
Wisconsin Family Impact Seminars
Briefing Report

Building Resiliency and Reducing Risk:
What Youth Need from Families
and Communities to Succeed



University of Wisconsin-Extension
Center for Excellence in Family Studies
School of Human Ecology
University of Wisconsin-Madison

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First Edition

**Wisconsin Family Impact Seminars
Briefing Report**

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January 1998

**University of Wisconsin-Extension
Center for Excellence in Family Studies
School of Human Ecology
University of Wisconsin-Madison**

We gratefully acknowledge the financial support of the
Helen Bader Foundation, Inc. &
The Lynde and Harry Bradley Foundation, Inc. &
Elizabeth C. Davies

Purpose, Presenters, and Publications

Family Impact Seminars have been well received in Washington, D.C., by federal policymakers, and Wisconsin is one of the first states to sponsor the seminars for state policymakers. Family Impact Seminars provide state-of-the-art research on current family issues for state legislators and their aides, Governor's Office staff, state agency representatives, educators, and service providers. Based on a growing realization that one of the best ways to help individuals is by strengthening their families, Family Impact Seminars analyze the consequences an issue, policy, or program may have for families.

The seminars provide objective nonpartisan information on current issues and do not lobby for particular policies. Seminar participants discuss policy options and identify common ground where it exists.

"Building Resiliency and Reducing Risk: What Youth Need from Families and Communities to Succeed" is the 10th seminar in a series designed to bring a family focus to policymaking. This seminar featured the following speakers:

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Each seminar is accompanied by an in-depth briefing report that summarizes the latest research on a topic and identifies policy options from across the political spectrum. Copies are available at Extension Publications, Room 245, 30 North Murray Street, Madison, WI 53715, (608) 262-3346.

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Executive Summary

Almost half of America's youth aged 10 to 17 are estimated to abuse alcohol and other substances, fail in school, commit crimes, or engage in early unprotected intercourse. Yet some youth who face many risks are remarkably resilient. They do well despite the odds. Karen Bogenschneider of the University of Wisconsin-Madison and Extension describes two promising models for preventing problems and promoting resiliency in youth.

The risk model suggests that human development is influenced by a myriad of risk factors that occur within individuals, families, peer groups, schools, and communities. We know that risk factors such as problems at home and negative peer pressure at school put a child in jeopardy. The more risk factors, the greater the danger. The protective model focuses on factors that help kids overcome even glaring disadvantages such as mental illness, parental neglect or abuse, poverty, or war. Positive influences such as good social skills or a close relationship can protect these youth from risk. To prevent youth problems and promote resiliency, Bogenschneider proposes a risk/protective model that focuses on both reducing risk factors and enhancing protective factors. Almost 30 scientifically substantiated risk and protective factors are summarized in the paper.

In recent years, we have learned that certain types of programs don't work: providing "information only"; relying on scare tactics; building self-esteem; teaching values clarification or decision making skills to children too young; and bringing together high-risk kids, which actually worsens behavior. Based on the risk/protective model, several implications are drawn for policymakers: focus on proven risk and protective processes, develop comprehensive approaches, involve parents for long-term success, invest in programs with evidence of effectiveness, intervene early and continuously, and build on supports that already exist within communities. Below is a description of three effective prevention programs that have incorporated concepts of a risk/protective model.

Tena St. Pierre of The Pennsylvania State University describes an evaluation of three similar community-based programs that operate through local Boys & Girls Clubs. The programs were targeted at high-risk, racially mixed youth, mostly aged 10 to 12, in neighborhoods with high crime rates and drug use. Many of the parents of these youth experienced high levels of stress in their lives; were socially isolated; had few friends; and had no phone, transportation, or job.

The first program, Prevention Only, offers a developmentally appropriate curriculum aimed at teaching youth social and personal competence skills, drug resistance strategies, and techniques for serving as positive role models. A second program, called Prevention Plus, incorporated the same curriculum and also

added monthly youth activities, such as holiday parties, cooking classes, and group outings. The third program, called FAN Club, similar to Prevention Plus, involved parents in such activities as regularly scheduled social activities, educational enrichment, support with daily life or crises, and leadership opportunities.

For the evaluation, youth who participated in each of these groups were compared with a control group that participated in regular Boys & Girls Club activities, but did not receive any additional treatment. Drug knowledge was significantly greater in all program groups than in the control group. Youth who participated in the FAN Club, which included parent involvement, reported an increased ability to refuse alcohol and marijuana, compared with the control group, which received no treatment. Thus, targeting only youth in drug prevention programs has a positive impact, but involving parents together with youth is even more effective. The parent involvement FAN Club is one of six drug prevention programs recommended by the Center for Substance Abuse Prevention.

The findings suggest that local community organizations such as Boys & Girls Clubs, 4-H, Scouts, YMCAs, and YWCAs hold promise for helping youth resist the pressures to use drugs. Their positive reputations, enticing youth activities, flexibility, and unthreatening atmosphere are thought to make these organizations ideal for programming with high-risk youth and families. For example, youth who were experiencing discipline problems at school were often well behaved and cooperative with staff in club activities. Parents did not feel threatened by these clubs as they did by such other community organizations as the housing authority; the welfare or juvenile-justice systems; or the schools, where interactions frequently were related to complaints about their children.

David Andrews of The Ohio State University describes the Adolescent Transitions Program (ATP), which has been featured by the National Institute of Drug Abuse as an effective program for preventing juvenile crime among high-risk youth and families. Sixth graders were taught how to self-regulate behavior, develop prosocial peers, set limits, and solve problems. Once a week for 12 weeks, parents practiced problem solving, communication, limit setting, supervision, and discipline. Researchers evaluated the effectiveness of the program for just parents, just teens, a combination of parents and teens, and a control group.

The parent-only training was effective in improving parent-child relationships, reducing aggressive behavior, and reducing teen smoking and marijuana use. Providing training for parents and teens showed no effects. Surprisingly, the teen-only group actually reported more smoking and worse school behavior than the control group. Apparently, bringing high-risk youth together reinforced problem behaviors. The parent focus was the best intervention strategy for producing positive outcomes.

Martha Farrell Erickson describes Project STEEP, recognized by both the Child Welfare League of America and the Centers for Disease Control for promoting healthy parent-infant relationships. Based on studies of resiliency, the single most

important factor accounting for good outcomes in children who face risks is a secure relationship with one caring supportive adult. During the participants' second trimester of pregnancy, the STEEP program begins both home visits and group sessions, which continue until the baby is a year old. Mothers are taught about infant development, basic child care, and how to be more sensitive to the baby's needs. Compared with nonparticipants, mothers who participated fully in STEEP had more appropriate play materials in their homes, were more responsive, and scored higher on the quality of the home environment. STEEP mothers also reported more social support and less depression than nonparticipants. Such findings demonstrate the effectiveness of prevention programs that begin early to improve parent-child relationships and provide social support for new parents.

A Checklist for Assessing the Impact of Policies on Families

The first step in developing family-friendly policies is to ask the right questions:

- What can government and community institutions do to enhance the family's capacity to help itself and others?
- What effect does (or will) this program (or proposed policy) have for families? Will it help or hurt, strengthen or weaken family life?

These questions sound simple, but they can be difficult to answer.

The Family Criteria (Ad Hoc) Task Force¹ developed a checklist to assess the intended and unintended consequences of policies and programs on family stability, family relationships, and family responsibilities. The checklist includes six basic principles about families that serve as the measure of how sensitive to and supportive of families policies and programs are. Each principle is accompanied by a series of family impact questions.

The criteria and questions are not rank ordered (Ooms & Preister, 1988). Sometimes these criteria conflict with each other, requiring trade-offs. Cost effectiveness also must be considered. Some questions are value-neutral. Others incorporate specific values. People may not always agree on these values, so sometimes the questions will require rephrasing. However, this tool reflects a broad, nonpartisan consensus, and it can be useful to people across the political spectrum.

Checklist: A Tool for Analysis

Check all that apply. Record the impact on family well-being.

1. **Family support and responsibilities.** Policies and programs should aim to support and supplement family functioning and provide substitute services only as a last resort.
 - ' How does the proposal (or existing program) support and supplement parents' and other family members' ability to carry out their responsibilities?
 - ' Does it provide incentives for other persons to take over family functioning when doing so may not be necessary?
 - ' What effects does it have on adult children's ties to their elderly parents?

¹Adapted from T. Ooms & S. Preister (Eds.) (1988). In *A strategy for strengthening families: Using family criteria in policymaking and program evaluation*. Washington, DC: Family Impact Seminar.

- ' To what extent does the policy or program enforce absent parents' obligations to provide financial support for their children?
 - ' Does the policy or program build on informal social support networks (such as community/neighborhood organizations, churches) that are so essential to families' daily lives?
2. **Family membership and stability.** Whenever possible, policies and programs should encourage and reinforce marital, parental, and family commitment and stability, especially when children are involved. Intervention in family membership and living arrangements is usually justified only to protect family members from serious harm or at the request of the family itself.
- ' What incentives or disincentives does the policy or program provide to marry, separate, or divorce?
 - ' What incentives or disincentives are provided to give birth to, foster, or adopt children?
 - ' What effects does it have on marital commitment or parental obligations?
 - ' How does the policy or program enhance or diminish parental competence?
 - ' What criteria are used to justify removal of a child or adult from the family?
 - ' What resources are allocated to help keep the family together when this is the appropriate goal?
 - ' How does the policy or program recognize that major changes in family relations such as divorce or adoption are processes that extend over time and require continuing support and attention?
3. **Family involvement and interdependence.** Policies and programs must recognize the interdependence of family relationships, the strength and persistence of family ties and obligations, and the wealth of resources that families can mobilize to help their members.
- ' To what extent does the policy or program recognize the influence of the family and family members upon individual needs or problems?
 - ' To what extent does it involve immediate and extended family members in working toward a solution?
 - ' To what extent does it acknowledge the power and persistence of family ties, especially when they are problematic or destructive?
 - ' How does it assess and balance the competing needs, rights, and interests of various members of a family? In these situations, what principles guide decisions (i.e., the best interests of the child)?

4. **Family partnership and empowerment.** Policies and programs must encourage individuals and their close family members to collaborate as partners with program professionals in delivery of services to an individual. In addition, parent and family representatives are an essential resource in policy development, program planning, and evaluation.
 - ' In what specific ways does the proposed or existing program provide full information and a range of choices to families?
 - ' In what ways do program professionals work in collaboration with the families of their clients, patients, or students?
 - ' In what ways does the policy or program involve parents and family representatives in policy and program development, implementation, and evaluation?
 - ' In what ways is the policy or program sensitive to the family's need to coordinate the multiple services they may require?
5. **Family diversity.** Families come in many forms and configurations, and policies and programs must take into account their different effects on different types of families. Policies and programs must acknowledge and value the diversity of family life and not discriminate against or penalize families solely for reasons of structure, roles, cultural values, or life stage.
 - ' How does the proposal or program affect various types of families?
 - ' If the proposed or existing program targets only certain families, for example, only employed parents or single parents, what is the justification? Does it discriminate against or penalize other types of families for insufficient reason?
 - ' How does it identify and respect the different values, attitudes, and behavior of families from various racial, ethnic, religious, cultural, and geographic backgrounds that are relevant to program effectiveness?
6. **Targeting vulnerable families.** Families in greatest economic and social need, as well as those determined to be most vulnerable to breakdown, should have first priority in government policies and programs.
 - ' Does the proposed or existing program identify and target publicly supported services for families in the most extreme economic or social need?
 - ' Does it give priority to families who are most vulnerable to breakdown and have the fewest supports?
 - ' Are efforts and resources targeted on preventing family problems before they become serious crises or chronic situations?

