child Abuse & Domestic Violence**

According to a report by the National Center for Education Statistics (1994) children are often the unintended victims of battering. The risk of child abuse is significantly higher when partner assault is also reported. Nearly half of men who abuse their female partners also abuse their children. Children in violent homes face dual threats -- the threat of witnessing traumatic events, and the threat of physical assault. Additionally, this report found that children who are abused might be:

- injured during an incident of parental violence;
- traumatized by the fear from their parent or guardian or helplessness in protecting their parent or guardian;
- blame themselves for not preventing the violence or for causing it; or
- be abused or neglected themselves.

In another study, Cellini (1995), one-third of the families reporting a violent incident between the parents also reported the presence of child abuse. Also found in this study was that women being battered are less able to care for their children. Eight times as many women report using physical discipline on their children while living with their batterer than those who live alone or with a non-battering partner (Curry, Ball, & Fox, 1992).

Despite limitations of research, a few consistent results indicate that women who experience physical violence during pregnancy are more likely to be young (under 25), single, of lower socioeconomic status, and unhappy about being pregnant than women who do not experience physical violence during pregnancy (Gaxmararian, Adams, Saltzman, Johnson,

Bruce, Marks, Zahniser, & the PRAMS Working Group., 1995). Women who experience physical violence during pregnancy also tend to receive inadequate prenatal care and experience housing problems. National survey data supports these results and suggest that younger pregnant women have higher rates of battering than older pregnant women (Saltzman, 1990). The long-term ramifications of witnessing domestic and child abuse and the importance of detecting and stopping abuse in the home as early as possible cannot be over-emphasized.

### **Victimization from Neglect, Physical Abuse, and Sexual Abuse**

The National Committee for the Prevention of Child Abuse estimates that more than 2.5 million children were abused or neglected in the United States in 1991 (Fox, 1996). Neglect was defined as an excessive failure by caregivers to provide food, clothing, shelter, and medical attention. Major findings of Fox (1996) reported that neglected and abused children tend to become more violent juveniles and adults and increases the likelihood of arrest as a juvenile by 53%. Neglected children's rates of arrest for violence were almost, but not as high as physically abused children's (Fox, 1996). Reported explanations by the National Center on Child Abuse and Neglect (NCCAN) for the increased number of abused children might be related to mothers who are abusing substances or economic stress in families who feel uncertain about their employment (Bureau of Justice Statistics, 1992).

#### *Family Protective and Resilience Factors*

The probability of a youth developing developmental problems increases rapidly as the number of risk factors increase in comparison to the number of protective factors (Dunst & Trivette, 1994; Rutter, 1990; 1993). The objective of family-focused prevention programs should be to not only decrease risk factors, but to also increase ongoing family protective mechanisms. According to Bry and associates (**in press**), the five major types of protective family factors include: 1) supportive parent-child relationships (Brook, 1993; Dishion, et al., 1988; Werner & Smith, 1992), 2) positive discipline methods (Catalano, et al., 1993; Dishion et al., 1988; Kellam, et al., 1983); 3) monitoring and supervision (Ary, Duncan, Duncan, & **Hops, submitted**; Chilcoat et al., 1995; Loeber & Stouthamer-Loeber, 1986); 4) family advocacy for their children (Brunswick, et al., 1992; Kandel & Davis, 1992; Krohn & Thornberry, 1993); and 5) seeking information and support for the benefit of their children (Nye, Zucker, & Fitzgerald, 1995). The longitudinal study of urban delinquency (Huizinga, Loeber, & Thornberry, 1995) supported that parental supervision, attachment to parents, and consistency of discipline were the most important family protective factors in promoting resilience to delinquency in high-risk youth.

Resilience researchers (Kumpfer & Bluth, in press; Luthar, 1993; Werner, 1986) and those researchers focusing on family strengths (Gary, 1996; Dunst & Trivett, 1994) have also specified similar family protective mechanisms that help children from very high risk families to successfully avoid delinquency and drug use and develop positive life adaptation. The characteristics of strong resilient African-American families have been found to be:

- 1) a strong economic base,

- 2) achievement orientation,
- 3) role adaptability,
- 4) spirituality,
- 5) extended family bonds,
- 6) racial pride,
- 7) respect and love,
- 8) resourcefulness,
- 9) community involvement, and
- 10) family unity (Gary, Beatty, Berry, & Price, 1983).

The challenge to family intervention researchers is to develop and test interventions that effectively address such a broad range of family protective factors. Research data from the OJJDP Program of Research on Causes and Correlates of Juvenile Delinquency from three longitudinal studies in Denver, Colorado; Rochester, New York; and Pittsburgh, Pennsylvania suggest that delinquency risk factors are not simply additive, but interact to produce higher levels of risk burden (Thornberry, 1994). Additionally, they are moderated by protective factors in the family or youth environment and internal resiliency factors or processes (Kumpfer, 1995; Kumpfer, Bluth, in press). If youth had only one of the 12 protective factors identified, the reductions in delinquency were negligible; however, if there were multiple protective factors (nine or more), the risk of delinquency was reduced to below 25 percent.

## **Part II: Review of Family Strengthening Program**

Today there are many different types of parenting and family strengthening programs designed to address the family problems previously discussed. Psychotherapy has stressed the importance of family interventions. Coleman and Stanton (1978, p. 479) wrote: "It is an understatement to say that family approaches to psychotherapy have increased in popularity and breadth during recent years." Family systems theory and family therapy techniques are widely taught in training programs for therapists.

The increased success of treatment when the family is involved is widely acknowledged by therapists and documented in the research literature (Gurman & Kniskern, 1978; Stanton & Todd, 1982). Most therapists are acutely aware of the damage that a family can do to client's therapeutic progress if the family is not supportive of the treatment goals or are unaware of their

impact on the client. Obvious and subtle forms of sabotage occur as family members attempt to redevelop the former family balance and dynamic.

A number of prevention researchers (Loeber & Stouthamer-Loeber, 1986; Fraser, Hawkins and Howard, 1986; McMahon, 1987) strongly support family-focused prevention interventions as the most effective intervention strategy for delinquency and substance abuse (Kaufman & Kaufman, 1979; Kaufman, 1986; Stanton & Todd, 1982).

## Definition of Family

The family is the basic institutional unit of society primarily responsible for child-rearing functions. When families fail to fulfill this responsibility to children everyone suffers. Families are responsible for providing physical necessities, emotional support, learning opportunities, moral guidance and building self-esteem and resilience.

This review considers the "family" to be the constellation of adults or siblings who care for a child. Non-traditional family arrangements include single parent families, divorced families with joint custody of the child, children living with extended family members, adoptive parents, protective custody (such as temporary or permanent foster homes, group homes or institutions), and step-parents, (sometimes in blended families with children from two or more prior marriages).

A structurally non-traditional family does not necessarily indicate a high-risk family. The relationships within the family and the amount of support and guidance provided the child are the most important variables in the prediction of delinquency. In general, if the remaining family is stable, supportive and well managed, children who have lost a parent to divorce or death do not appear to be at greater risk of delinquency (Mednick, Baker, & Carothers, 1990). However, as the recent final report to the National Commission on Children points out:

When parents divorce or fail to marry, children are often the victims. Children who live with only one parent, usually their mothers, are six times as likely to be poor as children who live with both parents (U.S. Department of Commerce, 1990). Some researchers have found they are also more likely to suffer more emotional, behavioral, and intellectual problems resulting in a higher risk of dropping out of school, alcohol and drug use, adolescent pregnancy and premature childbearing, juvenile delinquency, mental illness, and suicide (Emery, 1988; McLanahan, 1980; Zill & Schoenborn, 1988).

These findings are opposed by other researchers (Rosen & Neilson, 1982; Farnsworth, 1984; Gray-Ray & Ray, 1990; Parson & Mikawa, 1991; White, 1987) who have found no association between single-parent families and delinquency. Some studies suggest that sons appear to develop more problems than daughters when the loss of a father is early in their development; however, adolescent girls are particularly vulnerable to emotional distress when they lose their fathers (Baltes, Featherman, & Learner, 1990; Hetherington, Anderson, & Stanley-Hagan, 1989; Hetherington & Parke, 1986; Zaslow & Hayes, 1986). The work of other researchers has not supported these differential age and gender effects (Wells & Rankin, 1991).

Living in an abusive or conflict-ridden, two-parent home is considered by experts generally more harmful for children than divorce. Loeber and Stouthamer-Loeber (1986) concluded after reviewing about 40 studies examining family structure and delinquency that marital discord was a stronger predictor of delinquency than family structure. According to Wright and Wright (1992) four factors may explain the relationship between single-parent families and delinquency: 1) economic-deprivation, 2) reduced supervision, formal controls, social supports; 3) living in poverty neighborhoods characterized by high crime rates and alienation (McLanahan & Booth, 1989), and 4) an increased criminal justice system response to children from single-parent families. Because of the importance of fathers, reducing these factors by socializing and protecting children, providing additional monetary support and community leadership, marriage counselors are emphasizing solving family problems within marriage (Peterson & Zill, 1986; Taylor, 1991).

An increasing number of children live in complex, shifting, highly stressed family arrangements. These include homeless children and children living in foster care. In these cases, it is more difficult to describe the total family environment and the impact on the child. Few studies have been conducted on the impact of such family environments.

### *Family Strengthening*

From as early as the turn of the century experts in juvenile delinquency (Morrison, 1915) have recognized the family's early and primary role in influencing delinquency. A number of literature reviews or meta-analyses of research studies (Geismar & Wood, 1986; Henggeler, 1989; Loeber & Dishion, 1983; Loeber & Stouthamer-Loeber, 1986; Snyder & Patterson, 1987) all support the conclusion that family functioning variables have an early and sustained impact on family bonding, conduct disorders, school bonding and adaptation, choice of peers, and later delinquency in youth. Although research suggests that peer influence is the final pathway for most youth to delinquency and drug use, the major predictor of whether youth associate with delinquent or drug using peers is their family relationship (Kumpfer & Turner, 1990/1991; Oetting, 1992; Oetting & Beauvais, 1987; Newcomb, 1992). In fact parental support has been found to be one of the most powerful predictors of reduced substance use in minority youth (King, Beals, Manson, & Trimble, 1992). Also, Dishion (Dishion, French, & Patterson (1995) and Hansen and associates (1987) have found that increased parental supervision is a major mediator of peer influence. Models testing more finely the aspects of the family dynamics related to youth problem behaviors (antisocial behavior, substance abuse, high risk sex, and academic failure) find family conflict associated with reduced family involvement at the first time they surveyed which is significantly predictive of inadequate parental supervision and peer deviance at the second time they surveyed. Ary, Duncan, Duncan, & Hops (**submitted**) found direct paths from parental supervisions and peer deviance to problem behaviors, suggesting not all family risk processes are mediated by deviant peer involvement.

This etiological research suggests parenting and family interventions improving family conflict, family involvement, and parental monitoring should reduce problem behaviors including substance abuse (Mayer, 1995). Parenting skills training programs are effective in reducing coercive family dynamics (Webster-Stratton, Kolpacoff & Hollingsworth, 1988) and improving parental monitoring (Dishion & Andrews, 1995). Other researchers like Bry, Schutte,

and Fishman (1991) believe improving parenting practices is the most effective strategy for reducing later adolescent behavior problems. Strengthening families could significantly reduce delinquency, youth violence, and drug abuse.

Recent research suggest that the most critical family factors that help youth to avoid associations with delinquent peers is parental supervision and monitoring that is closely linked with parental care and support (Ary, Duncan, Duncan, & Hops, **submitted**). Family dysfunction and poor parental supervision and socialization are major influences on children's subsequent delinquency. In fact, community environmental factors, such as poor schools and neighborhoods as correlates of poverty, have not been supported as powerful predictors of delinquency as family risk and protective factors discussed below.