What Youth Need to Succeed: The Roots of Resiliency

Karen Bogenschneider

Adolescence is an age of promise, but also a time of risk (Lerner, 1995; McCord, 1990; Newcomb, Maddahian, & Bentler, 1986). Almost half of America's youth aged 10 to 17 are estimated to abuse alcohol and other substances, fail in school, commit crimes, or engage in early unprotected intercourse (Dryfoos, 1990a). Yet some youth who face many risks are remarkably resilient. They do well despite seemingly insurmountable odds. This paper describes two promising models for preventing problems and promoting resiliency in youth. Rather than focusing solely on either model, I propose a dual focus on reducing risk factors and enhancing protective factors. A summary of almost 30 scientifically substantiated risk and protective factors is followed by implications for developing effective prevention programs and policies.

In the last 20 to 30 years, we've tried a variety of approaches to preventing problem behaviors. As a result, our scientific knowledge of how to prevent youth problems has reached an all-time high. We have learned that certain types of programs don't work: providing "information only"; using scare tactics; building self-esteem (Dryfoos, 1990a; Higgins, 1988a); teaching values clarification or decision-making skills to children too young to grasp the concepts (Howard, 1988); and bringing together high-risk kids, which actually reinforced risky behaviors (Dishion, Andrews, Kavanagh, & Soberman, 1996). Two theoretical models that recently emerged, the risk-focused model and the protective-focused model, hold promise as the bases for programs and policies that build resiliency.

Two Promising Prevention Models

Risk-Focused Model

One of the most successful prevention models in the last 3 decades emerged from medical epidemiology, which investigates the causes of disease in populations (Hawkins, Catalano, & Miller, 1992). This model addresses factors that increase risk. For example, in heart disease these risks are a family history of heart disease, smoking, too little exercise, and too much dietary fat. Informing people about these risks and encouraging lifestyle changes actually reduced the incidence of heart disease.

This approach can also work in human development. One of the most important advances in the field of child development (Garbarino, 1994) is the recognition that human development, like heart disease, is influenced not by just one risk, but by multiple risks. Taking steps to reduce or eliminate these risks holds promise for preventing youth problems (Hawkins et al., 1992; Segal, 1983).

Protective-Focused Model

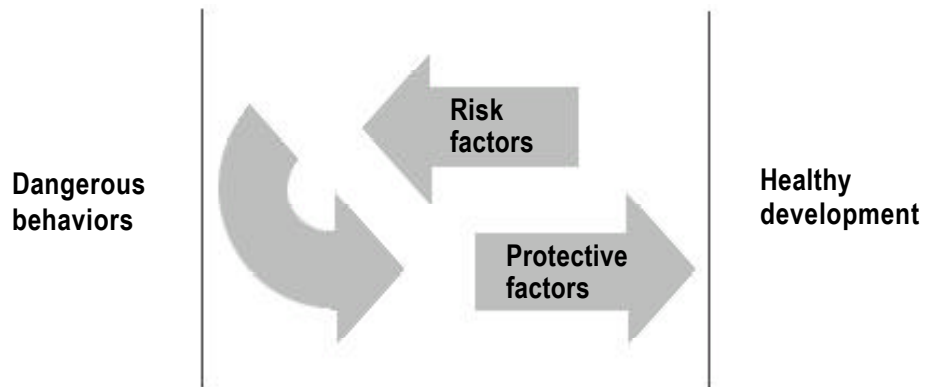
A second model emerged from studies of children who did well despite facing overwhelming odds in their lives such as mental illness, physical disabilities, parental neglect and abuse, parental alcoholism, poverty, or war. Researchers asked: What is right with these children? What protects them? (Garmezy, 1983; Rutter, 1979, 1983, 1987; Werner, 1990; Werner & Smith, 1982). Even with glaring disadvantages and the most adverse conditions, it was unusual for more than a third (Werner, 1992) to a half of children (Rutter, 1985) to display serious disabilities or disorders. These findings suggest that it is important to focus on the characteristics of the children and the circumstances that protect children and foster resiliency and competence.

Although it is tempting to choose one model over the other to guide prevention professionals and policymakers, I argue that both have some validity and neither alone fully captures the reality of the diverse youth population (Bogenschneider, 1996a). For building resiliency in youth, I propose a risk/protective model combining both approaches.

The Risk/Protective Model

The core of this risk/protective approach is simple. As illustrated in Figure 1, to prevent youth problems and promote resiliency, you must identify what factors increase the risk of the problem and then eliminate the factor or reduce its effects. Alternatively, you can identify factors that protect against problems and support or enhance those factors.

Figure 1. The Risk/Protective Model



Recently, some resiliency proponents have argued that the risk and protective models are incompatible and that the protective model is more valuable (Benard 1993; Johnson, 1993; Morse, 1993). Focusing only on protective factors to help youth negotiate a risky environment seems shortsighted if one does not simultaneously work to reduce the number of risks they face. Otherwise, it is like encouraging smokers to exercise without encouraging them to quit smoking

(Hawkins, Catalano, & Haggerty, 1993). I propose working on both risk and protective factors because reducing risk curtails the number of protective factors youth need, and bolstering protection enables youth to deal with more risks.

Risks are hazards in the individual or the environment that increase the likelihood of a problem occurring. The presence of a risk does not guarantee a negative developmental outcome, but it increases the odds of one occurring. Just as a high-fat diet doesn't guarantee a person will get heart disease, a single risk seldom places a child in jeopardy. Risks accumulate, like lead poisoning (Cowen, 1983). The more risk factors, the greater the danger.

Protective factors are safeguards in the individual or the environment that enhance youngsters' ability to resist problems and deal with life's stresses. The more protective factors, the more likely a young person will avoid hazards. In this paper, resiliency implies characteristics of individuals that enable them to overcome severe problems, whereas protective factors denote aspects of both individuals and their environments.

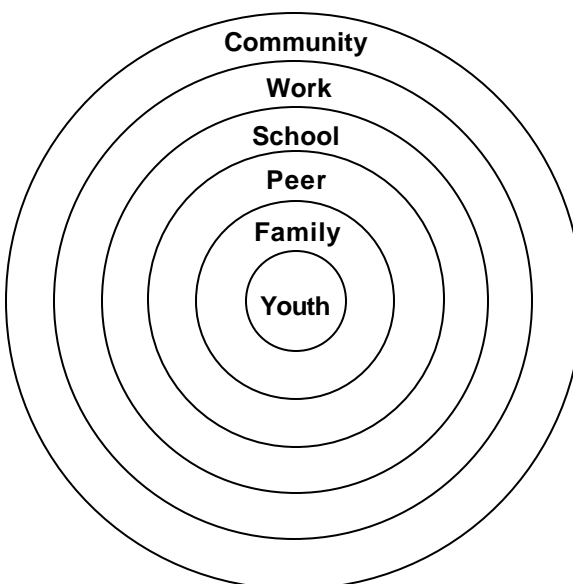
Risk and protective factors are not just opposite sides of the same coin, however. For example, if long work hours is a risk factor, short work hours is not necessarily a protective factor. Risk and protective factors emerge from different kinds of studies. Risk factors, for example, lead directly to a negative developmental outcome for most youth. Protective factors, however, emerge from studies of youth who succeed despite adverse conditions such as parental alcoholism, neglect, poverty, and war.

Thus, protective factors exert their benefits only when a risk is present (Rutter, 1987). That is, in families without discord a good relationship with at least one parent made little difference in predicting conduct problems. For children growing up in families with discord, however, a good relationship protected children; only one fourth of those who had a good relationship with one parent showed a conduct problem, compared with three fourths of children who lacked such a relationship (Rutter, 1983). Thus, processes that protect youth from risk under conditions of stressful life events do not necessarily predict better outcomes for children whose lives are relatively stress free (Rutter, 1987; Werner & Smith, 1982). In statistical terms, risk processes are main effects and protective processes are interactions (Garmezy, Masten, & Tellegen, 1984; Zimmerman & Arunkumar, 1994).

The rest of this article summarizes risk and protective factors related to the well-being of youth. They are reviewed beginning at the individual level and proceeding to the family, peer, school, work, and community settings (see Figure 2). These factors are illustrated with data from one of my studies of 1,200 adolescents and their parents in rural, suburban, and urban school districts in Wisconsin (Bogenschneider, Raffaelli, Wu, & Tsay, in press). At the end I draw some implications of this approach for developing effective prevention programs and policies.

Protective factors exert their benefits only when a risk is present.

Figure 2. Levels of Influence on Youth Development



Individual Risk Factors

Antisocial behavior. Boys who are aggressive at ages 5, 6, and 7 are more apt to abuse drugs and commit delinquent acts as teenagers (Hawkins, Lishner, & Catalano, 1987). About 40 of 100 kids who are aggressive in the early elementary grades go on to exhibit serious behavior problems in adolescence. As summarized in *Wisconsin Family Impact Seminar Briefing Report No. 4* (Bogenschneider, 1994a), seven programs for preventing early aggressiveness and juvenile crime have proven promising: parent management training, early childhood intervention and family support, functional family therapy, teaching problem-solving skills, social perspective-taking training, community-based programs, and broad-based intervention programs (Kazdin, 1987; Zigler, Taussig, & Black, 1992).

Alienation or rebelliousness. Kids who rebel or who feel alienated from their family, school, or community are more apt to abuse drugs and become depressed (Hawkins, Lishner, & Catalano, 1987).

Early involvement. The earlier experimentation begins, the less likely young people will have the maturity to avoid negative consequences. For example, the younger the age at which intercourse occurs, the less likely that contraception will be used (Higgins, 1988b). Similarly, when substance use begins before the age of 15, the risk of later drug dependency increases by 6 to 10 times (Robins & Przybeck, 1987).

Individual Protective Factors

Well-developed problem-solving skills and intellectual abilities. Resilient youth are not necessarily intellectually gifted, but they possess good problem-solving skills. These intellectual abilities help them control their impulses and concentrate, even when other parts of their lives are chaotic (Werner & Smith, 1982).

Self-esteem and personal responsibility. For kids who face many risks, the belief that one can impact one's own fate is a safeguard (Rutter, 1985, 1987). Self-esteem, however, protects youth in some cases, whereas in other cases it does not. No evidence exists that working on self-esteem alone will reduce risky behaviors.

Well-developed social and interpersonal skills. Resilient youth have personalities that attract and maintain supportive relationships (Werner, 1990). Teaching social skills, specifically teaching teens how to recognize and resist peer pressure to engage in risky behaviors, has proven effective in reducing early sexual activity, smoking, and marijuana use (Ellickson, 1997; Howard & McCabe, 1990).

Religious commitment. Regardless of denomination, faith equips youth with a sense of security, a belief that their lives have meaning, and confidence that things will work out despite hard times (Hawkins, Lishner, Jenson, & Catalano, 1987; Higgins, 1988a, 1988b; Werner, 1990).

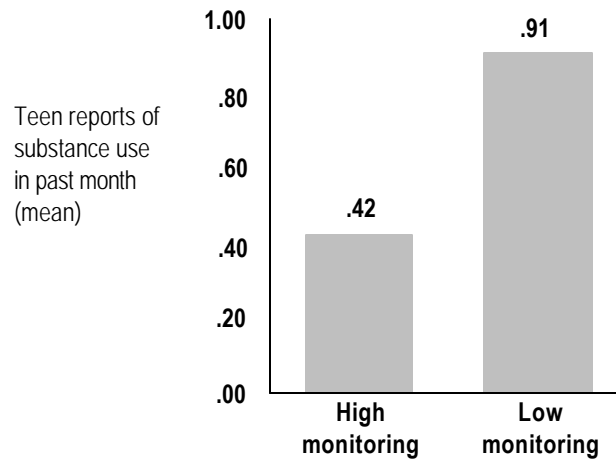
Family Risk Factors

Poor parental monitoring. Youth problems are more likely when parents fail to monitor or supervise their children (Lamborn, Mounts, Steinberg, & Dornbusch, 1991; Patterson & Stouthamer-Loeber, 1984). Knowing where children are, who they are with, and what they are doing is one of the most powerful means of avoiding virtually any risky behavior. Importantly, parent educators have been able to teach parents to more closely monitor their children's activities and whereabouts through parent education classes (Patterson, 1986) and through instructional newsletters for parents (Bogenschneider & Stone, 1997).

Parental monitoring is a potent influence on teen substance use and delinquent behaviors.

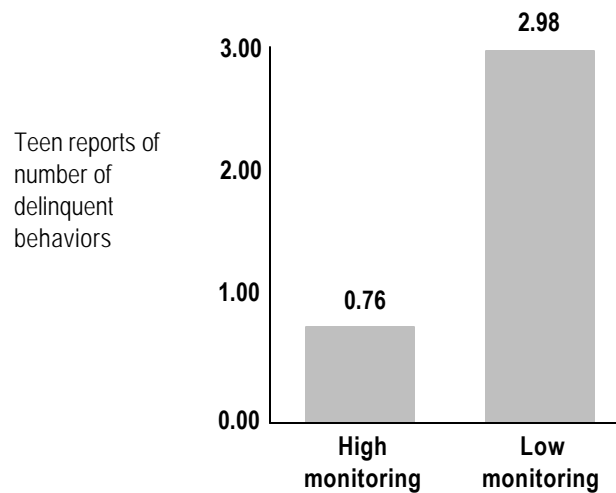
In my studies, parental monitoring is a potent influence on teen substance use and delinquent behaviors. As shown in Figure 3, teen use of substances such as tobacco, alcohol, and marijuana was over twice as high among teens who reported low monitoring by their fathers as among those who reported high monitoring. Similarly, in Figure 4, teens' reports of delinquent behaviors, including belonging to a gang; being suspended from school; and being involved in shoplifting, vandalism, or a physical fight, were almost four times higher among those who reported low levels of monitoring by their mother, compared with teens who reported high monitoring. In these analyses, as in those that follow, these effects are above and beyond any influences of parent education, family structure, and child gender.

Figure 3. Does Father's Monitoring Affect Teen Substance Use?



Note. $F(4,217) = 31.96, p = .00$. Analyses control for father's education, family structure, and child gender.

Figure 4. Does Mother's Monitoring Affect Delinquent Teen Behaviors?

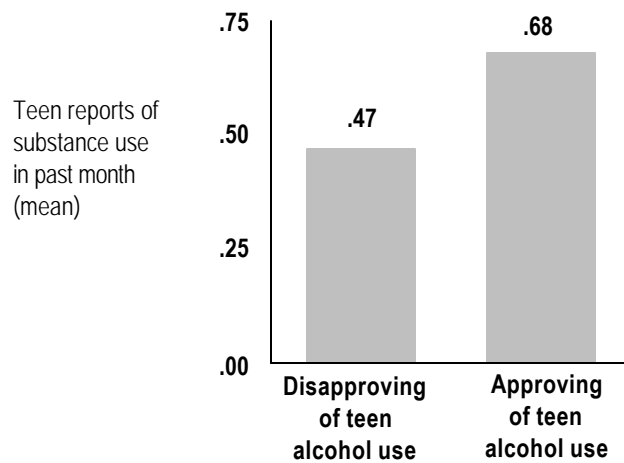


Note. $F(4,281) = 114.43, p = .00$. Analyses control for mother's education, family structure, and child gender.

Distant, uninvolved, and inconsistent parenting. An authoritative parenting style is associated with fewer youth problems than parenting that is too strict, too permissive, or uninvolved (Steinberg, 1991). Authoritative parents are warm and responsive, while still providing firm, consistent rules and standards for youth behavior. In the past two decades, home visiting has emerged as one of the most effective methods for promoting more competent parenting (Olds, Henderson, Chamberlain, & Tatelbaum, 1986; Riley, 1994). It has also proven effective in preventing child abuse, increasing child IQ, and establishing secure parent-child attachments.

Unclear family rules, expectations, and rewards. Problems are less likely when families communicate clear positions on issues such as drinking and sexual involvement, and establish consequences if rules are broken (Hawkins, 1989). With substances, for example, permissive parental values about teen alcohol use are a strong predictor of teen substance use, stronger even than parents' own alcohol use (Ary, Tildesley, Hops, Lichtenstein, & Andrews, n.d.; Barnes & Welte, 1986; Kandel & Andrews, 1987). As shown in Figure 5, substance use was significantly higher among teens with mothers who were the most approving of teen alcohol use, compared with those who were the most disapproving.

Figure 5. Do Mother's Values Regarding Teen Drinking Affect Teen Substance Use?



Note. $F(4,360) = 15.39, p = .00$. Analyses control for mother's education, family structure, and child gender.

Low parental involvement in school. Parents who are involved in their children's school activities, such as attending parent-teacher conferences, helping with homework when asked, and watching their children in sports or activities, have children who perform better academically, even children as old as high school students (Bogenschneider, 1997). When parents were uninvolved in such activities, children reported lower grades, a greater likelihood of dropping out of school, and poorer homework habits (Baker & Stevenson, 1986; Epstein, 1982, 1985; Rumberger, Ghatak, Poulos, Ritter, & Dornbusch, 1990). Parental involvement in schooling was a potent predictor of school success regardless of ethnicity, parent education, family structure, and parent or child gender (Bogenschneider, 1997). Moreover, parent educators have been able to teach parents of elementary and high school students to become more involved in the schooling of their children (Simich-Dudgeon, 1993; Smith, 1968).

Marital conflict. Marital conflict contributes to youth problems, specifically hostile behavior directed toward others (Crockenberg & Covey, 1991; Mann & MacKenzie, 1996). Marital conflict influences children primarily by interfering with competent parenting, even among children as old as adolescents (Davies & Cummings, 1994; Miller, Cowan, Cowan, Hetherington, & Clingempeel, 1993).

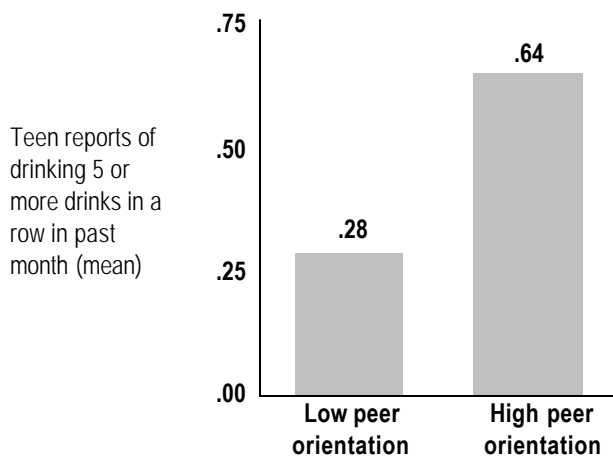
Family Protective Factors

A close relationship with one person. One good relationship can do much to offset the effects of bad relationships (Rutter, 1985). Among high risk families, this close relationship often occurs with a grandparent or other relative, but it can also be a teacher or neighbor who takes a special interest in the child (Werner, 1990).

Peer Risk Factors

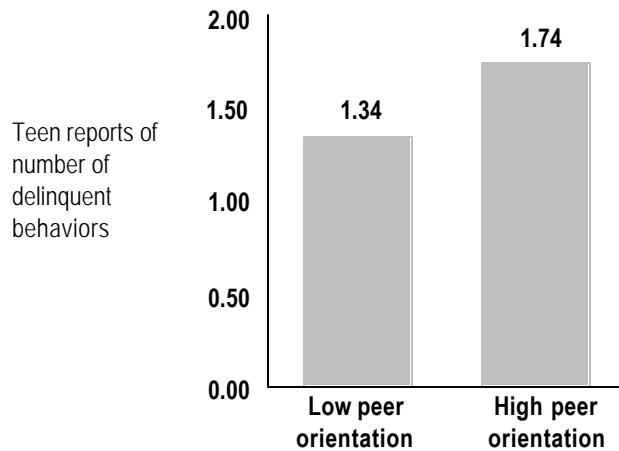
Association with peers who engage in problem behaviors. Hanging around with deviant peers increases the odds that youth will get involved in risky behaviors (Barnes, Farrell, & Banerjee, 1994; Newcomb & Bentler, 1989; Small & Luster, 1994). With teen substance use, for example, peer influence is estimated to be four times more important than parental influence (Kandel & Andrews, 1987). Among teens who reported a high orientation to peers, the average frequency of getting drunk (five or more drinks in a row) in the past month was over twice as high as the average for those who reported low orientation to peers (Figure 6). In Figure 7, teens who reported a high orientation to peers committed nearly one third more delinquent acts than teens who were less oriented to peers.

Figure 6. Does Peer Orientation Affect Whether Teens Get Drunk?



Note. $F(4,285) = 8.89, p = .00$. Analyses control for mother's education, family structure, and child gender.

Figure 7. Does Peer Orientation Affect Delinquent Teen Behaviors?



Note. $F(4,281) = 13.51, p = .02$. Analyses control for father's education, family structure, and child gender.

Parents, however, still remain an important influence and can restrain their children's peer orientation by being responsive in such ways as expressing love or praise, being available when needed, and engaging in give-and-take discussions (Bogenschneider, Raffaelli, Wu, & Tsay, 1997).

Peer Protective Factors

A close friend. Kids who have one close friend are more likely to adapt to stressful situations successfully (Werner, 1990).

School Risk Factors

School transitions. If you wanted to invent a social institution to mess up kids, you couldn't invent anything better than a junior high school (Price, 1989). Compared with students who make only one school transition from eighth grade to high school, students in school systems with middle schools or junior highs must make two transitions. And these transitions occur just as they are experiencing a whole host of changes in their physical appearance, thinking, and social relationships. When students move into a middle school or a junior high, alcohol and drug abuse are more apt to increase, while academic achievement, extracurricular participation, and psychological well-being are more apt to decline (Carnegie Council, 1989; Simmons, 1987; Steinberg, 1991). Younger students are more likely to be affected, as are borderline students, those who lose friends during the move, or those who begin dating at this time (Simmons, 1987; Simmons, Blyth, Van Cleave, & Busch, 1979; Simmons, Burgeson, Carlton-Ford & Blyth, 1987).