Increasing research suggests that conduct disorders and other behavioral and temperament traits that increase a youth's vulnerability to delinquency develop as a fairly stable pattern as early as five years of age. Characteristics of these young children that appear to developmentally vector them in the direction of a comorbid developmental psychopathology of delinquency, drug abuse, and other developmental problems (Alexander, 1996) include:

impulsivity, reduced ego control, and attention deficit disorder (Farrington, et al., 1990; Hinshaw, et al., 1993; Cicchetti, Rogosch, Lynch, & Holt, 1993);

difficult temperament (Patterson, 1986; Rothbart, Adadi, & Hershey, in press);

below average verbal IQ (DeBaryshe, et al., 1993; Tremblay, Masse, Perron, & Leblanc, 1992) and academic underachievement (Hinshaw et al., 1993);

negative affect (Compas, 1987) and difficulties with emotional regulation (Cole & Zahn-Waxler, 1992);

social incompetence (Blechman, Prinz, & Dumas, 1995);

aggression and coercion as means to rewards (Patterson, Reid, & Dishion, 1992; Quay, 1993).

The overlap of these delinquency risk factors with those for drug abuse and alcoholism are striking (see Kumpfer, 1987; Kumpfer, 1989). In fact, family epidemiological research suggests that many psychiatric disorders run in the same families. At first, the "Unholy Triad" of anti-social personality, substance abuse, and Briquet's Syndrome with psychosomatic tendencies were found to be co-morbid family diseases (Robins & Ratcliff, 1979). Since early onset is often a sign of higher genetic loading for an emotional or behavioral disorder, Kumpfer (1991) suggested that early onset delinquency as manifest in chronic career delinquents can be considered a "family disease". Aggressive subtypes of conduct disorders are suggested to have underlying biological predispositions (Quay, 1993).

The stability of these "pre-delinquent" characteristics should not seem as such mystery when one considers that genetics, family environment, and the characteristics of their caretakers remain fairly stable. Children are socialized and learn their patterns of behavior, their values,

and emotional responses within the context of the family. If they live in a non-traditional, counter culture environment, they will develop non-traditional norms (Richters & Cicchetti, 1993 a & b).

Although prevalent mythology assures parents that they are not responsible for their adolescents actions because, peers are the primary influences, research suggests that family influences remain roughly comparable to peer influences for quite some time (Loeber, 1990). In fact, in the areas of substance abuse, which typically develop several years later than delinquency, research by Coombs, Paulson, and Richardson (1991) suggest the primary reason for youth to use drugs is peer influence; however, the primary reason not to use drugs is parental disapproval. Hence, it is possible that research with prosocial youth would show that parental influence is still the primary influence during adolescence. This does not mean that these prosocial youth don't make their own decisions, simply that if they had to choose between parental or peer wishes, they would more likely follow the recommendations of their parents.

Programs that use volunteers or professionals working directly with a child are considered "surrogate" parenting programs. Examples of these programs include Big Brothers or Big Sisters, Partners, Foster Grandparent programs (if they work with the child and not the parent), intensive foster parent programs or professional group home programs. They technically do not meet the criteria for a parent or family strengthening program, but they are covered in this review, within a loose definition of "family" as child rearers.

A national search for the best methods for strengthening families yielded 25 different intervention strategies (as well as many variations or combinations). These do not exhaust all the possibilities. One of the reasons for such a wide diversity of family strengthening programs is that the needs of the families vary and programs must be tailored to meet those needs. As shown in Table 1, major factors to consider in the selection of the most appropriate family program are the age of the child at risk and the level of identified dysfunction of the family.

The most popular and promising intervention strategies address problem types by age of child and severity of family or child problems listed in Table 1. One major dichotomy of the intervention strategies are those that involve the parents with at least the target child, often called *family approaches*, and those that involve the parents or caretakers only, called *parenting approaches*. Basic applications and variants of each of these two major approaches will be discussed below, including several exemplary programs.

Table 1. Matrix of Program Types by Age of Child and Severity of Family or Child Problems (continues on next page)

AGE	GENERAL POPULATION FAMILY PROGRAMS	HIGH-RISK FAMILY PROGRAMS	IN-CRISIS FAMILY PROGRAMS
PRE-PARENT	High school parent education Parent/teen sex education Teen pregnancy prevention	Pre-parenting High school pre-parenting Pregnancy prevention/sex education	Pre-parenting education for foster care youth Pre-parenting for delinquents in custody

AGE	GENERAL POPULATION FAMILY PROGRAMS	HIGH-RISK FAMILY PROGRAMS	IN-CRISIS FAMILY PROGRAMS
PRENATAL	Infant parenting and health care Parent education	Prenatal substance abuse prevention program Infant mortality case management	Teen pregnancy case managing Pregnant teen school Pregnant teen residency
INFANCY & TODDLER	Parent education (TV, video) Parent Support	In-home parent education (PHS, nurse, social worker) Parent side Case work Family services Parent support	Protective services Nurturing program for child abuse/neglect Foster parents Teen parent support services Young parents school
CHILDHOOD	Parent education School-based home; school achievement programs Media-based prevention	Preschool parent training School and treatment agency Parent training Parent aid Family skills training Parent Involvement	Family services Family skills training Foster parent training Protective services Family preservation Family unification Family treatment Residential shelter Day treatment Parent aid Parent training
PRETEEN & ADOLESCENT	Parent education Family education Family meetings and activities Sex education	Family communication and relationship enhancement Parent support groups Family volunteers Parent involvement in youth group Surrogate parent training Parent/school/treatment-truancy Juvenile diversion/gang prevention Parent education Parent skills training Drop-out education prevention	Family therapy Family services Parent or family support Protective services Family preservation Intense probation Teaching family model Day treatment/alternative school Foster parent program Residential treatment

Family-focused interventions appear to be more effective than either child-focused or parent-focused approaches. Child-only approaches, not combined with parenting or family approaches, can have negative effect on family functioning (Szapocznik & Kurtines, 1989, Szapocznik, 1997). If high-risk youth are aggregated, deteriorated youth behaviors can occur (Dishion & Andrews, 1995). Reviews of early childhood programs (Dadds et al., 1992;

Mitchell, Weiss, & Schultz, 1995; Yoshikawa, 1994), elementary school-aged children's programs (Kazdin, 1993; Kumpfer & Alvarado, 1995; Patterson, Dishion, & Chamberlin, 1993), and adolescent programs (CSAP/PEPS, **in press**; Szapocznik, 1997) support the effectiveness of family-based interventions. In fact, a number of adolescent family programs have found significant reductions in substance use (Henggler, Pickrel, & Brondino, *in press*; Lewis, Piercy, Sprendle, & Trepper, 1990; Szapocznik, 1997). In recent years there has been a shift from focusing therapeutic activities primarily on the child, to improving parents' parenting skills and, to recognizing the importance of changing the total family system (Szapocznik, 1997; Parsons & Alexander, 1997).

Newly developed family-focused skills training programs are more comprehensive and include structured parent skills training, children's social skills, and parent/child activities sometimes called behavioral family therapy, behavioral parent training, or family skills training. The new family skills training approaches often also offer a number of additional family support services (i.e., food, transportation, child care during sessions, advocacy, and crisis support). A few examples of these structured family-focused interventions include the author's Strengthening Families Program (Kumpfer, DeMarsh, & Child, 1989) effective with substance-abusing parents and ethnic parents (Kumpfer, Molgaard, & Spoth, 1996); Focus on Families (Haggerty, Mills, & Catalano; 1991) for methadone maintenance parents (Catalano, Haggerty, Gainey, & Hoppe, submitted; Gainey, Catalano, Haggerty, & Hoppe, submitted); the Nurturing Program (Bavolek, Comstock, & McLaughlin, 1983) for physically and sexually abusive parents; Families and Schools Together (FAST) (McDonald, Billingham, Dibble, Rice, & Coe-Braddish (1991) for high-risk students in schools; and the Family Effectiveness Training (FET) (Szapocznik, Santisteban, Rio, Perez-Vidal, & Kurtines, 1985). See Kumpfer (1993, 1997), Kumpfer & Alvarado (1995), and CSAP/PEPS (**in press**) for reviews these family programs.

Other researchers are employing these broad-based family skills programs as part of even more comprehensive school-based, intervention strategies. The FAST TRACK program (Bierman, Greenberg, & the Conduct Problems Prevention Research Group (CPPRG), 1996; McMahon, Slough, & the CPPRG, 1996), one of the largest prevention intervention research projects ever funded by the National Institute for Mental Health, is one exemplary example. This selective prevention program implemented with high-risk kindergartners nominated for the program because of risk factors including conduct disorders, is being implemented in several different sites in the nation with a large team of nationally recognized prevention specialists, including Drs. Lochmann, Coie, Biersman, McMahon, Greenberg, Dodge and Slough. FAST TRACK includes McMahon's behavioral parent training, which is also incorporated in SFP. Parents were found to be quite satisfied with this type of parent training that involves therapist coaching and interactive practice between the parent and the child (McMahon, Tiedemann, Forehand, & Grist, 1993).

One distinguishing feature of these new parent and child skills training programs, which the author calls family skills training programs, is that they provide structured activities in which the curriculum addresses improvements in parent-child bonding or attachment (Bowlby, 1969; 1982) by coaching the parent to improve play time with the child during Child's Game. This "special therapeutic play" has been found effective in improving parent-child attachment (Egeland & Erickson, 1987; 1990). Using intervention strategies developed by Kogan (1980) and Forehand & McMahon (1981), the parents learn through observation, direct practice with immediate feedback by

the trainers and video tape, and trainer and child reinforcement how to improve positive play (Barkeley, 1986), by following the child's lead and not correcting, bossing, criticizing, or directing. Teaching parents therapeutic play has been found to improve parent-child attachment and improve child behaviors in emotionally disturbed and behaviorally-disordered children (Egeland & Erickson, 1990; Kumpfer, Molgaard, & Spoth, 1996). These family programs encourage family members to increase family unity and communication and reduce family conflict as found in prior SFP studies.

## Family Prevention Approaches

Several major family interventions have been used to help prevent delinquency, substance abuse, and other teen problems. These include family skills training programs, family education programs, family therapy, family services, and in-home family crisis services or family preservation programs. Each intervention type is discussed below.

### *Family Skills Training Program*

The multi-component family skills training approach appears to impact the largest number of measured family and youth risk/protective factors according to a separate outcome analysis conducted by Dr. Kumpfer for PEPS and presented at the National Institute for Drug Abuse family conference (Kumpfer, 1996). Because multi-component family skills training programs generally incorporate behavioral parent training, children's skills training, and behavioral family therapy, they address more risk and protective factors.

Research by Aktan, Kumpfer, and Turner (1996) evaluated the Safe Haven Program for the prevention of substance abuse through a nonequivalent comparison, repeated measures, quasi-experimental design. The Safe Haven Program is a family skills training program for African American families which have one parent who is a substance abuser. The program was found to be effective in increasing parenting efficacy and behaviors toward children, improving children's risk and protective factors and behaviors, and supporting treatment reductions in the parent and family illegal substance use (Aktan, Kumpfer, and Turner, 1996).

McMahon (1987) has reviewed a number of behavioral family therapy programs. These programs are often called behavioral family therapy (if trained therapist work with the individual families) or behavioral family training (if multifamily groups are used), and include separate structured skills-training groups for the parents and the children in the first hour using a guided participant modeling by trainers (Rosenthal & Bandura, 1978). In the last hour, the family is brought together to practice learned skills and participate in fun family activities. The Nurturing Program (Bavolek, Comstock, & McLaughlin, 1983), Families and Schools Together, the Strengthening Families **in press**, and Family Effectiveness Training (Szapocznik, Santisteban, Rio, Perez-Vidal, & Kurtines Program (**SFP**) (Kumpfer, DeMarsh, & Child, 1989), Focus on Families (Catalano et. al., 1989) have all been used for substance and delinquency prevention. Family skills training programs have been evaluated rigorously by researchers and found to be effective in reducing a number of family, parent, and child risk factors for delinquency.