Academic failure. Failing in school increases the risk of youth problems, just as youth problems increase the risk of school failure (Brooks-Gunn & Furstenberg,

1989; Hawkins, 1989; Hawkins, Lishner, & Catalano, 1987). For example, youth who fail in Grades 4, 5, and 6 are more apt to abuse alcohol in high school (Hawkins, 1989; Hawkins, Lishner, & Catalano, 1987).

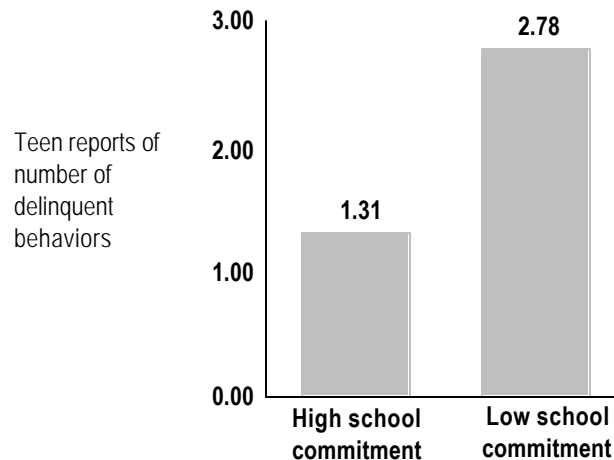
Low commitment to school. Students who hate school, who see little value in education, and attend only so they can smoke cigarettes or hang out with their friends are at higher risk for problems (Hawkins, 1989).

Large high schools. According to Garbarino (1994), if he could do only one thing for American teenagers, he would ensure that no child attends a high school larger than 500. Large high schools produce more alienation, more antisocial behavior, and higher dropout rates. In small high schools, extracurricular participation is twice that in large schools, and borderline students feel a sense of involvement and obligation equal to that of better students (Barker & Gump, 1964).

School Protective Factors

Positive school experiences. Positive school experiences are not limited to academic achievement; school success can occur in art, music, or sports (Rutter, 1987; Werner, 1990). A special relationship with a teacher or the opportunity to take positions of responsibility can also be beneficial. In Figure 8, students who reported a high commitment to school reported less than half as many delinquent behaviors as students who reported a low commitment to school.

Figure 8. Does School Commitment Affect Delinquent Teen Behaviors?



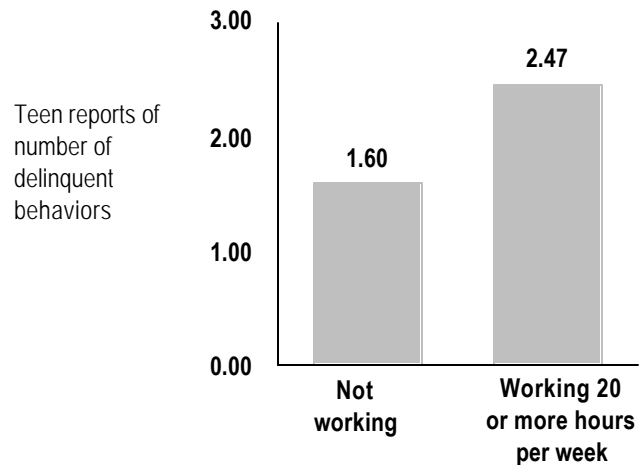
Note. $F(4,135) = 11.66, p = .00$. Analyses control for mother's education, family structure, and child gender.

Work Setting Risk Factors

Long work hours. Among inner city populations, adolescents who work are no more likely to engage in delinquent behaviors than nonworkers. In other samples,

however, high school freshman and sophomores who work more than 15 hours weekly are at higher risk for alcohol and drug use, delinquency, and school failure; for juniors and seniors, working more than 20 hours a week is problematic (Steinberg, 1991). As shown in Figure 9, teens who worked 20 or more hours per week reported significantly more delinquent behaviors than those who did not work.

Figure 9. Do Long Work Hours Affect Delinquent Teen Behaviors?



Note. $F(4,88) = 5.16, p = .03$. Analyses control for mother's education, family structure, and child gender.

Work Setting Protective Factors

Required helpfulness. Work benefits youth if their work makes an important contribution to the family; for example, if children are needed to bring in extra income or help manage the home, work provides a meaningful role for youth (Werner, 1990).

Community Risk Factors

Low socioeconomic status. Risk factors occur in bunches; being poor increases the number of risk factors and magnifies their damage (Hawkins, Lishner, Jenson, et al., 1987; Werner & Smith, 1982).

Complacent or permissive community laws and norms. Policies that are unwritten, unclear, or unenforced increase youth involvement in risky behaviors. Teens are more apt to drink, for example, when adults drink and the community doesn't mind if teens drink (Baumrind, 1987). Clear community messages, like higher taxes on liquor, decrease the rate of alcohol use among both light and heavy users (Hawkins, 1989; Higgins, 1988a). Raising the drinking age from 18 to 21 reduces alcohol use, but is less effective among heavy users.

Low neighborhood attachment and high mobility. Youth problems are more likely when neighbors don't know each other; parents have few opportunities to talk with one another; and no community standards exist regarding curfews, drinking, and dating (Hawkins, 1989).

Media influences. The link between television viewing and aggression in children is firmly established (Eron, 1982; Huesmann, Lagerspetz, & Eron, 1984). The connection between TV viewing and either drinking or sexual activity is not as clear-cut; yet alcohol manufacturers target an estimated \$2 billion of advertising annually toward youth.

Community Protective Factors

Belonging to a supportive community. Resilient youth rely on a greater number of people such as neighbors, teachers, and clergy than youth who do not cope as well (Garmezy, 1983; Werner, 1990; Werner & Smith, 1982). Mothers are also warmer and more stable when there are more adults around to help. For example, social isolation is one of the best predictors of a child-abusing family (Werner & Smith, 1982).

Bonding to family, school, and other social institutions. Youngsters who feel emotional ties to their family, school, or community are more apt to accept values and behaviors society deems desirable (Hawkins, Lishner, & Catalano, 1987). To build these ties, kids need opportunities for involvement, the skills to be successful, and rewards for their accomplishments (Hawkins, 1989).

Cumulative Risk

In one study of 10-year-old children, the presence of one risk factor wasn't much more likely to be associated with psychiatric disorder than when no risk factors were present; with two risk factors, there was four times the chance of problem behaviors, and with four risk factors, the risk increased as much as 20 times (Rutter, 1979). In my study, I examined whether the number of risks (e.g., low parental monitoring, negative peer pressure, and academic failure) affected teen substance use and delinquent behaviors. In Figures 10 and 11, as the number of risks increases so does the likelihood that the teen will use substances or commit delinquent acts.

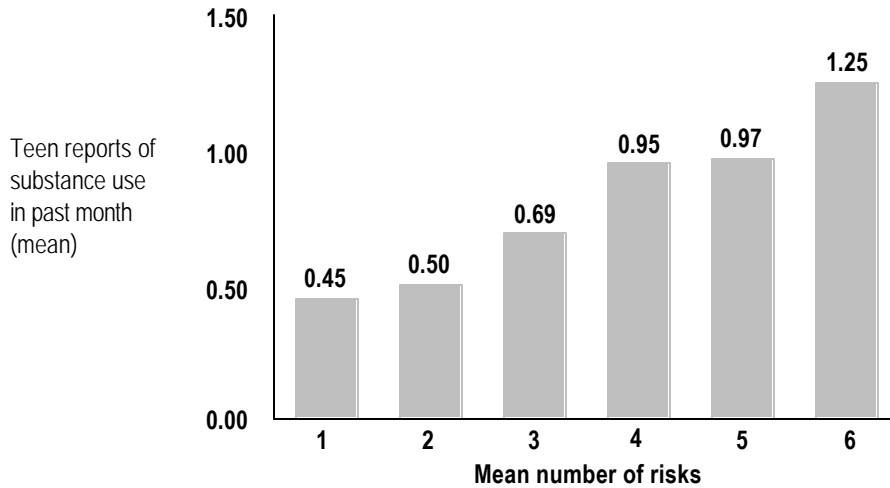
A limitation of this approach is that not all risk or protective factors are equally important. Some factors may be more important for one child than another, in one period of development than another, and in one setting than another. Moreover, some risk factors are more important for some youth problems than others. For example, harsh and inconsistent parenting is a risk factor for violent juvenile crime, but not for nonviolent juvenile crime.

The bottom line is that if we are serious about supporting youth, we need to address as many of these risk and protective factors as possible. As illustrated in Figure 12, if a community decides to address alcohol use and abuse, they may need a multidimensional approach. Parent education may be needed, schools can

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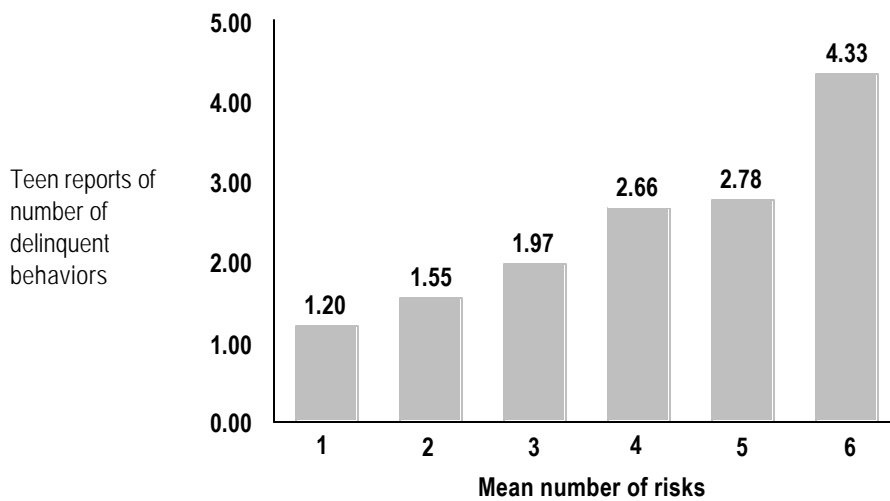
be reorganized, programs can teach refusal skills, and so forth. Model programs exist to address many of these risk and protective factors.

Figure 10. Do the Number of Risks Affect Teen Substance Use?



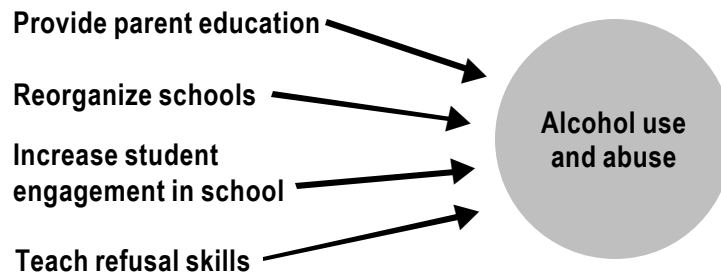
Note. $F(9,634) = 11.44, p = .00$. Analyses control for mother's education, family structure, and child gender.

Figure 11. Do the Number of Risks Affect Delinquent Teen Behaviors?



Note. $F(9,622) = 9.09, p = .00$. Analyses control for mother's education, family structure, and child gender.