Several of these programs have undergone rigorous research evaluation designs. The Strengthening Families Program (SFP) was developed after a research project funded by the National Institute on Drug Abuse (NIDA) demonstrated that combining parent and youth skills training with family skills training was more effective in decreasing risk factors than either parent training or child training only (DeMarsh & Kumpfer, 1986). The program is an intensive 14-week parenting and youth skills-training program specifically for drug abuse prevention with 6-to 12-year old children of drug- or alcohol-abusing parents. Strengthening Family Parent Program has been modified to be culturally relevant, and has been found effective in decreasing child and family behavioral and emotional precursors of drug use for rural and urban African American families (the Safehaven Program; Kumpfer, Bridges, & Williams, 1993), Hispanic families, and Asian and Pacific Islander families. Strengthening Families Program II (Molgaard & Kumpfer, 1994) is a 7-week adaptation of SFP for sixth-grade rural youth and low-income parents. This school-based family program, complete with videotapes, is currently being evaluated by Iowa State University (Spath & Redmond, **in press**) in a massive large-scale dissemination trial in Iowa funded by the National Institute of Mental Health. In addition, these researchers are evaluating the efficacy of the Hawkins and Catalano's, Preparing for the Drug-Free Years Program. This five-session parent program (one session includes the youth) includes videotapes and works well for statewide dissemination through schools and community agencies. Focus groups have been conducted to tailor the program for high-risk and ethnic families. Catalano and associates (**in press**) are currently testing the effectiveness of a 33-session, parent and child skills-training program, called Focus on Families, for methadone maintenance patients that also includes in-home case management and starts with a 5 hour family retreat. The children attend 2 parent sessions to practice developmentally appropriate skills with their parents.

More details concerning program design and evaluation of these and other exemplary programs are located in Part IV of this document.

#### *Family Education Programs*

These programs provide the family with lectures or educational sessions on family values, responsibility to society and others, law-related education, family communications, alcohol and drug use, relationship enhancement techniques, and other family strengthening strategies. This approach has been used as either a single session or a series of lectures or experiential sessions conducted in schools, churches, community centers, juvenile courts, youth rehabilitation centers, adolescent group homes, alcohol and drug treatment centers and public agencies. Workbooks are also available for families to conduct independent family discussions at home.

#### *Family Therapy*

This group of programs includes a number of different clinical approaches to the family such as:

Structural Family Therapy (Minuchin, 1974; Szapocznik et al., 1983),

Strategic Family Therapy (Haley, 1963),

Structural-Strategic Family Therapy (Stanton and Todd, 1982), and

Functional Family Therapy (Alexander and Parsons, 1973, 1982),

Multisystemic Family Therapy (Henggeler & Borduin, 1990).

Structural family approach targets the interactions between family members as a basis for changing maladaptive patterns (Powell & Dosser, 1992). Structural family therapy facilitates families coping skills and autonomy. The therapeutic goal is to empower families by increasing the present quantity, quality, complexity, and accessibility of coping strategies and helping them to discover their own new patterns of response in the future (Powell & Dosser, 1992).

Strategic family therapy suggests that therapist will be Apragmatic, problem focused, and goal directed in their interventions (Szapocznik & Kurtines, 1989). So that therapist can work quickly they need to be pragmatic, using strategies that may seem unconventional; narrowing the problem focus so that interventions may be specific and well thought-out (Szapocznik & Kurtines, 1989). Structural-strategic family therapies combine the elements of structure (patterns of interaction) and strategic (goal-directed and problem-specific) to their interventions. An example of this approach is the Brief Strategic Family Therapy (BSFT) (Szapocznik & Kurtines, 1989). The Brief Strategic Family Therapy is one of the exemplary programs and is written in further detail in Part IV.

The cornerstone of the functional family therapy approach is the assumption that people create an interpersonal world they respond to. Response feedback from the family to this interpersonal world characterizes a member=s function. This perceived function is presumed to be an important motivator of behavior (Alexander, Waldron, Newberry, and Liddle, 1988). The approach incorporates four steps: 1) identify behavioral patterns that distinguish deviant from nondeviance, 2) matching-to-sample philosophy identifies those variables that maintain deviant behavior, 3) selection of a subset of potentially modifiable variables, and 4) development of an intervention program to modify the subset of variables (Alexander, Waldron, Newberry, and Liddle, 1988). In 1973, Alexander and Parsons evaluated the functional family approach primarily for the prevention of delinquency in young status offenders. They found reductions in recidivism and improvements in problem behaviors as well as a preventive impact on delinquency in younger siblings (Klein et al., 1977). The Functional Family Therapy program by Alexander and Parsons (1973) is one the exemplary programs listed in Part IV.

The multi-systemic approach to prevention of behavior problems in children and adolescents uses interventions that are present-focused and action-oriented. Multi-Systemic Therapy (MST) works through intra-personal (e.g., cognitive) and systemic (i.e., family, peer, school) factors that are known to be associated with adolescent antisocial behavior (Bourduin, et. al., 1995; Henggeler & Borduin, 1990). Individualized and flexible interventions are necessary for MST because different combinations of these factors are relevant for different adolescents and their families (Bourduin, et. al., 1995). These family intervention approaches depend on the discretion of the individual therapist to determine the appropriate application and

timing of specific techniques and exercises. The MST of Borduin & Henggeler (1995) is also one of the exemplary programs listed in Part IV.

### *Family Services*

This is the traditional family service model in which a large number of needed services are brokered by a caseworker or a case manager. High-risk families often need more than family therapy or skills training. Rather, they often have immediate basic needs, such as food, clothing, medical care, and housing. Emphasis on family services is to target the family early, prenatal and early infancy interventions. Decreasing tobacco, alcohol, and drug use in pregnant women may have added benefits of preventing later substance abuse in both the mother and the child (Resnick et. al., 1997). Only after these emergency needs are met can the family begin to consider parenting and family enhancement program involvement. Several programs being tested to prevent problems in 0 to 5 years olds include: the nurse home visitation trails (Olds & Pettitt, 1996), family services and family support (Yoshikawa, 1994), family paraprofessional case management programs (Kumpfer, Sasagawa, & Cheng, 1995), infant stimulation, toy making and language development support in home by trained staff and programs to reduce conduct problems in 3 to 5 year olds (Maguin, et.al., 1994; Nye, et. al., 1995). Yoshikawa (1994) has provided some preliminary assessment results that look promising on these multi-component programs. These programs are relatively new, therefore research is still forthcoming to determine the level of effectiveness for multi-component programs.

### *Family Preservation Programs*

This approach includes a number of in-home crisis services that are often used for the preservation of the family when out-placement of a child is imminent. Homebuilders, the prototype program, was developed in Washington by Haapala and Kinney (1979). This model has been so successful in reducing placement of youths in state custody and institutions or group homes that it is currently being replicated in many states. In this model, a team of highly trained family services workers arrive at the family's home and provide whatever in-home services are needed. The intervention is very much like that delivered by the traditional social worker, but the services are more intensive and short term.

Recently, support has been generated to abandon family preservation as a child welfare practice, the prevention of child placement outside the family, but rather a focus on the delivery of family services (Wells & Tracy, 1996). Danzy and Jackson (1997) researched family preservation and support services in connection to kinship care. Kinship care looks to family relatives to assist in providing services such as child care or tutoring. They found that kinship care has a historical significance in preserving the African American family and should be included development plans for family preservation programs (Danzy & Jackson, 1997).

### *Surrogate Family Approaches*

If the biological parents are not involved with the child or able to participate in parent or family programs, working with extended family members or other parent surrogates is possible. Parenting and family programs have been developed for adoptive parents, blended families,

group home parents, foster grandparents, Big Brothers or Big Sisters, volunteer sponsors, and for foster parents (Guernsey, 1974). This approach may often occur in community group home setting for victims of domestic violence or homelessness (Whitman, 1995). There is usually no cost to the client and entry into the shelter is provided on first come first served basis (Whitman, 1995). The home may offer therapeutic services and interventions for the children. Thus, the home or shelter becomes an extended family (Whitman, 1995).

At the Oregon Social Learning Center's (OSLC) Specialized Foster Care model, institutionalized or to-be-institutionalized delinquents are assigned specially selected and trained foster care parents. The foster parents have daily contact with the OSLC staff and the youth's teacher. Chamberlain and Reid (1987) reported success in preventing recidivism among youth who completed the program.

The Teaching Family Model (TFM) was developed for married couples who run community-based residential programs for treating conduct disordered adolescents. The prototype of this type of surrogate family model is Achievement Place, which first opened in Kansas in 1967. There are now over 215 residential group homes employing this treatment model (Wolf, Braukmann, and Ramp, 1987). The "teaching parents" are rigorously trained in a one-year training program that culminates in certification by the National Teaching-Family Association.

The Teaching Family Model has been evaluated by the originators (Kirigin, Braukmann, Atwater and Wolf, 1982) and by an independent evaluation (Weinrott, Jones and Howard, 1982). Both evaluations found significant reductions in official records of delinquent behaviors in youths in the TFM program compared to youths in other group homes. These reductions lasted for the time they were in the residential homes, but did not continue in the following year. A longer term follow-up may reflect later " sleeper effects ". Chamberlain and Reid (1987) report that a similar approach to the foster parent TFM program developed by Patterson and colleagues has demonstrated reductions in conduct disorders over time.

## Parenting Approaches

The major parenting approaches defined and described below include: behavioral parent training, parent education, parent support groups, in-home parent education or parent aid, parent involvement in youth groups, and Adlerian parent groups.

### *Behavioral Parent Training Programs*

This group of programs teaches parents of a difficult child how to discipline the child more effectively and control overt conduct disorders. The programs are highly structured and trainers use programmed instructional aids and manuals with special topics and exercises with homework assignments each week. Typically a course includes 8 to 14 weekly sessions lasting about 1 to 2 hours. Skills typically taught include behavioral shaping principles of positive reinforcement, attending to wanted behaviors and ignoring unwanted behaviors. Parents are taught first how to "catch your child being good" and reward the child for good behavior. These

techniques improve the child's problem behavior and develop a more positive relationship between parents and children. Once parents have mastered paying attention to the good things their children do, they are taught to decrease inappropriate or unwanted behaviors by not attending to these behaviors or using mild punishments, such as time outs, natural consequences, and loss of privileges.

The basic parent education and training programs have been well documented to be effective in reducing problem behaviors in children. There is less evidence concerning the applicability of these programs to reduce delinquency, since the programs work primarily with younger children. The programs have, however, demonstrated effectiveness for reducing overt conduct disorder problems in children. Approximately 50% of all children diagnosed with conduct disorders develop delinquency in adolescence and the others often show other social and developmental problems (Kazdin, 1987).

There are many types of behavioral parent training programs, but most are variants of the parenting model developed by Patterson and his associates at the Oregon Social Learning Center. Patterson's book: *Families: Applications of Social Learning to Family Life* (1975) explains this type of parent training. Family members read his other book, *Living with Children* (1976) prior to starting the group. Another widely used parenting resource book is Becker's book called *Parents are Teachers: A Child Management Program* (1971).

### *Parent Education Programs*

Parent education programs are distinguished in this paper from parent training programs in that education programs generally involve fewer sessions and do not have the parents practice skills in the groups or do assigned homework. Parent education programs can range from a single motivational lecture to a series of lectures that may involve experiential exercises and self-ratings. Program topics include a wide range of ideas on how to improve youth behavior and values.

These programs generally involve teaching parents ways to improve their parenting or family relationships. Sometimes these programs involve increasing awareness of community resources to help their family or child. Parent education may include appropriate behavioral expectations, ways to better supervise and discipline children, tips for how to improve moral and ethical thinking in children, ways to discuss family values and ways to monitor stealing and lying. Such programs also often include information about the risks of alcohol and drug use, early warning signs of use, other behavioral or family risk factors, the family disease concept, and ways to talk with children about alcohol and drug abuse.

Parent education can be conducted in many different ways. For example, high-risk families may not have time to attend parenting classes, but most watch television. Popkin's Active Parenting Program has been shown on PBS in the state of Washington. Some parenting programs are available on audiotape or videotape to be reviewed at home. Magazines often carry feature or serial articles on improving parenting and family relations. Some businesses offer parenting classes during lunch hours (an excellent way to attract fathers). Some school

alcohol and drug prevention programs include homework assignments to be done with the parents.

Popular anti-drug programs, such as the Parents' Resource Institute for Drug Education (PRIDE), and the National Federation for Drug Free Youth, include parent education components. The parent education components discuss such topics as teaching parents how to talk to their children about alcohol or drugs (as does the National Council on Alcoholism's "Talking With Your Kids About Alcohol" developed by the Prevention Research Institute).

Hawkins and his associates (Hawkins, Lishner, Jenson, and Catalano, 1987) have developed a risk factor based parent education program, called Preparing for the Drug-free Years, that can be implemented in five sessions with the support of video tapes. The program works well for statewide dissemination through schools and community agencies. The program is being tailored for high-risk and ethnic families.

#### *Parent Support Groups*

These groups are generally grassroots organizations of parents who provide support and education for members. Examples of these groups include The National Federation of Parents for Drug Free Youth, Toughlove, PRIDE, The Cottage's Families in Focus, Mothers at Home, Mothers of Pre-Schoolers (MOPS) and Families in Action. These national organizations provide parenting and alcohol and drug education materials. Their local chapters often offer parent support groups. In these support groups parents can share their concerns and problem-solve with the group. Some of these groups, like Toughlove, provide temporary respite care for parents having problems with their adolescents. Some organizations, like STRAIT, provide residential treatment for drug-using youths, followed by several months of living with other parents in the support group. **(Karol has notes on page 21 of her hard copy)**

#### *Parent Aid or In-home Parent Education*

This type of program offers parent education to parents who find it difficult to come to group meetings. Teen Moms is an example of this type of program. Professional public health nurses and social workers often deliver in-home parent education and occasionally parent training to new mothers. If paid professionals are not available, parent aids are sometimes used to deliver these services. Parent aids are highly trained volunteers who are willing to work in homes to teach parents to improve care of an infant.

Home visitation varies enormously in dosage levels, content, skill, and context. Yet there are common effects reported across all these variations. These common effects may be linked to a common core of home visitation is a visitor who cares about child raising sitting down in a home with a parent and a child. Visitors can be nurses, social workers, preschool teachers, psychologists or paraprofessionals. They can provide cognitive information, emotional support, or both. They can actively teach parents, by directly working with the children in the home or they can passively watch and listen, providing constructive feedback. Home visitors can be trained in health, human development, cognitive and social skills or some mixture of these subjects. Despite the type of home visitor, they provide a bridge between the parent,

usually a mother, and instruction. The Prenatal & Early Childhood Nurse Home Visitation is a program that sends nurses to the homes of pregnant women who are predisposed to infant health and developmental problems (i.e., at risk of pre term delivery and low-birth weight children) (Olds, 1986, 1988). This program is one of the exemplary programs that can be found in more detail in Part IV of this literature review.

#### *Parent Involvement in Youth Groups*

This approach includes a wide variety of ways to get busy or distrustful parents to become more involved with their child through the child's participation in a preschool, school, church, or children's agency group or activity. High-risk parents, who would not volunteer for a parent training group, are gradually involved in the children's groups and are exposed to improved parenting skills through observing teachers or trainers work with the children. For example, City Lights in Washington, D.C. gradually gains the trust and interest of inner city, low SES parents by calling them to notify them about their child's achievements in their youth activities program. After a period of increasing contact, parents occasionally are willing to volunteer to help with the youth activities or join a parenting group.

Headstart and pre-school programs have for some time informally taught parenting skills by involving parents in preschool activities. The positive results of the Perry Pre-school Project may be mainly due to this direct modeling of appropriate ways to discipline, support, and help children. The parents learn by watching the teachers and by working with their own child and other children. In San Antonio, the Los Niños Project includes three levels of parent involvement in the children's groups, ranging from no involvement to helping with food and materials for the groups, and, finally, to helping with the children's activities.

#### *Adlerian Parenting Programs*

These programs are based on clinical psychology principles of improving the whole person. Dinkmeyer and McKay's (1976) Systematic Training for Effective Parenting (STEP) is based on the theoretical teachings of Alfred Adler. This program involves local groups of parents in 8 to 12 weekly two-hour sessions covering parenting topics such as understanding the child's behavior and emotions, using encouragement, listening and communicating more effectively, disciplining by using natural and logical consequences rather than punishment, establishing family meetings, and developing confidence as a parent. The goal of this program is to improve the child's self-concept and dignity.

The popular Parent Effectiveness Training (PET) program developed by Gordon (1970) is based on the self-theory of Rogers. The primary focus of this program is enhancing the family's communication, problem-solving, and mediation skills. Parents are taught active and reflective listening skills and the use of open-ended questions. They are taught to consult with children regarding problems, but to leave the child to make his or her own choices. Parents also learn about parental power and the problems of being overly permissive or authoritarian. Another popular program that stresses communication is Glenn's (1984) "Developing Capable

Young People" program. This 10-session program focuses on the parent's role in socializing children in pro-social ways.

Unfortunately, it is still very difficult to determine whether or not Adlerian parenting programs really work. To date, there have been no effective results, this may be because studies have not shown that they work.

## Prevention is Cost-Effective

Delinquency and drug abuse is preventable and cost effective. The costs of incarcerating and treating juveniles are conservatively estimated at \$34,000 to \$64,000 per year (Camp & Camp, 1990; Cohen, 1994). The cost of a young adult's (ages 18-23) serious, criminal career is estimated at \$1.1 million (Cohen, 1994). In contrast, Head Start intervention programs that involve the parents are effective in reducing predictors of delinquency like school academic failure for as little as \$4,300 per year. Unfortunately, few prevention programs have calculated their costs and benefits, but programs that have show cost-benefit ratios in the range of 8:1 (Kim et. al., 1995). According to a meta-analysis review of delinquency prevention programs by Lipsey (1992), a California delinquency prevention program saved law enforcement and juvenile justice systems \$1.40 for every \$1 spent on the program. Program evaluations of delinquency prevention programs highlighted in Delinquency Prevention Works (Office of Juvenile Justice and Delinquency Prevention (OJJDP), 1995) suggest there are effective programs in reducing delinquency as well as precursor risk factors.

A study conducted by the RAND Corporation in 1996 entitled, *Diverting Children from a Life of Crime Measuring Cost and Benefits* determined the benefits of programs that divert youth who have not yet committed crimes from doing so, and at what cost (Greenwood, Model, Rydell, & Chiesa, 1996). A comparison was made based on the crime reduction estimates of four interventions programs to the California three-strikes program. The three-strikes program was believed to effect a twenty-one percent (21%) reduction in crime worth \$5.5 billion a year. Four different approaches to early intervention for at-risk children were considered:

Home visitations by child-care professionals beginning before birth and extending through the first two years of childhood, followed by four years of day care.

Parent training and family therapy with young children who have shown aggressive behavior in school.

Incentives (e.g., cash, other) to induce disadvantaged high school students to graduate.

Supervision of high-school-age youth who have already exhibited delinquent behavior.

Costs included the delivery of a set of services to at-risk youth or their families beginning in the current year and the eventual benefits in terms of crimes prevented over time for that group of youths. According to Greenwood and associates (1996), an estimate of the cost and benefits of these approaches relative to the California's three-strikes law findings suggested that

three of the four approaches compared favorably in terms of serious crime prevented per dollar expended. Specific findings were as follows:

The cost of preventing crimes with a well-designed graduation incentive program is estimated to be approximately \$4,000 per crime. The effects of such a program are felt in a short time period, less than 5 years, because the targeted youth are close to the most crime-prone years.

Parent-training and family therapy intervention programs were found to be relatively cost-effective over the long run at a cost of approximately \$6,500 per serious felony prevented. However, the effect of this type of intervention usually does not show any significant consequences for at least 10 years because participating youths are usually in the seven-to-ten-year age range.

Delinquent supervision programs cost nearly \$14,000 per serious crime prevented. The impact of such programs is almost immediate because the intervention comes just prior to the peak age of criminal behavior 16 to 20 years of age.

Early home visitation and day care intervention were not as cost-effective because of an almost 15-year delay between when the intervention is applied and when it begins affecting serious street crimes. The cost per crime prevented is estimated to be \$29,400 per child over a period of 5 years. However, early childhood intervention has been shown to reduce rates of child abuse about fifty (50%) percent.

From this study, it is apparent that a cost-benefit approach to reduce long-term delinquency effects should be comprehensive. A comprehensive approach would include: 1) incentives to promote high-school graduation and reducing school drop-out rates, 2) parent-training programs and family interventions, and 3) supervision programs during early onset of delinquent behavior may be several times more cost-effective in reducing serious crime than long mandatory sentences for repeat offenders. The authors suggest that the previous type of cost-effective programs could reduce the financial burden of prisons and divert youth from a life of crime.

There are cost-effective strategies that can prevent delinquency by successfully reducing risk factors and strengthening protective factors in the lives of at-risk children. Some of these strategies are included in the OJJDP Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders (Howell, Krisberg, Hawkins, Catalano, et al., 1995) and the former Strengthening American's Families: Promising Parenting Strategies for Delinquency Prevention (Kumpfer, 1993). The National Institute of Justice (NIJ) and OJJDP are promoting many of these prevention strategies in partnership with state and local communities. The National Juvenile Justice Action Plan also supports OJJDP's Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders (Wilson & Howell, 1993) by providing local communities with lists of resources, a summary of research, and examples of model programs that can be adapted to meet local needs.

OJJDP's Action Plan (1996) advocates strengthening families' capabilities to supervise and nurture the positive development of their children. Family strengthening programs can provide assistance through teaching effective parenting skills, therapeutic child play, family

communication, and supervision and monitoring (Kumpfer & Alvarado, 1995). The review of the top twenty-five family programs for the prevention of delinquency, titled Strengthening America's Families (Kumpfer, 1993), includes some family strengthening models that provide additional family support for very high-risk families through home visitations, family therapy, family preservation or family reunification intensive services, on-going neighborhood parent support groups and even in-home family therapy for youth on house arrest (Kumpfer, 1993).

Failure to strengthen families to raise productive, competent, pro-social children will make the United States less competitive in the 21st Century. Unfortunately, economic circumstances, cultural norms, and federal legislation in the last two decades have created an environment that is less supportive of strong, stable families.

Because these reviews suggest there is no one single best family intervention program, providers in the field must carefully select the best program for their target population. Providers can use guidelines to determine the most effective program from a larger number of effective programs. NIDA has specified a number of principles for prevention that can be used to guide that selection process (Sloboda & David, 1997). Following is a listing of principles useful in reviewing and selecting family programs for implementation.

Parenting and family interventions must be tailored to the developmental stage of the child and specific risk factors in the families served. Unfortunately, some programs ultimately fail to have long-term impact on negative outcomes, (delinquency and drug use) in special high-risk populations, because they are insufficient to impact the large number of risk factors affecting high-risk children. Some general principles for best practices in family programs to have maximum impact in improving parenting, family relationships and youth functioning have been discovered, namely:

## Comprehensive Interventions

Comprehensive interventions are more effective in modifying a broader range of risk or protective factors and processes in children. Interventions attending to the entire range of developmental outcomes of the child (i.e., cognitive, behavioral, social, emotional, physical, and spiritual) through improvements in all environmental domains (i.e., society/culture, community/neighborhood, school, peer group, and family/extended family) naturally demonstrate increased effectiveness on positive developmental changes in youth. Our research reviews of different programs (Kumpfer, 1996a; Kumpfer, 1997) suggests that many programs are effective in the areas they target for changes in youth, parents, or families, but many focus too narrowly and hence have more limited results.

## Family-focused

Family-focused programs are more effective than child-focused or parent-focused only. The first wave or phase of child development interventions taught therapists, teachers, prevention specialists and other youth workers to provide enrichment or therapeutic experiences for children. In order to maximize dosage and reduce cost, the second phase of child development interventions focused on training the parent or caretaker to better nurture and care for the child's needs. As the concept of comprehensive prevention or treatment interventions

dealing with many different precursor domains emerged, interventions addressing the child, parent, and interactive family system became more popular. Research comparing the effectiveness of these three types of program foci on the broader range of children's anti-social and prosocial behaviors find the combined approach of all three programs most effective (DeMarsh & Kumpfer, 1985). A number of early childhood education program reviews (Yoshikawa, 1994) have also concluded that comprehensive, holistic, family-focused programs are the wave of the future and should be the central target of future research (Mitchell, Weiss, & Schultz, in press).