Figure 12. A Multidimensional Risk/Protective Focus



Operationalizing the Risk/Protective Model

This model was used as the basis for forming 22 community coalitions of parents, educators, community leaders, and youth in Wisconsin, ranging from a small agricultural community of less than 700 people to a 12-block inner-city neighborhood in Milwaukee (see Bogenschneider, 1996a). These coalitions were successful in developing comprehensive plans to prevent risky behaviors such as alcohol use, depression, and violence. They have reduced risk and strengthened protective factors through such comprehensive prevention strategies as providing parent education and family support; establishing parent networks and parent-teacher associations; developing consistent, clear laws and norms regarding youth involvement in risky behaviors; and providing meaningful roles to bond youth to the community. At last count, over 30 local policies had been changed, including reducing the number of liquor licenses, stiffening the penalties for selling alcohol to minors, increasing the penalties for underage drinking, and reducing the supply of alcohol. To date, we know that we were successful in reducing documented risks and bolstering proven protective processes. A scientific evaluation of the success of reducing adolescent drinking in two communities is underway (Bogenschneider, Olson, Small, Boelter, & Vizenor, 1998).

Implications for Policymakers

According to the risk/protective model, youth are more apt to make a successful transition into adulthood when they are supported by a loving family, close friends, good schools, and caring communities. In this final section, I turn to implications of the risk/protective approach for developing prevention programs and policies.

1. Focus on proven risk and protective processes. Despite little evidence that improving self-esteem reduces problem behaviors, “Selling self-esteem to children has become big business” (Dryfoos, 1991, p. 633). Policymakers and prevention programmers could benefit from a number of papers reviewing risk and protective factors in the areas of academic achievement (Higgins & Mueller, 1988;

Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987), child abuse (Belsky, 1990), depression (Bogenschneider, 1993a; Harn, 1991; Petersen, Compas, Brooks-Gunn, Stemmler, Ey, & Grant, 1993), drug and alcohol abuse (Bogenschneider 1993b; Hawkins et al., 1992), juvenile delinquency (Bogenschneider, 1994b; Hawkins, Lishner, Jenson, et al., 1987), suicide (Alcohol, Drug Abuse, and Mental Health Administration, 1989), and teenage pregnancy (Higgins, 1988b; Bogenschneider, 1996b; Small & Luster, 1994).

2. Develop comprehensive approaches. Like most diseases, risky behaviors in youth cannot be cured with one treatment (Dishion et al., 1996). Most problem behaviors have not one cause, but many. All too often, we look for “magic bullets,” quick solutions to complex problems, which result in piecemeal, Band-Aid approaches. Youth problems are much too complex and the solutions much too comprehensive for any single policy or program. The best approach may vary by personality, age, and context. For example, in a disadvantaged inner-city neighborhood, the best approach may be to focus on protective factors to instill a sense of hope into a seemingly desperate situation. In a rural community or a middle-class suburb, the best approach may be one that jars complacency and overcomes denial by emphasizing the risks that even youth living behind white picket fences may face.

3. Involve parents for long-term success. In a longitudinal study that followed children from birth to age 32, the parenting that children received was a stronger predictor of their long-term outcomes than even the biological complications they may have faced during pregnancy, delivery, and the early years of life (Werner, 1992). Mounting evidence suggests that parent education and family support improves parenting competence (Patterson, 1986; Powell, 1986; Wandersman, 1987; Weiss, 1988), which, in turn, is thought to benefit children (Bronfenbrenner, 1986; Zigler & Styfco, 1993). Changes in parenting practices continue to benefit children long after the formal program ends.

4. Invest in programs with evidence of effectiveness. Avoid Band-Aid solutions and the latest trendy approaches. Only good programs produce good results (Zigler & Styfco, 1993). We know what doesn't work—providing information only, using scare tactics, building self-esteem, teaching values clarification or decision-making skills to children who are too young, and bringing together only high-risk youth. This paper notes some of the prevention strategies that we know work, such as teaching parents specific parenting practices and ways to become involved in their children's schooling, and teaching youth social perspective-taking and refusal skills. We also know some methods that work, such as home visiting, parent education classes, instructional newsletters, and broad-based community approaches.

5. Intervene early and continuously. There are no magical periods of development (Zigler & Styfco, 1993). Programs provided early, however, hold the greatest promise (Reid, 1993; Yoshikawa, 1994). For example, Patterson's parent education program reduced early child aggressiveness with a success rate of 63% for children aged 3½ to 6 and only 27% with children 6½ to 12 (Patterson, Dishion, & Chamberlain, 1993). Prevention efforts that begin before school entry can fo-

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cus more exclusively on parenting; after school entry more comprehensive strategies are needed to also target academic failure and problems with peers. Thus, for maximum effectiveness, programs need to begin early, preferably before problem behaviors develop, and they need to continue to ensure that healthy behaviors, once begun, are sustained (Dryfoos, 1990b). Expecting any short-term program to keep kids out of trouble is unrealistic. Programs that offer “boosters” through high school produce longer-lasting effects than one-time lessons (Ellickson, 1997).

6. Build on the supports that already exist in the community. Policies need to take steps to foster, not replace or weaken, naturally occurring sources of support for parents in the extended family, neighborhood, and community. If parents are unavailable, other persons can play a supportive role: grandparents, older siblings, caring neighbors, ministers, Big Brothers and Big Sisters, and youth workers in 4-H or YMCA/YWCA (Werner, 1992). Policies can create formal structures to encourage people to develop and rely on their own sources of social support, which in the future will render the formal programs obsolete (Bronfenbrenner & Weiss, 1983).

7. Remember the lesson of resiliency—the odds can be changed. From studies of parent education, we know that human beings possess the capacity for more competent parenting if given reliable information on how to do so and that social policies and programs can help parents become more competent. From studies of children who succeed against the odds springs the message of hope (Werner, 1992). Some things work, “if not for every vulnerable child, at least for many; if not all the time, at least some of the time; if not everywhere, at least in some places” (Werner, 1992, p. 112).

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This article is based on the following:

Bogenschneider, K. (1996). An ecological risk/protective theory for building prevention programs, policies, and community capacity to support youth. *Family Relations*, 45(2), 127-138.

Bogenschneider, K., Small, S., & Riley, D. (1990). *An ecological, risk-focused approach for addressing youth-at-risk issues* (Wisconsin Youth Futures Technical Report No. 1). Madison WI: University of Wisconsin-Madison/Extension.

Copies of either are available by calling Meg Wall-Wild at (608) 262-8121.

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Involving Parents of High-Risk Youth in Drug Prevention

Tena St. Pierre

Adolescent drug use, particularly of marijuana, has doubled in the United States since 1991, and cigarette smoking has gone up by nearly a half. Alcohol consumption remains steady with half of all high school seniors, almost 40% of 10th graders, and more than a quarter of 8th graders reporting some use within the past 30 days (Johnston, O'Malley, & Bachman, 1996).

This dramatic upsurge in use calls for renewed focus on prevention, particularly on strategies that build on experience, theory, and prior research. Over the last 30 years, prevention efforts have evolved from unsuccessful information programs to comprehensive strategies that target multiple early risk factors.

The family environment, in particular, has a powerful influence on adolescents' potential drug use. Given this, prevention researchers strongly advocate interventions that go beyond a focus only on the youth (Johnson & Solis, 1983; Lorion, 1988; Pentz et al., 1989; Perry, 1986; Tobler, 1986) and involve parents in drug prevention programs (DeMarsh & Kumpfer, 1986; Hawkins, Catalano, & Miller, 1992). Our research, reported in this paper, seems to confirm this, showing that parents' participation in prevention programs contributed significantly to positive results for their children.

In addition, prevention programs must be appropriate to youths' developmental stages and must continue over several years. This ensures that programming meets their needs as they grow through adolescence and encounter influences that increase their risk for trying various drugs and activities (Battjes & Bell, 1995; Connell, Turner, & Mason, 1985).

This article describes research supporting the significance of the family in helping prevent youth drug use. It discusses youth drug prevention programs and an accompanying parent program offered at Boys & Girls Clubs of America, and reviews strategies used to involve the parents. It also reports evaluation results and describes implications for policymakers.

Family Influence: Research and Past Programs

Research on how families influence adolescents' drug use has identified these risk factors:

- Poor bonding between children and parents (Brook, Brook, Gordon, Whiteman, & Cohen, 1990)
- Low parental involvement in activities with children (Kandel & Andrews, 1987)

- Maternal isolation (Werner & Smith, 1982)
- Poor family management practices (Coombs & Landsverk, 1988)
- Family history and parental approval of drug use (Hawkins, 1988)

As a result, prevention researchers strongly advocate involving parents in youth programs aimed at preventing drug use (DeMarsh & Kumpfer, 1986; Hawkins et al., 1992). However, it is extremely challenging to identify and effectively implement prevention programs appropriate for high-risk families. Many general family life skills programs exist as well as some directed toward preventing youth drug use.

Most of these programs, however, were designed for middle-class White parents. Most follow structured curricula in weekly sessions. The lectures, discussions, role-playing, and homework they use are not appropriate for high-risk families (Alvy, 1988; DeMarsh & Kumpfer, 1986).

Furthermore, there are few published evaluations of parent programs designed specifically to prevent or reduce drug use by high-risk youth (DeMarsh & Kumpfer, 1986), probably because attracting and retaining parents among low-income populations is very difficult (Chilman, 1973; Halpern, 1990). Poverty, poor housing, and unemployment—everyday stresses in these families’ environments—make it difficult to recruit and retain parents (Chilman, 1973). The typically small participation by low-income parents is well documented (Cohen & Rice, 1995; DeMarsh & Kumpfer, 1986; Miller & Prinz, 1990). And attempting to involve them takes continuous labor-intensive efforts, which are difficult for program staff to sustain over time (Ruch-Ross, 1992). Researchers also shy away from such programs because it is tremendously difficult to evaluate them using scientifically accurate methods (Van Hasselt et al., 1993).

Poverty, poor housing, and unemployment make it difficult to recruit and retain parents.

SMART Programs and FAN Clubs: A 3-Year Study

The researchers designed a 3-year study of youth drug prevention programs in Boys & Girls Clubs. There were 16 clubs from eight states in the East, South, and Midwest. Four Boys & Girls Clubs participated in each of the following groups in the study:

- Youth prevention program, monthly youth activities, and parent involvement (Family Advocacy Network or FAN group)
- Same youth prevention program and youth activities without parent involvement (Prevention Plus group)
- Same youth prevention program without youth activities (Prevention Only group)
- No program (Control group)

The Boys & Girls Clubs that participated were located in “severely distressed neighborhoods.” A neighborhood was considered severely distressed if it met at least four of five indicators (Annie E. Casey Foundation, 1994). Average percent-

ages on four indicators for the census tracts where the study clubs were located were

- incomes below poverty level above 27.5% (study groups 34%),
- public assistance recipients above 17% (study groups 20%),
- female-headed households above 39.6% (study groups 43%), and
- high school dropouts above 23.3% (study groups 48%).

The clubs were also located in high-risk neighborhoods with high crime rates and prevalent drug sales and use. Fifty-eight percent of youth participants reported that “many” or “most” people in their neighborhoods were using illegal drugs, and 61% had seen illegal drugs sold there. Seventy-eight percent said they had been offered illegal drugs, half of them “three or more times.” Sixty percent said it would be easy to get marijuana, and 49% said it would be easy to get other illegal drugs.

Three hundred youth, mostly aged 10–12, participated in all seven testing occasions over the 36-month study. Participants were racially mixed and about two thirds male (see Table 1).

Table 1: Age, Race/Ethnicity, and Gender by Condition

	FAN		P+		PO		C	
	N	%	N	%	N	%	N	%
Age								
10	17	17.7	2	3.1	2	2.4	8	14.3
11	41	42.7	30	46.9	49	58.3	21	37.5
12	36	37.5	30	46.9	32	38.1	24	42.9
13	1	1.0	1	1.6	1	1.2	3	5.4
*	1	1.0	1	1.6				
Race/ethnicity								
Caucasian	21	21.9	26	40.6	16	19.0	21	37.5
Hispanic	19	19.8	0	0.0	21	25.0	2	3.5
Black	52	54.2	36	56.3	45	53.6	28	50.0
Black Hispanic/Other	4	4.2	2	3.1	2	2.4	5	8.9
Gender								
Female	34	35.4	22	34.4	28	33.3	23	41.1
Male	62	64.6	42	65.6	56	66.7	33	58.9

Note: FAN = Family Advocacy Network Club group; P+ = Prevention + Youth Activities group; PO = Prevention Only group; C = Control group.

*Respondents did not provide their age.

Youth Programs

The youth programs offered over 3 years were Start SMART, Stay SMART, and SMART Leaders. They are sequential and developmentally appropriate. All three focus primarily on peer and other social influences on youth to use drugs, and on developing skills to resist those pressures. (See Table 2 for session titles.)

Table 2: Program Sessions in Start SMART, Stay SMART, and SMART Leaders

Start SMART	Stay SMART	SMART Leaders
1. Here We Are . . . All Together	1. Gateway Drugs	1. Orientation to the SMART Leaders Program
2. Consequences	2. Decision-Making	2. Improving Self-Image
3. Puberty	3. Advertising	3. Coping with Stress
4. Friendship	4. Self-Image and Self-Improvement	4. Resisting Media Pressures
5. Ways of Saying "No"	5. Coping with Change	5. Being Assertive in Pressure Situations
6. Say It Like You Mean It	6. Coping with Stress	
7. Everyone Is Not Doing It	7. Communication Skills	
8. Media Manipulation	8. Social Skills: Meeting and Greeting (A)	
9. Creating Commercials	9. Social Skills: Boy Meets Girl (B)	
10. Making SMART Moves	10. Assertiveness	
	11. Relationships	
	12. Life Planning Skills	

Start SMART was adapted by Boys & Girls Clubs from Project SMART (Johnson et al., 1996). Stay SMART was adapted from the Botvin (1983) Life Skills Training program. Both programs teach social and personal competence skills; help youth identify and resist peer and other social pressures to use alcohol, cigarettes, and marijuana; and help youth resist pressures to engage in early sexual activity. Boys & Girls Clubs added sessions on friendship and puberty to Start SMART and topics designed to prevent early sexual activity to the Stay SMART program.

SMART Leaders (St. Pierre & Kaltreider, 1988), developed during a previous study with Boys & Girls Clubs, was given to graduates of the first two programs. It encourages participants to be positive role models and influence peers to resist pressures to use alcohol, tobacco, and other drugs, and to resist early sexual activity. It was designed to reinforce skills learned in Start and Stay SMART programs, to meet youths' developmental needs as they grew older, and to create an overall club environment with drug-free norms.

When no structured prevention programs were taking place, youth participated in monthly activities. These were designed to stress norms of nondrug use and to keep the youth involved in the prevention program. Activities included rap sessions (talking together), holiday parties, crafts, cooking classes, computer games, ice skating, and other group outings.

Youth Outcomes

The 10- to 12-year-old youth participants in the SMART programs completed a questionnaire seven times in 36 months, including a pretest and six posttests. The self-reports measured 12 areas: social skills, knowledge, alcohol, marijuana, and cigarette attitudes; ability to refuse alcohol, marijuana, and cigarettes; and alcohol, cigarette, chewing tobacco, and marijuana behavior. For the refusal questions, responses were on 5-point scales from 1 = *very easy to refuse* through 5 = *very hard to refuse* and 1 = *I'm sure I'd refuse* through 5 = *I'm sure I'd accept*.

Parent participation greatly contributed to positive results for youth.

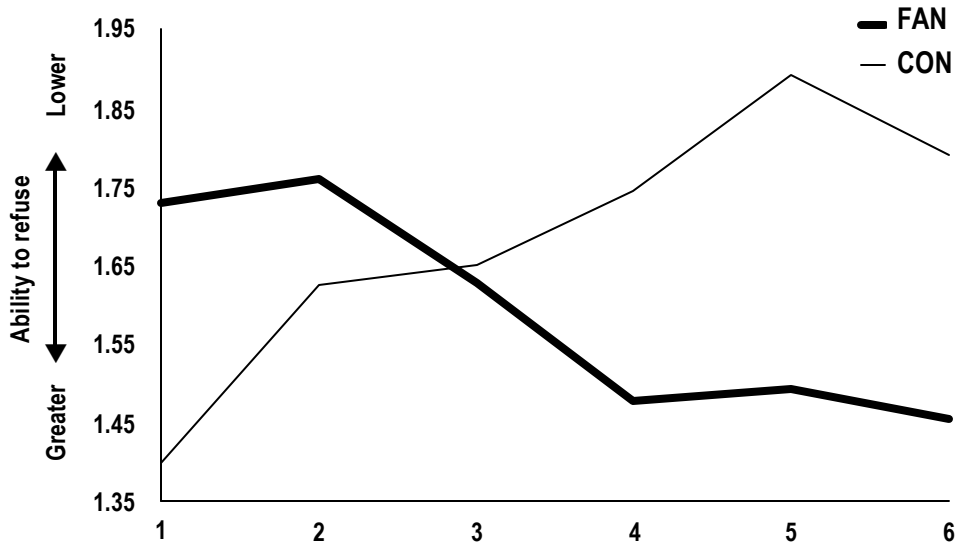
There were significant positive results for youth in the parent involvement FAN Club group for alcohol refusal; marijuana refusal; marijuana attitudes (the social benefits of using it); and knowledge of the health consequences and prevalence of alcohol, tobacco, and other drug use. Specifically, FAN Club youth, over time, reported an increased ability to refuse alcohol. In contrast, the control group showed a significant decrease (see Figure 1). Youth in the Fan Club group also showed a slight but significant increase in reported ability to refuse marijuana, whereas the other three groups showed a decrease (see Figure 2).

FAN Club group youth, over time, did not significantly increase their perceptions of the social benefits (attitudes) of using marijuana, whereas control group youth did increase their perceptions significantly. The other two groups also did not significantly increase their perceptions of the social benefits of using marijuana.

Thus, targeting only youth in drug prevention programs has a positive impact, but involving parents together with youth is even more effective. We believe that parent participation greatly contributed to positive results for youth and that the strategies used to recruit and retain the parents were integral to that success.

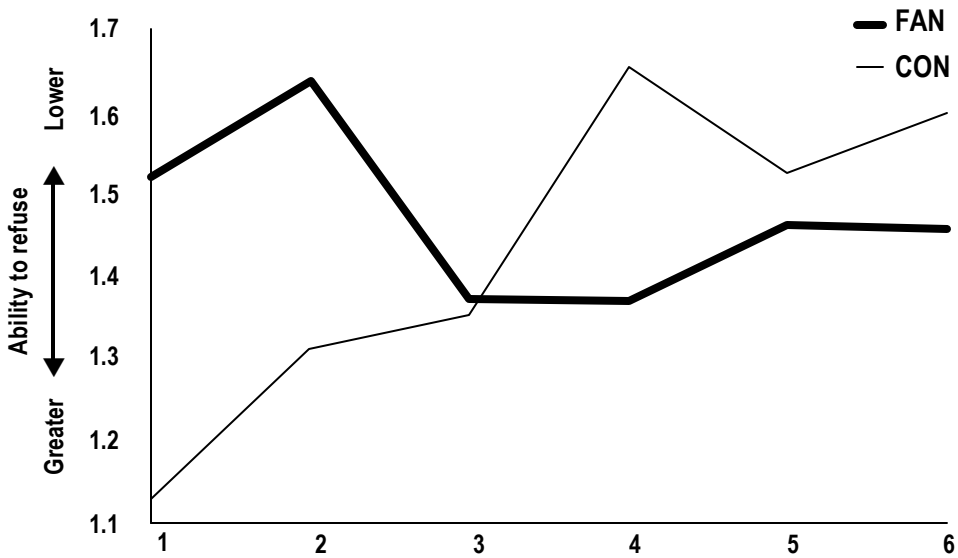
Drug knowledge was significantly greater in all the program groups than in the control group. Also, the control group showed a fairly steady, though not significant, decrease in ability to refuse cigarettes over time, whereas the other three groups did not show any significant patterns of change. There were no significant differences among the groups on any of the other scales.

Figure 1: Mean Alcohol Refusal by Club and Time, Adjusted for Baseline Differences



Note: FAN = Family Advocacy Network Club group; CON = Control group.

Figure 2: Mean Marijuana Refusal by Club and Time, Adjusted for Baseline Differences



Note: FAN = Family Advocacy Network Club group; CON = Control group.

The Parent Involvement Program

The parent involvement program or FAN Club was designed to strengthen high-risk families. The goals included creating a bond between program youth and their parents, reducing maternal isolation, providing opportunities for families to participate in pleasurable activities together, assisting parents to influence their children to lead drug-free lives, and providing social and instrumental support. Based on the family support-resource model (Weissbourd & Kagan, 1989), the FAN Club was designed to

- focus on families' strengths rather than deficits,
- inspire parental confidence and competence,
- respond to family cultural preferences and values,
- take a developmental view of parents,
- be flexible and responsive to parental needs,
- encourage voluntary participation by parents, and
- include parents as partners in planning and implementing the program.

Offering a developmental continuum of activities allowed parents to participate at their level of readiness. The flexible program let families participate according to their needs and wants. The program was geared to meet the needs of the parents, many of whom experienced high levels of stress in their lives with little support. Many were socially isolated, had few friends, no phone, no transportation, and no job.

The program was geared to meet the needs of the parents, many of whom experienced high levels of stress in their lives.

The program was conducted by a full-time coordinator who also offered the youth prevention programs and a part-time parent assistant from the target population. These staff provided structure for activities, reminded and often persuaded parents to attend, and provided transportation when necessary. The FAN Club offered four broad categories of activities.

Basic Support Activities helped families cope with daily life or with particular crises. It was offered one-to-one by the coordinator, who made routine home visits. Types of activities included going along to appointments with social services agencies, helping parents deal with their children's schools, supporting parents with a family member involved in the criminal justice system, linking parents in crises with helping networks and shelters, transporting them to medical or court appointments, and visiting them in the hospital.

Parent Support Activities were regularly scheduled social activities selected by parents and participated in as a group, including potluck dinners, attending one another's churches, bingo, picnics, crafts projects, pool parties, meeting for coffee, ice cream socials, movies, bowling, and skating.