### Long-term and Enduring

Family programs should be long-term and enduring. Short-term interventions with high-risk or in-crisis families are only bandaids on dysfunction of the family. Such efforts do not result in functional changes within the family that allow long term solutions rather than a temporary reduction of the external symptoms. Although recruitment for long term programs can be very difficult, once high-risk families are involved in a family intervention, they often do not want to terminate participation.

### Sufficient Dosage or Intensity

Sufficient dosage or intensity is critical for effectiveness. The needier the family is in terms of number of risk factors/processes, the more time is needed to modify those family dysfunctional processes. Time must be allowed for developing trust, determining the family's needs, providing or locating support services for basic needs, and comprehensively addressing deficit areas (CSAP, 1993). To produce longitudinal effectiveness, the family intervention must be of sufficient dosage (at least 45 hours with high-risk families). Kazdin (1995) has estimated that at least 30-40 contact hours are needed for a positive and lasting impact of family programs, particularly because high-risk families frequently miss sessions and have difficulty implementing the skills taught at home (Kumpfer & Alvarado, 1995; Kumpfer & DeMarsh, 1985). Some parent and family programs fail to have much impact, because they do not spend enough time on each skill or principle taught. Skills training interventions need to build on prior learned skills and require demonstration of those prior learned skills while simultaneously learning new skills. Many parent education or training interventions fail with high-risk families because they are too short to really reduce risk-producing processes and behaviors and increase protective processes and behaviors in these parents. Short-term parent education programs are essentially for normal families. These short-term educational programs stress that such programs must be short to attract parents to attend. While this assumption may be true for very busy working parents of children with few problems, it is not as true of high risk or in-crisis families who want help.

### Culturally Sensitive

Tailoring the parent or family intervention to the cultural traditions of the families involved improves recruitment, retention, and outcome effectiveness. Understanding the cultural parenting assumptions of different ethnic groups participating in the parenting or family programs improves program success (Catalano, et.al., 1993, Kumpfer & Alvarado, 1995). Many

traditional cultures may have exceptionally strong ties to extended family members, may stress cooperation and sharing rather than competition and individual autonomy. Some cultures may exhibit a more authoritarian approach to parenting with extremely high expectations for children's performance. Understanding why these parents hold these values and their beliefs about children help the program developers and group leaders improve the program's effectiveness for these parents. For instance, Interviews with African American parents participating in the Detroit Strengthening Family Program, Safehaven program revealed that these parents believe that their children must be more obedient because of the potentially lethal dangers of the inner city streets. Because of differences (e.g., levels of child supervision, research terminology, Wilson, 1987) in cultural understandings and lack of background in the psychological principles underlying many parent education programs, many so called "high-risk" parents may actively reject the underlying assumptions of intervention efforts or merely take more time to really understand.

Ethnic families want parenting and family programs developed specifically for their parenting issues, family needs, and cultural values. Kazdin (1993) has recommended deriving culturally relevant principles to guide modifications of existing model programs rather than developing separate models for each diverse ethnic group. Unfortunately, few existing model family programs (e.g., those developed and tested within National Institute of Drug Abuse/National Institute of Mental Health clinical research trials aimed at preventing drug use and delinquency) have been modified for ethnic families to the degree that they now have culturally appropriate training and parent/child handbooks, video tapes, films, or evaluation instruments translated into different languages. Research-based exceptions include Szapocznik's individual structural family therapy model (Szapocznik, Kurtines, Santisteban, & Rio, 1990; Santisteban, et al., 1993) and Family Effectiveness Training or Bicultural Effectiveness Training Program (Szapocznik, et al., 1986, 1989) for high-risk pre-adolescents and adolescents; Alvey's Confident Parenting Program for parent training models for African-American and Hispanic families (Alvey, Fuentes, Harrison, and Rosen (1980), and Kumpfer's Strengthening Families Program for rural and urban African-American, Hispanic, Asian, Pacific Islanders, English or French Canadian families, and Australian families (Kumpfer, Molgaard, & Spoth, 1996). In any case, cultural modifications of proven programs with general population families for ethnic families require an organized, culturally sensitive, theoretical framework to guide these changes (Ho, 1992).

### Developmentally-appropriate

Addressing developmentally-appropriate risk and protective factors or processes at specific times of family need, when participants are receptive to change is important. Tailoring the intervention to specific family needs can be done on an individual family assessment basis (L'Abate, 1977) or based on focus or research assessment data from similar families in the special population being addressed. Occasionally, a very short-term program can have high impact on some participants if the material covered exactly addresses a few major needs of the parent or child. In addition, research demonstrates that interventions are most effective if the participants are ready for change process (Spoth & Redmond, 1996a & b). Parents in the Iowa Project Family were targeted for a family intervention in the sixth grade, because this is an age

when even normally well adjusted youth begin having behavioral and emotional adjustment problems. Parents are "ready" to participate and change, because they already see the beginnings of oppositional behavior. Outcome results suggest that the Iowa Strengthening Families Program (Molgaard & Kumpfer, 1994) was effective in reducing risk factors for drug use (Spoth, Redmond, & Shin, in press).

The four major types of parenting interventions appear to be developed with an eye to the cognitive and developmental competencies of children at different ages and parenting tasks. They include the following:

family support

parent training

family skills training

family therapy

For instance, in-home family support and cognitive/language development exercises are most effective with children from birth to 3 years (Yoshikawa, 1994). Professional medical support from home visits by a nurse is most often used with high-risk families from conception to age three (Olds & Pettitt, 1996). Behavioral parent training programs or family skills training programs (behavioral family therapy involving the parent and child in structured skills training activities) are most effective with children 3 to 12 years of age (CSAP, in press). Family therapy or family skills training combined with behavioral parenting stressing parental monitoring is most effective with early adolescents and adolescents (Kumpfer, 1996).

### Change Ongoing Family Dynamics

Family programs are most enduring in effectiveness if they produce changes in the ongoing family dynamics and environment. There is suggestive evidence that family programs that encourage families to hold *family meetings* weekly after the program ends have the longest effectiveness, because they change the internal family organization and communication patterns of the family in positive and enduring ways (Catalano, Haggerty, Fleming, & Brewer, 1996; Kumpfer, 1996a). Improving *parenting skills* produces an ongoing intervention that is more effective over time than short-term interventions with children or adolescents only (McMahon, 1996). Effectiveness of family interventions decay gradually with time (Harrison & Proschauer, 1995), but probably can be strengthened with new developmentally-appropriate *booster sessions* as recommended by Botvin (1995).

### Early Start

If parents are very dysfunctional, interventions beginning early in the lifecycle (i.e., prenatally or early childhood) are more effective. Trying to improve the parenting of problem junior high or high school students is an uphill battle. For every family program we have implemented and evaluated, we have wished that for some children, the intervention had begun earlier. After the initial NIDA SFP clinical trials, the Project Reality, methadone maintenance

clinic began targeting pregnant drug-abusing women for improved parenting skills. Since pregnancy has generally been found to be a time when many women are willing to decrease drug use and also to sign up for classes to improve their parenting, many federal and state drug abusing women's programs (CSAP, CSAT, NIDA, and NIAAA) target pregnancy for recruitment and family interventions. Improved pregnancy outcomes and increased services have been documented so far, but long term improvements on the children have not been documented (Rahdert, 1996).

## Family Relations, Communication, and Parental Monitoring

Components of effective parent and family programs include addressing strategies for improving family relations, communication, and parental monitoring. Although research has shown that the final pathway to delinquency and drug use is through *peer influence* (Kumpfer & Turner, 1991; Newcomb, 1995; Swain, Oetting, Edwards, & Beauvais, 1989), the family precursors are lack of *parental monitoring* that is moderated by *parental caring* and positive parent/child relationships (Duncan, Duncan, & Hops, 1996; Brook, et al., 1984; 1990). Effective programs start first with improving the parent/child *relationship* and then focus on family communication and parent monitoring and *discipline* (Kumpfer, 1996b). The more effective *behavioral skills training programs* are distinguished from parent education, because they include a *structured and sequenced series of parenting skills* that are role played and practiced in the group or in homework assignments, resulting in increased success in the implementation of such skills.

## Recruitment and Retention

High rates of recruitment and retention are possible with families. Although many family intervention providers have a very poor turnout for their first attempts at implementing family programs, with increasing experience the retention rates can generally be significantly improved if barriers to attendance are reduced. An *80% to 85% retention rate* is possible for most programs if transportation, meals or snacks, and child-care are provided (Aktan, 1995). The intervention should be located in a non-threatening environment and provided by sensitive, trained, and caring professional staff members. Recruitment rates will vary with the type of program, incentives, types of clients targeted and time of day offered (Spoth & Redmond, 1996b). While program length may be an issue in recruiting families, it is generally not an issue in retention, because many families do not want the program to end once they have attended more than three or four sessions. An ongoing parent support group or booster sessions can help address this need for continuation of the program.

## Videotaping of Effective Parenting Skills

Videos of families demonstrating good and poor parenting skills helps with program effectiveness and client satisfaction. Video tape vignettes and video-based programs are demonstrating significant long-term program effectiveness (Webster-Stratton, 1990a; Webster-Stratton, 1996) even when self-administered (Webster-Stratton, Kolpacoff, & Hollinsworth, 1988; Webster-Stratton, 1990b). Families generally want to see videos that include local issues

and that are racially matched. Having the children watch the parenting videos or the parents watch the children's videos, improves generalization and implementation of the video content. Computer interactive videos, allowing self pacing, self-testing, and selection of major content areas based on needs, may be even more effective (Gordon, 1996; 1997).

### Trainer's Personal Efficacy

The effectiveness of the program is highly tied to the trainer's personal efficacy and characteristics. Although little data exists on how much of the effectiveness of a family program is due to the trainer versus the standardized curriculum, estimates range from 50% to 80%. Qualitative evaluations of trainer effectiveness, participant satisfaction ratings, and long-term follow-up interviews with participants (Harrison, Proschauer, & Kumpfer, 1995) delineate nine important staff characteristics for program effectiveness: 1) communication skills in presenting and listening, 2) Warmth, genuineness, and empathy first detailed in studies of therapist's effectiveness by Carkhuff and Truax (1969), 3) openness and willingness to share, 4) sensitivity to family and group processes, 5) dedication, care and concern for families, 6) flexibility, 7) humor, 8) credibility, and 9) personal experience with children as parent or child care provider.

Parent trainers with backgrounds in the type of program being implemented are best. Staff who share the same general philosophy and background as the program is promoting are most effective. Personal, caring, empathetic and experienced staff members are rated the highest by the program participants, retain families better, and produce better results. The best family and parenting programs are only as effective as the quality of the staff delivering the program. See Aktan (1995) for some guidelines for hiring high quality staff for family programs.

## Part IV: OJJDP Family Strengthening Project

According to OJJDP Administrator Shay Bilchik: "Working to strengthen families is a linchpin in OJJDP's overall delinquency prevention strategy" (Office of Juvenile Justice and Delinquency Prevention, 1995). Although many effective programs have been developed, few of the researchers and practitioners who developed them have had the time to disseminate the results effectively. The compilation and dissemination of these program results is paramount in combating delinquency. In order to address this dilemma, the University of Utah in cooperation with OJJDP developed a unique strategy to identify family-based model programs and then effectively disseminate them nationwide.

This section of the monograph summarizes the results of this OJJDP-funded technology transfer program that focuses on strengthening families for the prevention of delinquency.

### History

Through a 1987 cooperative agreement with OJJDP, Dr. Kumpfer and her associates at the University of Utah conducted a national search for effective family strengthening programs. During that search, 25 programs were selected from more than 500 that had been nominated. An OJJDP publication was developed to highlight these 25 programs (Kumpfer, 1993). The project

culminated in a national conference held in Salt Lake City, UT, in December 1991. Through an additional cooperative agreement with OJJDP, awarded in 1995, Drs. Kumpfer and Alvarado and her associates continued work begun in 1987 to disseminate information on model family approaches.

### **1995 National Search for Model Programs**

In 1995, the University of Utah began implementation of a four-phase technology transfer process:

#### **Phase 1: National search, literature review and dissemination through the Web.**

This effort included a national search for programs focusing on children (at all ages) and families with a range of problems. Nomination forms were sent to representatives of four government agencies in every state and they were asked to nominate programs in their state which were family focused and had a proven record of effectiveness. The representatives were asked to nominate programs that had evaluation results associated with them that demonstrated effectiveness. The individual programs were then contacted and additional information was requested including published articles and information on program evaluation results. In addition, a review of the scientific literature was conducted to identify programs which may not have surfaced through the state nomination process. Programs identified in the 1983 Family Strengthening Project were also contacted and asked to update their file and provide any recent available information on the program. A panel of national family research experts was convened to review the program information.

After the programs were scored on the strength of the theoretical foundation, content, dissemination capability, quality of the research design, outcome results, and number of replications, the top programs in each category were selected from the more than 126 nominated programs. Programs were rated “exemplary” if they had been tested using an experimental design with control groups and had positive findings; “model” if the program had been researched using an experimental or quasi-experimental design with a comparison group and had positive findings; and “promising” if a non-experimental design with positive findings was utilized and there was supporting qualitative data.

This search identified 11 exemplary family programs, 14 model programs, and 9 promising programs for a total of 34 top programs. It is important to note that once additional research is conducted on many of the programs, particularly the promising approaches, they may be eligible to move to another category. Hence, the program developer should be contacted to obtain the most recent research findings particularly if an agency is considering implementing a program in their community. A list of the programs by category follows:

#### Exemplary Programs

Functional Family Therapy  
Helping the Noncompliant Child

Iowa Strengthening Families Program for families with Pre-& Early Teens  
Multisystemic Therapy Program  
Parents and Children Training Series: The Incredible Years  
Prenatal & Early Childhood Nurse Home Visitation  
Preparing for the Drug Free Years  
Raising a Thinking Child: I Can Problem Solve Program for Families  
Strengthening Families Program  
Structural Family Therapy  
Treatment Foster Care

#### Model Programs

CEDEN Health and Fair Start Program  
CICC's Effective Black Parenting Program  
Families and Schools Together (FAST)  
Focus on Families  
Healthy Families Indiana  
HIPPI  
Home-Based Behavioral Systems  
HOMEBUILDERS  
MELD  
Nurturing Parenting Program  
Parents Anonymous  
Parent Project  
Parenting Adolescents Wisely  
Strengthening Hawaii Families

#### Promising Programs

Bethesda Day Treatment Center  
Birth To Three  
Families in Focus  
Family Support Program  
First Steps  
Health Start  
Home Base Program  
Project SEEK  
Strengthening Multi-Ethnic Families and Communities

In order to provide another means of dissemination, one-page descriptions of each program were also created for the project Web site: [www.strengtheningfamilies.org](http://www.strengtheningfamilies.org). Contact information is provided by the program developer.

**Phase 2: Two national conferences.**

In order to further the dissemination and training goals, two national conferences were convened. Strengthening America's Families conferences were held in Snowbird, UT, in October 1996 and in Washington, D.C., in March 1997. More than 600 people attended the two conferences, which provided training workshops, roundtable discussions and resource fairs for the 34 programs found useful for reducing risks for delinquency in many different ethnic and cultural groups.

**Phase 3: Regional training of trainers.**

Ten 2- to 3-day workshops were conducted for the eight most popular parenting and family programs. The programs selected were identified by national conference attendees as the prevention programs they wished to be trained in and to implement locally. The workshops were free or at an extremely low cost. Stipends were offered for training workshops for an additional 11 programs.

**Phase 4: Technical assistance and publications.**

During phase 4, currently in progress, technical assistance is being offered to agencies implementing the programs for which regional training was held and for which stipends were offered. Process and outcome evaluations also are being conducted for a limited number of agencies, which receive mini-grants to promote high-quality program implementation. In addition, OJJDP has begun a Bulletin series to periodically publish history, program content, format, and results of these outstanding family programs.

**Program Matrix**

Strengthening America's Families Programs are listed according to an additional classification in Table 2 of this section. The programs are matrixed by age and level of prevention programming: universal (general population), selective (high-risk population), and indicated (in-crisis population) prevention (Gordon, 1987; Mrazek and Haggerty, 1994). This classification is utilized for ease in identifying and selecting programs to meet specific needs. For example, an agency may want to locate a program that serves an extremely high population of mothers of newborn infants. They can use the matrix to narrow down the programs they may want to explore further for possible implementation in their community. Additional information on this classification system is provided.

The Institute of Medicine (IOM) (1994) introduced this new classification to prevention interventions in 1994 based on a risk-benefit point of view that incorporates the risk to an individual of getting a disease which must be weighed against the cost, risk, and discomfort of the preventive intervention (Gordon, 1987). Gordon's (1987) system consists of three categories universal, selective, and indicated prevention measurement and intervention. These classifications have been used to group OJJDP's Strengthening America's Families Programs.

**Universal Prevention Interventions**

Universal interventions for families are applied to the general population of families and youth (Aktan, Kumpfer, Turner, 1996). Examples would be school-based programs, media campaigns, and community interventions to prevent substance abuse and juvenile delinquency. Programs include Preparing for the Drug-free Years (Hawkins & Catalano, 1992), Families and Schools Together (FAST) (McDonald, 1996), and the Iowa Strengthening Families Programs (Molgaard & Kumpfer, 1995).

### **Selective Prevention Interventions**

Selective interventions are targeted to high-risk individuals or families as members of at-risk subgroups. The family as a unit tends not to be targeted because of specific individual needs assessments or diagnoses (Aktan, Kumpfer, Turner, 1996). Family interventions at this level are generally longer in length, more intrusive by involving parent and youth in ways to target behavioral changes (Aktan, Kumpfer, Turner, 1996). Behavioral changes attempt to reduce epidemiologically or empirically established risk factors such as 1) demographic risk factors, 2) psychosocial environmental risk factors, and 3) biological genetic risk (Kumpfer et. al., in press). Examples of selective family prevention interventions are the Strengthening Families Program (Kumpfer, DeMarsh, & Child, 1989) for substance abusing families and other culturally-modified version for high-risk African-American families (Aktan, 1995; Aktan, Kumpfer & Turner, 1996), Spanish-speaking families and Asian/Pacific Islander families (for overview of all versions see Kumpfer, Molgaard, & Spoth, 1996).

### **Indicated Prevention Interventions**

Indicated prevention programs are designed to address the multiple risk factors in individual families (Aktan, Kumpfer & Turner, 1996). These identified or diagnosed problems could include school failure, delinquency, non-compliance or drug use in the child or indicators of parenting dysfunction such as child physical or sexual abuse, severe neglect, or other parental pathology (Aktan, Kumpfer & Turner, 1996). Indicated prevention programs are even more intrusive, longer and can involve in-home therapeutic or family support sessions as are done in family preservation programs and some family services or family case management programs (Aktan, Kumpfer & Turner, 1996). Often involve individual rather than group sessions with a highly trained therapist. Examples of these programs include Prenatal and Infancy Nurse Home Visitation Program (Olds & Petit, 1996) and Functional Family Therapy Program (Alexander & Parsons, 1982). Additionally, many prevention programs are categorized as both prevention and treatment (Aktan, Kumpfer & Turner, 1996). For example, the family therapy programs are considered therapeutic for conduct disorders in the child or severely dysfunctional parenting (Aktan, Kumpfer & Turner, 1996). However, they are still categorized as indicated prevention programs if the child is not currently a substance abuser, because they are effective in preventing the developmental progression from conduct disorders to drug abuse (Aktan, Kumpfer & Turner, 1996). The Multisystemic Family Therapy program is an example of this type of classification, both prevention and treatment (Henggeler & Borduin, 1990; Henggeler, Melton, and Smith, 1992).

### **Strengthening America's Families Program Matrix**

	Universal (General Population)	Selected (High Risk Population)	Indicated (In-Crisis Population)
0-5 (age)	HIPPY (Model) New York, NY  MELD (Model) Minneapolis, MN  First Step (Promising) Cannon, City, CO  Birth to Three (Promising) Eugene, OR	Health Start (Promising) St. Paul, Minnesota  I Can Problem Solve (Exemplary) Philadelphia, PA  Healthy Families Indiana (Model) Indianapolis, IN	Prenatal and Early Childhood Nurse Home Visitation Program (Exemplary) Denver, CO  CEDEN Healthy and Fair Start (Model) Austin, TX
6-10 (age)	Preparing for the Drug Free Years (Exemplary) Seattle, WA	Strengthening Families Program (Exemplary) Salt Lake City, UT  Video-Based Parenting (Exemplary) Seattle, WA  Strengthening Hawaii Families (Model) Honolulu, HI	Helping the Non-Compliant Child (Exemplary) Seattle, WA  Focus on Families (Model) Seattle, WA
11-18 (age)	Iowa Strengthening Families Program (Exemplary) Ames, IA	Families and Schools Together (Model) Madison, WI  Families in Focus (Promising) Salt Lake City, UT  Family Support Program (Promising) Rocky Mountain, VA	Multi-Systemic (Exemplary) Charleston, S.C./Columbia, MO  Functional Family Therapy(Exemplary) Salt Lake City, UT  Home Based FFT (Model)- Athens, OH  Structural Family Therapy (Exemplary) Miami, FL  Treatment Foster Care (Exemplary) Eugene, OR
0-18 (age)	Parents Anonymous (Model) Compton, CA  Parent Project (Model) Round Lake, IL	Nurturing Parenting Program (Model) Arden, NC  Strengthening Multi-Ethnic Families and Communities (Promising) Los Angeles, CA  Effective Black Parenting (Model) Studio City, CA	Project Seek (Promising)- Lansing, MI  Homebuilders (Model) Federal Way, WA  Parenting Adolescents Wisely (Model) Athens, OH  Bethesda Day Treatment (Promising) Milton, PA  Coordinated Children Services (Promising) Huntington, NY

## Exemplary Program Descriptions

Follows are one-page descriptions for each of the 11 **exemplary** programs, written by the University of Utah staff in collaboration with the program developer. Generally the description provides information on goals of the program, target population it serves, program structure/content and evaluation. Contact information for the program developer or contact is provided. If the program has a web-site, that information is also available. For information on all 34 programs, you may go to the project Web site: [www.strengtheningfamilies.org](http://www.strengtheningfamilies.org) or contact the University of Utah, Family Strengthening Project at 801-581-7718 for a booklet.

### Functional Family Therapy

James F. Alexander, Ph.D.  
1329 Behavioral Science  
University of Utah  
Salt Lake City, UT 84112  
(801) 581-6538 FAX: (801) 581-5841  
jfafft@psych.utah.edu

Functional Family Therapy (FFT) is an empirically-grounded, family-based intervention program for acting-out youth. A major goal of Functional Family Therapy is to improve family communication and supportiveness while decreasing the intense negativity so often characteristic of these families. Other goals include helping family members adopt positive solutions to family problems, and developing positive behavior change and parenting strategies. Although originally designed to treat middle class families with delinquent and pre-delinquent youth, the program has recently included poor, multi-ethnic, multi-cultural populations, with very serious problems such as conduct disorder, adolescent drug abuse, and violence.

The program is conducted by family therapists working with each individual family in a clinical setting, which is standard for most family therapy programs; more recent programs with multiproblem families involve in-home treatment. The model includes four phases: (1) an introduction/ Impression Phase; (2) a Motivation (Therapy) Phase; (3) a Behavior Change Phase; and (4) a Generalization (more multisystem focused) Phase. Each phase includes assessment, specific techniques of intervention, and therapist goals and qualities. The intervention involves a strong cognitive/attributional component which is integrated into systemic skill-training in family communication, parenting skills, and conflict management skills.

The FFT model has been evaluated many times beginning in 1971. The model's effectiveness has been independently demonstrated with a between-groups design, and its impact asserted at additional performance sites. FFT has demonstrated a significant reduction in recidivism when compared to alternative treatments and no treatment conditions. With less serious offenders, reductions ranged from 50-75%, and with very severe cases a 35% reduction in re-offense rate. These outcomes have also been associated with dramatically reduced treatment costs. In addition to outcome evaluations, FFT has focused on in-session therapist characteristics and family interaction processes, which are predictive of positive change. The most notable process changes appear to be in family communications patterns, especially the negative/blaming communications patterns. Process and outcome data demonstrate that therapists must be relationally sensitive and focused, as well as capable of clear structuring, in order to produce significantly fewer drop-outs and lower recidivism.