Educational Program Activities, also selected by FAN Club parents, were designed to provide education, knowledge, or enrichment. Examples include speakers to discuss parenting; culturally appropriate events; AIDS programs; gang prevention workshops; health fairs; and Keep SMART, the Boys & Girls Clubs parent drug prevention program.

Leadership Activities were those where parent volunteers did most of the planning and implementation. These included planning monthly meetings, fundraising, volunteering in Boys & Girls Clubs programs, visiting local nursing homes, and attending prevention program graduations.

On average, there were 24 activities offered in the first program year (6 months), 64 in Year 2, and 62 in Year 3 (both 9 months). Participation varied by club, by family, and by particular life events and stresses in individual families. Parent Support Activities drew the highest numbers. About half the parents attended one to four activities each year, whereas the remainder attended five or more. The means were 5.5 in Year 1, 10.1 in Year 2 and 8.6 in Year 3. Counting one parent per youth, 44% participated in at least one activity on average per month and 54% participated every other month. Summers, when parents decided to plan minimal activities, are not included.

Recruiting and maintaining parental involvement with high-risk populations is a fragile process that relies on the personal skills of staff.

Results and Limitations

Results for the youth prevention program with parent involvement are promising. In addition to finding positive results for youths' ability to refuse alcohol and marijuana, decreased perceptions of the social benefits of using marijuana, and greater drug knowledge, we learned a great deal about recruiting and maintaining parental involvement with high-risk populations. It is a fragile process that relies on the personal skills of staff and takes considerable time and effort.

It is not clear how and why the parent component contributed to the program's positive effects for parents' early adolescent children. Tests were not administered to parents because in this population giving a questionnaire could easily have driven them away. The FAN Club may have decreased risk factors for youth drug use by engaging youth and parents in activities together, by reducing maternal isolation, or by providing support. Alternatively, perhaps youth and families benefited from the full-time coordinator, who may have developed stronger bonds with program youth than did staff in the other two program groups.

The retention rate of 59.5% over the 3-year study may call into question its validity. However, compared with shorter school-based programs with possibly inflated results (Hansen, Tobler, & Graham, 1990), attrition rates for this study may not be excessive.

Finally, the effects did not extend to behavior, despite positive effects on refusal, attitudes, and knowledge. This is not an uncommon pattern in the literature (Dryfoos, 1990); however, it is unlikely that behavior changes would be significant in a sample this young because so few are actually using substances.

Strategies for Involving Parents

We found it is possible to involve many parents by using specific strategies. We identified six general groups of successful strategies.

Identify the Right Person to Lead the Program

Finding a program leader with specific inherent (rather than learned) characteristics was the most important strategy. Because empowering and strengthening families was a major goal, the FAN Club coordinator had to be a positive person who could remain optimistic and hopeful under very challenging circumstances. Coordinators needed to be not into power or control, confident but not aloof, and focused on families' strengths rather than deficits. They also needed to be highly creative, energetic, and enthusiastic.

It was helpful for FAN Club coordinators to be of the same culture/ethnicity as the populations they served, which is consistent with the literature (Cunningham, 1991). It was also very helpful to know the community and have a proven track record with community organizations and services. This let coordinators quickly link families to appropriate social service agencies and helping networks.

Identifying and recruiting individuals with these characteristics was not easy, especially given the low salaries paid by youth organizations and the need to work weekends and evenings.

Clearly Convey the Purpose of the Program

Although families in the study were extremely high risk and led stressful daily lives, they cared about the well-being of their children and did not want them to use drugs. The purposes of the FAN Club and the youth SMART programs were personally important to most parents. Therefore, coordinators regularly emphasized the program's goals and reminded parents that their children's attendance at sessions was important. This helped motivate parents to participate.

Build Relationships of Mutual Trust, Respect, and Equality

This was essential. In addition to making phone calls and home visits, coordinators also attended PTA meetings, local churches, and tenant association meetings. To reinforce parent involvement in the FAN Club events, coordinators called the next day to thank parents for coming and ask how they enjoyed the evening. They thanked them for contributing a good idea or told them how much the group enjoyed the dish they brought. With each contact made with respect and sincerity, trust gradually grew between coordinators and parents. For parents who didn't attend events, coordinators dropped by their homes to personally say they were missed and to remind them of the next activity.

Although families in the study were extremely high risk, they cared about the well-being of their children and did not want them to use drugs.

Create Parent Ownership and Group Bonding

Coordinators helped create a friendly informal atmosphere with refreshments and fun and encouraged parents to select activities they wanted. Over time, coordinators took less and less of the lead in organizing activities and parents took more of the lead. As each activity took place—ranging from parents’ selecting a parent education topic to more ambitious activities such as a community Black History program—numbers of parents involved went up, parent ownership of the program increased, and attachment and bonding among parents grew.

Provide Easy Access, Incentives, and Reminders

There were many logistical barriers that had to be removed before families could participate in the program. Most families did not own cars and had several small children. Coordinators, therefore, routinely provided transportation and child care for events. Sometimes FAN Club activities were taken to parents’ homes. All four FAN Club coordinators conducted the Keep SMART parent drug prevention program in the homes of some families who were reluctant to come to sessions at the Boys & Girls Club. Because of this personal interaction, some parents became comfortable enough to attend a FAN Club activity. Offering a variety of activities on different nights or afternoons of the week also increased access.

Food was the most popular of the many incentives tried. All FAN Club activities included refreshments selected by the parents. Some coordinators took parents out to dinner after an event to recognize their hard work in conducting it.

Reminders were always necessary, regardless of how well established the FAN Club became. Parents were typically telephoned both the day before and the day of the activity. Where there was no phone, the coordinator made a home visit. Postcards, personal invitations, and newsletters were also used.

A monthly calendar of activities was particularly effective. The coordinator distributed an attractive calendar to all families each month. It marked the dates of parent and family activities. Delivering the calendars also gave coordinators another reason to drop by the families’ homes.

Be Flexible but Persistent (Within Reason)

Coordinators learned early that many activities did not materialize as planned. It was important for them not to take low attendance personally and not to hold a grudge against parents who promised to show up but didn’t. Regardless of how much skill and persistence the coordinators demonstrated, some families never became involved.

As each activity took place, numbers of parents involved went up, parent ownership of the program increased, and attachment and bonding among parents grew.

Policy Implications

This study shows that organizations that serve youth, such as Boys & Girls Clubs, can also help reach high-risk parents. The clubs in this study had good community reputations as safe places where young people participated in constructive activities. Parents did not feel threatened and intimidated by these clubs as they did by such other community organizations as the housing authority; social welfare; the juvenile-justice system; or even the schools, where interactions frequently were related to complaints about their children. Too often, low-income parents were treated with disrespect in their communities, making them feel incompetent and powerless.

The clubs were often able to reach youth who had not bonded with school.

Youths' existing involvement in the club provided an ideal opportunity to reach out to parents in a positive, respectful way that laid the foundation for developing a trusting relationship over time. Participants in the parent involvement program were treated with dignity and equality, involving them as peers in developing and conducting program activities. This positive approach empowers parents and strengthens families, helping parents be more effective and nurturing in their parenting.

The Boys & Girls Clubs in our study could provide the flexibility required to reach high-risk families. Not limited by agency policies and school bureaucracies, clubs were able to tailor programs to individual needs and wants of families, including such things as family activities, social support for parents, parenting programs, and crisis intervention. They related to parents as peers, often visiting parents on their own turf (their homes) rather than communicating across an agency desk. They also provided aid and encouragement so that parents could develop the confidence and competence that enabled them to help themselves.

Having their children involved in the Boys & Girls Club was a major drawing card for attracting parents to the parent involvement program. Like many other youth organizations, Boys & Girls Clubs provided a safe, comfortable environment with recreational, social, and educational activities for youth who might otherwise be engaging in negative activities in their often unsafe and crime-ridden neighborhoods. Youth were attracted to Boys & Girls Clubs by these activities. At the same time, they benefited from the positive adult role models who staffed the club and who engaged them in the drug prevention program.

The clubs were often able to reach youth who had not bonded with school. Youth who were experiencing discipline problems at school or were frequently truant often were well behaved and cooperative with staff in the club environment. This made them more receptive to anti-drug-use messages. Male staff frequently served as surrogate fathers. They provided desperately needed positive adult role models and mentors for the many young males living in households headed by their mothers or grandmothers and whose fathers were incarcerated or in drug treatment facilities. Furthermore, the flexibility inherent in programming provided

by the Boys & Girls Clubs helped the staff tailor programs to the needs of individual youth, often engaging those not reached by school drug prevention efforts.

The Boys & Girls Clubs in our study extended the length of prevention program sessions when interest warranted; rescheduled sessions when attendance, competing activities, or poor behavior occurred; and provided makeup sessions in creative formats like club sleepovers. This programming flexibility helped ensure maximum exposure to the program sessions for all participants, a goal sometimes difficult to achieve in the school setting.

Implementing the FAN Club required support from the entire Boys & Girls Club organization. Gaining this support was challenging at times. Given their long-standing mission to serve youth, some staff found it difficult to accept an expanded mission to serve their parents. Most staff had little experience working with parents, and some blamed youths' parents for their children's problems. However, by the 2nd and 3rd years of the program, staff began to see some benefits from parent involvement. For example, when club members in the FAN Club project became disruptive, the coordinator helped staff understand that the youths' families were experiencing problems. Knowing this, staff could understand and be supportive rather than punitive. Staff also were positively impressed with parent involvement when parents volunteered to help around the club. Parents managed and served the entire summer lunch program at one site. This freed staff to focus on other club responsibilities.

Features inherent in Boys & Girls Clubs and other youth organizations such as Scouts, YMCAs, YWCAs, and 4-H Clubs make them especially valuable for involving high-risk, low-income youth and their parents in drug prevention programs. Positive reputations, enticing youth activities, flexibility, and unthreatening atmospheres make these organizations ideal for programming with high-risk parents to strengthen their families and to help these highly vulnerable youth resist the multiple pressures around them to become drug users.

Admittedly, implementing a parent involvement program like the Family Advocacy Network is demanding. However, given the growing increases in youth drug use and the family risk factors existing for high-risk disadvantaged youth, youth organizations may want to rethink their priorities. This study's results indicate that parent involvement and youth drug prevention together show promise for helping youth refuse alcohol, marijuana, and cigarettes.

Finally, although these research findings indicate that interventions targeting the family and youth domains are more effective than those targeting only youth, there were positive effects for the 3-year youth prevention program alone, compared with the control group. This should not be ignored. Given the financial constraints facing most youth organizations, it offers an alternative that holds promise for helping high-risk youth remain drug-free.

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Positive reputations, enticing youth activities, flexibility, and unthreatening atmospheres make Boys & Girls Clubs and other youth organizations ideal for programming with high-risk parents.

This article is based on the following:

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Preventing Delinquency Through Effective Parent Training and Adult Support

David W. Andrews

Problem behavior in children is not a disease that can be cured with one treatment. It depends on the situation, changing with the child's circumstances and development (Dishion, French, & Patterson, 1995). A variety of treatments and preventions are needed to meet the needs of individual children and families throughout childhood.