#### Helping the Noncompliant Child

Robert J. McMahon, Ph.D.  
University of Washington

Department of Psychology, Box 351525  
Seattle, WA 98195-1525  
(206) 543-5136 FAX: (206) 685-3157  
mcmahon@u.washington.edu

The "Helping the Noncompliant Child" parent training program by Forehand and McMahon (1981) is based on a parent training program originally developed by Dr. Constance Hanf. The long-term goals of the parent training program are: secondary prevention of serious conduct problems in preschool and early elementary school-aged children and the primary prevention of subsequent juvenile delinquency. Short-term and intermediate objectives include: a) disruption of coercive styles of parent-child interaction and establishment of positive, prosocial interaction patterns, b) improved parenting skills, c) increased child prosocial behaviors and decreased conduct problem behaviors. The program is designed for parents and their 3-8 year old children with noncompliance and/or other conduct problems. It has also been used with other high risk populations of children and parents.

Sessions are typically conducted with individual families rather than in groups. Parents and children participate in weekly 60-90 minute sessions (average number of sessions is 10). The program consists of a series of parenting skills designed to help the parent break out of the coercive cycle of interaction with the child by increasing positive attention for appropriate child behavior, ignoring minor inappropriate behaviors, providing clear instructions to the child, and providing appropriate consequences for compliance (positive attention) and noncompliance (time out). Skills are taught using extensive demonstration, role plays, and direct practice with the child in the training setting and at home. Progression from one skill to the next is based upon demonstrated proficiency.

Extensive research has demonstrated effectiveness of this program in helping children successfully adapt. Short-term effectiveness and setting generalization from the clinic to the home have been demonstrated for both parent and child behaviors as well as parents' perceptions of their children. Child compliance and inappropriate behavior have been shown to improve to within the "normal" range by the end of training. Long-term follow-ups up to 11-14 years after training support the effectiveness of the program. High parental satisfaction with the program has been documented.

The Strengthening Families Program: For Parents and Youth 10-14

Virginia Molgaard, Ph.D./Richard Spoth, Ph.D.  
Iowa State University  
Institute for Social and Behavioral Research  
2625 North Loop Drive, Suite 500  
Ames, IA 50010  
(515) 294-8762 or (515) 294-9752 FAX: (515) 294-3613  
email: molgaa@exnet.iastate.edu  
website: [www.exnet.iastate.edu/Pages/families/strength.html](http://www.exnet.iastate.edu/Pages/families/strength.html)

The Strengthening Families Program: For Parents and Youth 10-14 (SFP) resulted from an adaption of the Strengthening Families Program (SFP), originally developed at the University of Utah. Formerly called the Iowa Strengthening Families Program, the long-range goal for the curriculum is reduced substance use and behavior problems during adolescence. Intermediate objectives include improved skills in nurturing and child management by parents, and improved interpersonal and personal competencies among youth. Parents of all educational levels are targeted and printed materials for parents are written at an 8th grade reading level. All parent sessions, two youth, and two family sessions use videotapes portraying prosocial behaviors and are appropriate for multi-ethnic families.

The SFP 10-14 has seven two hour sessions for parents and youth, who attend separate skill-building groups for the first hour and spend the second hour together in supervised family activities. Four booster sessions are designed to be used six months to one year after the end of the first seven sessions, in order to reinforce the skills gained in the original sessions. Youth sessions focus on strengthening goal setting, dealing with stress and strong emotions, communication skills, increasing responsible behavior, and improving skills to deal with peer pressure. Youth Booster sessions focus on making good friends, handling conflict and reinforcing skills learned in the first seven sessions. Parents discuss the importance of both nurturing their youth while, at the same time, setting rules, monitoring compliance, and applying appropriate discipline. Topics include making house rules, encouraging good behavior, using consequences, building bridges, and protecting against substance abuse. Parent Booster sessions focus on handling parents' stress, communicating when partners don't agree and reinforcing earlier skills training.

Three controlled, longitudinal studies are underway. The first of these evaluated the Iowa Strengthening Families Program or ISFP (the SFP 10-14 is a revision of the ISFP) with a sample of families of sixth graders. There has been a large number of statistically significant ISFP intervention effects on primary child and parent outcomes through the tenth-grade follow-up assessment, four years following the pre-test. Key findings from intervention versus control comparisons include, but are not limited to: 1) positive effects on parenting behaviors directly targeted by the ISFP through the eighth-grade follow-up; 2) improvement in peer resistance skills and reduction in affiliations with anti-social peers at the seventh, eighth, and tenth grade follow-ups; 3) lower probabilities of initiating any type of substance use between the seventh and eighth grades, as indicated by latent transition analyses; 4) lower proportions of tenth-grade adolescents reporting lifetime use of alcohol, tobacco, and marijuana; 5) lower rates of growth in alcohol initiation, through the tenth-grade follow-up, as indicated by growth curve analyses; 6) lower past month frequency of cigarette use in the tenth grade.

A second study, now in its second year, includes three groups of families: 1) those whose youth receive the Life Skills Training (LST) intervention in school; 2) those whose families participate in the SFP 10-14, in addition to the LST; and 3) those whose families receive written materials. A third study includes African-American families who take part in the SFP 10-14 or participate in a wait-list control condition.

### Multisystemic Therapy Program

Scott W. Henggeler, Ph.D.  
(Contact) Keller Strother, President  
MST Services, Inc.  
268 W. Coleman Blvd., Ste. 2E  
Mt. Pleasant, SC 29454  
(843) 856-8226 FAX: (843) 856-8227  
[keller@mstservices.com](mailto:keller@mstservices.com)

Multisystemic therapy (MST) is an intensive family-based treatment that addresses the known determinants of serious antisocial behavior in adolescents and their families. As such, MST treats those factors in the youth's environment that are contributing to his or her behavior problems. Such factors might pertain to individual characteristics of the youth (e.g., poor problem solving skills), family relations (e.g., inept discipline), peer relations (e.g., association with deviant peers), and school performance (e.g., academic difficulties). On a highly individualized basis, treatment goals are developed in collaboration with the family, and family strengths are used as levers for therapeutic change. Specific interventions used in MST are based on the best of the empirically validated treatment approaches such as cognitive behavior therapy and the pragmatic family therapies. The primary goals of MST are to reduce rates of antisocial behavior in the adolescent, reduce out-of-home placements, and empower families to resolve future difficulties.

Several programmatic features are crucial to the success of MST. The use of a home-based model of service delivery (i.e., low caseloads, time limited duration of treatment) removes barriers of access to care and provides the high level of intensity needed to successfully treat youths presenting serious clinical problems and their multi-need families. Second, the philosophy of MST holds service providers accountable for engaging the family in treatment and for removing barriers to successful outcomes. Such accountability clearly promotes retention in treatment and attainment of the treatment goals. Third, outcomes are evaluated continuously, and the overriding goal of supervision is to facilitate the clinicians' attempts to attain favorable outcomes. Fourth, MST programs place great emphasis on maintaining treatment integrity, and as such, considerable resources are devoted to therapist training, ongoing clinical consultation, service system consultation, and other types of quality assurance.

Rigorous evaluation is a hallmark of MST. Well designed randomized clinical trials with chronic and violent juvenile offenders have demonstrated the capacity of MST to reduce long-term rates of criminal activity, incarceration, and concomitant costs. Other randomized trials have demonstrated that favorable outcomes are linked to therapist adherence to the MST treatment protocol. Current studies are examining the effectiveness of MST in treating a variety of serious clinical problems, evaluating variables that predict the successful dissemination of MST, and assessing the clinical and cost effectiveness of an MST-based continuum of care.

[The Incredible Years: Parents, Teachers, And Children Training Series](#)

Carolyn Webster-Stratton, Ph.D.  
University of Washington  
1411 8th Avenue West  
Seattle, WA 98119  
(206) 285-7565 (888) 506-3562 FAX: (206) 285-7565  
incredibleyears@seanet.com  
www.incredibleyears.com

Designed as prevention/intervention programs for parents and teachers of children ages 3-12 years. Short term objectives are to strengthen parenting and teacher competencies by training parents in positive communication and child-directed play skills, consistent and clear limit setting, nonviolent discipline strategies, how to teach their children to problem solve, manage their anger and promote positive parent-teacher partnership and collaboration. The objectives for the children are to strengthen social and academic competence, reduce behavior problems, and increase positive interactions with peers, teachers and parents.

*The Incredible Years, BASIC Parents Training Program* is offered to parents in groups to foster support, problem-solving and self-management. Groups meet for approximately 11-14 weeks to complete the curriculum(2 hours once a week). *The BASIC program* covers topics such as: Play, Helping Children Learn, The Value of Praise and Encouragement, The Use of Incentives to Motivate Children, Effective Limit Setting, and Handling Misbehavior. There are two versions of this *BASIC program*, one for young children (2 to 7 years) and one for early school-age children (ages 5 to 12 years). *The BASIC program* can be supplemented by another training series called Supporting Your Child's Education. This program covers topics such as: Promoting Children's Self Confidence, Fostering Good Learning Habits, Participating in Homework and Using Parent Conferences to Advocate for Your Child. Trained leaders show groups of parents the real-life videotape situations of parents and children and encourage discussion and problem-solving. *The Advanced Parent Training Program* takes an additional 14 sessions and covers topics such as: Effective Communication, Anger Management, Problem Solving and Family Meetings and Ways to Give and Get Support.

The Child Training Program, known as the "Dinosaur Social Skills and Problem-Solving Curriculum" dovetails with the parent training program and takes 22 weeks to complete. The program covers topics such as Learning Rules, Empathy Training, Problem-Solving, Anger Management, How to Be Friendly, How to Talk to Others, and How to Be Successful in School. The tapes are narrated by child-size puppets making use of fantasy, role play and cooperative activities to illustrate concepts.

The Teacher Training Program can be conducted in 36 hours-- which may be offered as full day workshops or for shorter periods on a weekly basis. The topics cover: The Importance of Teacher Attention, Praise and Encouragement, Motivating Students through Incentives, Preventing Problems, Decreasing Inappropriate Behavior in the Classroom, Building Positive Relationships with Difficult Children, and how to teach social skills and problem solving in the classroom.

The *Incredible Years* Parent, Child, and Teacher Training Programs have been researched and extensively field tested in randomized trials over the past 18 years with over 1000 families with young children who have aggressive behavior problems. The BASIC Parent Training Program has also been evaluated with over 700 high risk Head Start families as a prevention program. The Teacher Training Program has been evaluated in two independent, randomized trials with head start teachers as well as in studies with teachers of students in grades Kindergarten through grade three. Results indicate that parents and teachers were able to significantly reduce children's problem behaviors and increase their social competence and academic engagement. (References available from program developer).

Training in these programs lead to certification as a group leader. Therapeutic group process emphasizes cultural sensitivity and strategies such as collaboration, empowerment, re-framing, self-management, ways to give and get support, changing negative self-talk and "principle-training."

### The Prenatal and Early Childhood Nurse Home Visitation Program

David Olds, Ph.D.  
(Contact) Ruth A. O'Brien, Ph.D., RN  
Kempe Prevention Research Center for  
Family and Child Health  
1825 Marion Street  
Denver, CO 80218  
(303) 864-5210      FAX: (303) 864-5236  
obrien.ruth@tchden.org

The Prenatal and Early Childhood Nurse Home Visitation Program is a well tested model that improves the health and social functioning of low-income first-time mothers and their babies. Nurse home visitors develop a supportive relationship with the mother and family which emphasizes education, mutual goal setting, and the development of the parents' own problem-solving skills and sense of self-efficacy. Beginning in pregnancy, the nurses help women to improve their health behaviors related to substance abuse (smoking, drugs, alcohol) and nutrition, significant risk factors for pre-term delivery, low birth weight, and infant neuro-developmental impairment. After delivery, the emphasis is on enhancing qualities of care giving for infants and toddlers, thereby preventing child maltreatment, childhood injuries, developmental delay, and behavioral problems. Among the mothers, the program also focuses on preventing unintended subsequent pregnancies, school drop out, and failure to find work resulting in ongoing welfare dependence - factors that conspire to enmesh families in poverty and that increase the likelihood that women will have poor subsequent pregnancies and increase the likelihood for sub-optimal care of children. In order to achieve maximum outcomes in the preceding domains of functioning, nurses work to improve environmental contexts by enhancing informal support and by linking families with needed health and human services.

Using developmentally established protocols, nurses visit families as follows: (a) weekly during

the first month following enrollment, (b) every other week throughout the remainder of the woman's pregnancy, (c) weekly for the first six weeks postpartum, (d) every other week thereafter through the child's 21st month, and (e) then monthly until the child reaches age two. Visit protocols focus on five domains of functioning: personal health, environmental health, maternal role, maternal life course development, and family and friend support.

A summary of the major findings on maternal and child outcomes from two randomized clinical trials show a 25% reduction in cigarette smoking during pregnancy among women who smoked cigarettes at registration; 25% reduction in the rates of hypertensive disorders of pregnancy and less severe cases among those with the condition; 80% reduction in rates of child maltreatment among at-risk families from birth through the child's second year; 56% reduction in the rates of children's health-care encounters for injuries and ingestions from birth through child's second birthday; 43% reduction in subsequent pregnancy among low-income, unmarried women by first child's birthday; 83% increase in the rates of labor force participation by first child's fourth birthday; 30-month reduction in AFDC utilization among low-income, unmarried women by first child's 15th birthday.

### Preparing for the Drug Free Years

David Hawkins, Ph.D. and Richard Catalano, Ph.D.  
(contact) Developmental Research & Programs, Inc.  
Dan Chadrow  
130 Nickerson St., Suite 107  
Seattle, WA 98109  
(800) 736-2630 FAX: (206) 286-1462  
email: [moreinfo@drp.org](mailto:moreinfo@drp.org) website: [www.drp.org](http://www.drp.org)

Preparing for the Drug Free Years (PDFY), a program for parents of children in grades 4 through 8, is designed to reduce adolescent drug use and behavior problems. PDFY's skill-based curriculum helps parents address risks that can contribute to drug abuse while strengthening family bonding by building protective factors. PDFY reaches parents before their children begin experimenting with drugs. Sessions focus on family relationships and communication, family management skills, and resolution of family conflict.

PDFY incorporates both behavioral skills training and communication-centered approaches to parent training. Two volunteer workshop leaders deliver the program in five two-hour sessions or ten one-hour sessions. It is recommended that at least one of the workshop leaders be a parent. The sessions are interactive and skill-based, with opportunities for parents to practice new skills and receive feedback from workshop leaders and their peers. Parents learn about the nature of the drug problem as well as how to 1) increase children's opportunities for meaningful involvement in the family, 2) teach behavioral, cognitive and social skills needed for meaningful involvement, 3) provide reinforcement and appropriate consequences for behavior, 4) use family meetings to enhance communication and strengthen family bonds, 5) establish a family position on drugs, 6) reinforce children's refusal skills, 7) express and manage anger constructively, 8) increase children's participation in the family, and 9) create a parent support network.

PDFY has been vigorously evaluated. It is included in the National Institute of Drug Abuse's (NIDA) Preventing Drug Use Among Children and Adolescents: A Research-Based Guide. It is also a showcase program in the Center for Substance Abuse Prevention's (CSAP) "Parenting Is Prevention" initiative. Long-term results from evaluations of PDFY in Project Family in Iowa and in the Seattle Social Development Project showed significant reductions in children's antisocial behavior, improved academic skills, better bonding to pro-social others, and fewer incidents of drug use in school. Among parents assigned to the PDFY curriculum, intervention targeted parenting behaviors showed significant improvements for both mothers and fathers.

#### Raising a Thinking Child: I Can Problem Solve (ICPS) Program For Families

Myrna Shure, Ph.D.  
MCP/Hahnemann University  
245 North 15<sup>th</sup> Street, ADD MS 626  
Philadelphia, PA 19102-1192  
(215) 762-7205 FAX: (215) 762-8625  
EMAIL: mshure@drexel.edu

The focus of this program is on developing a set of interpersonal cognitive problem solving skills that relate to overt behaviors as early as preschool. By enhancing ICPS skills, the ultimate goal is to increase the probability of preventing later, more serious problems by addressing the behavioral predictors early in life. In addition to behavioral outcomes, the parent intervention is designed to help parents use a problem solving style of communication that guides young children to think for themselves. The program was originally designed for mothers or legal guardians of African-American, low-income four-year-olds. The program now includes parents of children up to age seven and has been expanded to include middle and upper-middle income populations in the normal behavioral range as well as those displaying early high-risk behaviors. These include those diagnosed with ADHD and other special needs.

The program takes ten to twelve week sessions to complete, although a minimum of six weeks is sufficient to convey the approach. The first section focuses on learning a problem solving vocabulary in the form of games. The second section concentrates on teaching children how to listen. It also teaches them how to identify their own and other's feelings, and to realize that people can feel different ways about the same thing. In the last section children are given hypothetical problems and are asked to think about people's feelings, consequences to their acts, and different ways to solve problems. During the program parents are given exercises to help them think about their own feelings and become sensitive to those of their children. Parents also learn how to find out their child's view of the problem and how to engage their child in the process of problem solving.

Among low-income African-American mothers, one pilot and two hypothesis-testing studies were done with their four-year-olds, and a three year follow-up with mothers and their six to seven-year-olds. Among middle and upper middle income Caucasian families participating in

the research and evaluations, relatively normal children with varying degrees of high-risk behaviors, as well as those with ADHD, significantly improved in alternative solution thinking, consequential thinking, and high-risk behaviors both in school and at home. Those trained in kindergarten or kindergarten and first grade also did better in their academic achievements.

### Strengthening Families Program

Karol L. Kumpfer, Ph.D.  
University of Utah  
300 So. 1850 E. Rm. 215  
Salt Lake City, UT 84112  
(801) 581-8498      FAX: (801) 581-5872  
email: karol.kumpfer@health.utah.edu

The Strengthening Families Program (SFP) is a family skills training program designed to reduce risk factors for substance use and other problem behaviors in high-risk children of substance abusers including behavioral problems, emotional, academic and social problems. SFP builds on protective factors by improving family relationships, parenting skills, and improving the youth's social and life skills. It is designed for families with children ages 6 to 10 and has been modified for African-American families, Asian/Pacific Islanders in Utah and Hawaii, rural families, early teens in the Midwest, and Hispanic families. Although originally developed for children of high-risk substance abusers, SFP is widely used for non-substance abusing parents.

SFP provides 14 weekly 2 hour meetings. It includes **three separate courses:** Parent Training, Children's Skills Training and Family Life Skills training. Parents learn to increase desired behaviors in children by using attention and reinforcements, communication; substance use education; problem solving; limit setting and maintenance. Children learn communication; understanding feelings; social skills; problem solving; resisting peer pressure; questions and discussion about substance use; and compliance with parental rules. Families practice therapeutic child-play and conduct weekly family meetings to address issues, reinforce positive behavior and plan activities together. SFP uses creative retention strategies such as transportation, child care and family meals.

Positive outcomes have been found in a number of independent program evaluations. Outcome results based on pre- post- and 6 month follow-up measures show that the three component design is most powerful. SFP improved child risk status in three areas 1) children's problem behaviors, emotional status and pro-social skills; 2) parents parenting skills; and 3) family environment and family functioning. SFP significantly improved family relationships, family organization, reduced family conflict and increased family cohesion were found. Also, sibling relationships, ability to think of family-oriented activities, clarity of rules and less social isolation by parents were found. Parents reported significantly decreased drug use, depression, use of corporal punishment and increased parental efficacy. Children showed improvements in

impulsivity, behaving well at home and fewer problem behaviors in general. Children also report less intention to use tobacco and alcohol.

### Structural Family Therapy

Jose Szapocznik, Ph.D.  
(Contact) Victoria B. Mitrani, Ph.D.  
1425 NW 10th Avenue, Third Floor  
Miami, FL 33136  
(305) 243-4592  
FAX: (305) 243-5577  
vmitrani@mednet.med.miami.edu

In 1975, the Spanish Family Guidance Center (a component of the Center for Family Studies) adopted Brief Structural/Strategic Family Therapy (BSFT) as its core approach (Szapocznik and Kurtines, 1989). One Person Family Therapy, Family Effectiveness Training, Bicultural Effectiveness Training, Structural Ecosystems Therapy and Structural Ecosystems Prevention have all been developed based on the BSFT model. The therapy evolved from a program with Cuban-American families with drug abusing and behavior problem youth, and is currently applied to families from other Hispanic-American groups and African-American families. Structural Ecosystems Therapy, which is an ecosystem version of BSFT is currently being applied and tested in the treatment of families of African-American HIV+ women and caregivers of patients with Alzheimer's disease, in addition to drug abusing youth.

Therapy is tailored to each specific family and delivered to individual families, sometimes in their homes. A basic premise of BSFT is that one important factor giving rise to symptoms such as substance abuse are families' maladaptive ways of relating. Therapists seek to change these maladaptive interaction patterns by choreographing family interactions in session in order to create the opportunity for new, more functional interactions to emerge. Major techniques used are joining (engaging and entering the family system), diagnosing (identifying maladaptive interactions and family strengths), and restructuring (transforming maladaptive interactions). Therapists are trained to assess and facilitate healthy family interactions based on cultural norms of the family being helped.

BSFT has been rigorously evaluated in a number of studies with experimental designs. The approaches have been found to be effective in improving youth behavior, reducing recidivism among youthful offenders, and in improving family relationships.

### Treatment Foster Care (TFC)

Patricia Chamberlain, Ph.D., Director  
Oregon Social Learning Center

160 East 4th  
Eugene, OR 97401  
(541) 485-2711 FAX: (541) 485-7087  
pattic@tigger.oslc.org

TFC is a parent training program that works with foster parents to provide 6 month placements to 12-18 year old adolescents referred because of histories of chronic delinquency. The teenagers biological parents (or other guardian) are also worked with intensively during the placement period as well as during a 12 month after-care period. Youth are referred by the juvenile justice system and are at-risk for commitment or have been committed to the Oregon State Training schools. Treatment goals for the youth are to reduce criminal behavior and substance use, improve school attendance and grades, reduce association with delinquent peers, and improve the youngsters ability to live successfully in a family setting. Treatment goals for the youth's family are to increase their parenting skills, particularly their ability to supervise and to use effective discipline strategies, to increase their level of involvement with their youngster, and to help them engage in pro-social activities in the community.

After intensive pre-service training, Treatment Foster parents are contacted daily to monitor youths progress/problems and they attend a weekly meeting where they receive supervision and support. TFC parents implement a daily behavior management program that is individualized for each youth. Each day youth have the opportunity to earn and lose points that translate into long and short-term privileges. As the youth progress through the program the level of supervision and control over their activities is titrated. Youth also participate in weekly individual therapy that is skill-focused and their parents/guardians attend weekly sessions as well. Youth attend public schools where their attendance and performance is tracked on a daily basis. Twenty-four hour, seven-day on-call support is provided to TFC parents and to parents/guardians during home visits and in after care.

The effectiveness of the TFC program has been evaluated in three studies: one comparing participation in TFC to a matched comparison group, one comparing the relative effectiveness of TFC for boys and girls, and the third a randomized clinical trial comparing TFC to group care (GC) placements for boys averaging 14.5 years old who had an average of 13 arrests pre-treatment. In that study boys were assessed at baseline, after they had been placed for 3 months, then every subsequent 6 months throughout two-year follow-up. significantly more of the boys in TFC completed their programs than in GC, they were institutionalized less often, and they had dramatically fewer arrests (less than half the rate of GC boys) in follow-up. In addition TFC boys reported significantly fewer psychiatric symptoms, had better school adjustment, returned to their family homes after treatment more often, and rated their lives as being happier than boys in GC. This model is now being adapted for working with adolescent girls who are referred by the juvenile justice system but who have serious mental health problems.