This article discusses research on prevention programs for adolescent problem behavior such as drug use, delinquency, or risky sexual behavior. It describes the Adolescent Transitions Program (ATP), a program for high-risk youth and their parents. Offered and evaluated in both a community and a school setting, it showed that interventions with families produced somewhat improved youth behavior. However, there was an unexpected negative effect of grouping high-risk youth. The article concludes with implications and suggestions for improving intervention programs.

The Variables: Adolescence, Early Antisocial Behavior, Parenting, and Deviant Peer Groups

There are good reasons to offer preventive interventions in early adolescence, ages 10 to 13, before problem behaviors begin or worsen. Problem behaviors increase dramatically during this stage of development, and that is true among youth in all industrialized nations (Gottfredson & Hirschi, 1994). Just because such problems are statistically "normal," however, doesn't mean they will fade away if left alone.

Adolescence

Youth who are delinquent in middle adolescence, ages 14 to 17, have more risk of problems as young adults (Stattin & Magnusson, 1991; West & Farrington, 1977), and adolescent substance use is a unique risk factor for drug and alcohol problems in young adulthood (Robins & Przybeck, 1985). Decades of research have identified antisocial behaviors like lying, stealing, noncompliance, and aggression as forerunners to adolescent problems. Youth who first show antisocial behavior in adolescence are likely to respond to prevention strategies such as community service, mentoring, and structured participation in youth organizations (Dryfoos, 1991).

Parenting

A substantial body of research shows poor parenting practices intensify antisocial behavior in children and adolescents (Dishion et al., 1995). As shown in Figure 1, violent behavior is rooted in harsh and inconsistent parenting during the preschool years (Patterson, 1986). Poor parenting leads to early aggressiveness. Early ag-

gressiveness branches out to trouble with teachers, rejection by peers, and poor school performance. Negative consequences snowball; poorly monitored by their parents, these youngsters drift into deviant peer groups (Dishion et al., 1991), which increases their odds of substance use and early police arrest (Dishion et al., 1995). Over time, these youth lack the skills to find stable work or marriages that might enable them to drop out of crime.

As the primary socializers of youth, parents can be very effective in modifying antisocial and inappropriate behavior. An evaluation of more than 500 family intervention programs by Kumpfer (1994) found no single program or approach to be most effective. In general, effective programs helped improve communication, problem solving, and family management (limit setting, consistent and proactive discipline, and supervision). Effective programs were also likely to be

- comprehensive,
- focused on multiple family members,
- long term,
- intensively focused on risk factors,
- developmentally appropriate,
- tailored to a selected audience,
- initiated as early in the child's life as possible, and
- delivered by well-trained individuals.

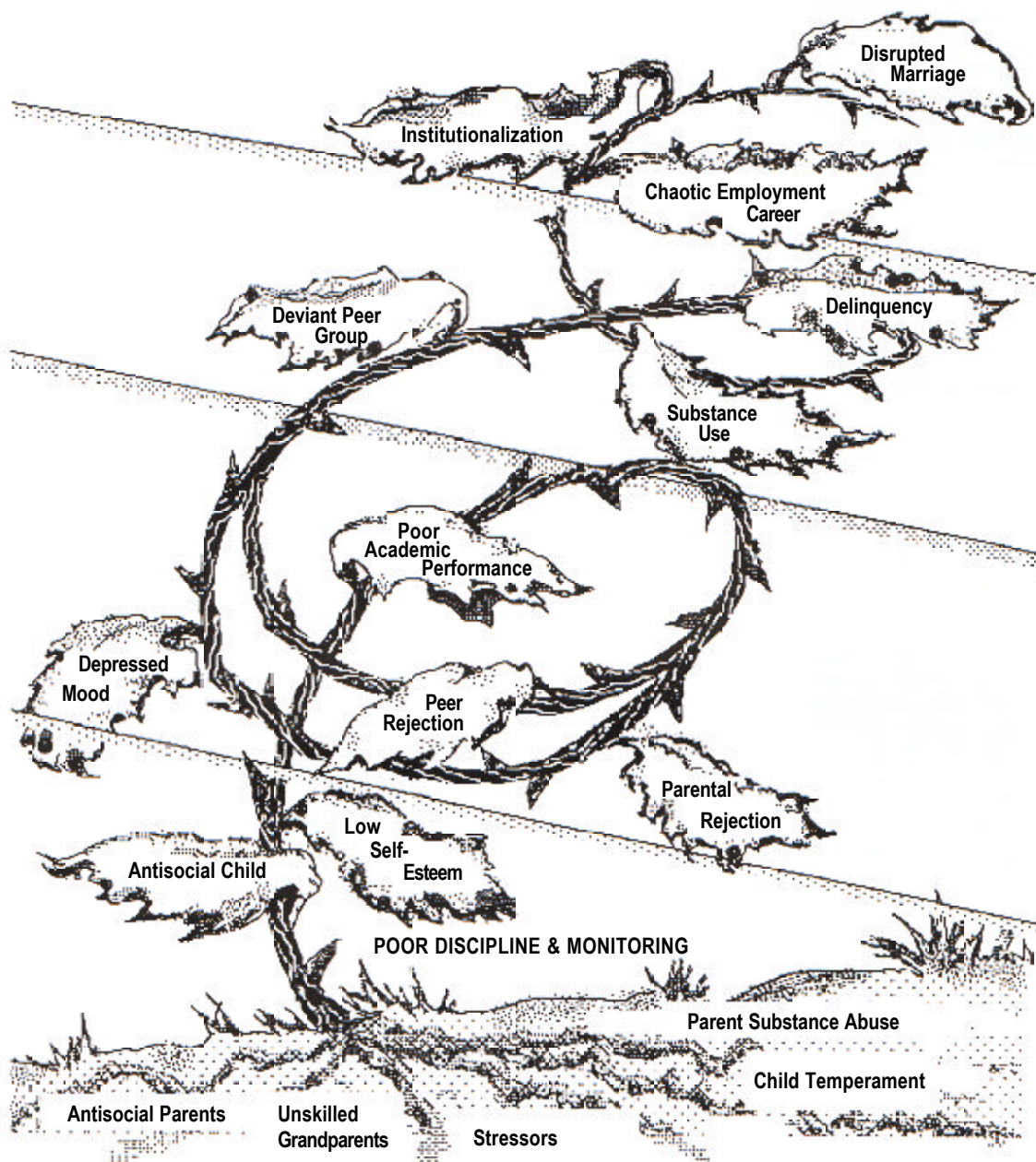
Two noteworthy programs have been particularly successful. The Strengthening Families Program (Kumpfer, DeMarsh, & Child, 1989) was designed to reduce antisocial behavior in families. The 14-session parent training program teaches parents to set goals and reinforce behaviors consistent with these goals, to improve communication, and to solve problems more effectively. Parents and children practice problem solving and communication skills in play situations, and there is a skill-building program for children. Research by Kumpfer and colleagues (1996) showed that the full program was most effective but that parent training alone effectively improved parenting skills and reduced problem behavior in children. The Adolescent Transitions Project described later in this article was effective in producing less negativity in families, fewer negative interactions among family members, and less antisocial and problematic behavior in the teens of participating parents (Dishion, Andrews, Kavanagh, & Soberman, 1995).

Early aggressiveness branches out to trouble with teachers, rejection by peers, and poor school performance.

Community and School Contexts

Antisocial behavior, parenting, and peer groups do not operate in a vacuum. They are highly affected by community contexts (Patterson, Reid, & Dishion, 1992). This suggests that effective intervention programs must also address the people and organizations surrounding the youth (Dishion et al., 1995).

Figure 1. The Vile Weed: How Violent Behavior Is Rooted in Early Childhood



Note. From *A Social Learning Approach, Volume 4: Antisocial Boys*, by G. R. Patterson, J. B. Reid, & T. J. Dishion, 1992, Eugene, OR: Castalia. Adapted with permission.

Unsupervised time not monitored by parents has been clearly associated with antisocial and delinquent behavior.

School is a major element in the youth's life (Kellam, 1990). It is a convenient meeting place and training ground for deviant peer groups (Dishion, Patterson, & Griesler, 1994). School-parent communications are key to helping parents monitor their children, set limits, and support academic progress (Reid, 1993). And, with most youth attending school through middle school, it is a good site for intervention (Trickett & Berman, 1989).

One school-based program, Fast Track, is state of the art in identifying high-risk children in school and delivering interventions to them, their parents, and peers (Conduct Problems Prevention Research Group, 1992). It successfully reduces antisocial and problematic behavior in first- and second-grade children (Bierman & Greenberg, 1996), helping them develop more appropriate social participation, prosocial behaviors, and social problem solving.

Other successful programs address both the antisocial and aggressive behavior and the misperceptions and faulty reasoning that often accompany it (Kendall & Lochman, 1994). For older youth, the Coping Power Program (Lochman & Wells, 1996) addresses anger management, emphasizing goal setting, awareness of feelings, taking the perspective of others, and social problem solving. The Life Skills Training Program for adolescents (Botvin & Tortu, 1988) focuses primarily on drug use, but the self-management and social skills it offers effectively help reduce antisocial behavior.

Interventions can also target the school's strategy for communicating with parents. When parents regularly receive specific, neutral information on attendance, homework, and class behavior, they are much better able to monitor and support their children's engagement with school (Heller & Fantuzzo, 1993).

Community activities also buffer against problem behavior. Adolescents spend about 42% of their time in discretionary activities (Timmer, Eccles, & O'Brien, 1985), much of it unsupervised. Unsupervised discretionary time not monitored by parents has been clearly associated with antisocial and delinquent behavior (Dishion et al., 1991). Unsupervised adolescents are also more likely to engage in early sexual intercourse and drug use, and are more susceptible to negative peer pressure. The majority of these activities take place between 3:00 p.m. and 7:00 p.m.

The literature on youth organizations suggests that youth who participate are at less risk than those who do not. However, nearly 29% of youth in the United States (approximately 5.5 million young adolescents) either do not have access to these programs or choose not to take advantage of them.

Communities with organized supervised activities have youth at lower risk than communities without such resources. Communities are best equipped to deliver prevention programs that are accessible and available to all youth. However, despite attempts to be inclusive, they have been only sporadically successful in reaching higher risk audiences (Carnegie Council, 1992).

Unsuccessful Youth Programs

Numerous other programs have been used directly with children and youth. The majority have not been evaluated systematically for effectiveness or have been found disappointing.

Programs using scare tactics have not reduced inappropriate behavior. These are programs like Scared Straight, in which hardened criminals lecture to young delinquents, and AIDS prevention programs designed to frighten youth into safer sexual behavior. In fact, gathering high-risk youth together for such interventions may glamorize inappropriate activity to the point that participants eagerly adopt it (Dishion & Andrews, 1995; Dryfoos, 1991).

Some prevention programs for substance abuse, like DARE and Just Say No, are popular and politically enticing, but prevention studies have repeatedly shown them to be largely ineffective (Dryfoos, 1991).

Peer-based prevention strategies should be used with caution. Older teens teaching refusal skills to younger teens has proven successful, yet there is little evidence that peer tutoring and peer counseling among same-age peers are effective in helping high-risk youth reduce their problematic behaviors.

Self-esteem programs designed to make young people “feel good about themselves” are trendy. However, low self-esteem, no matter how it is measured, has not emerged as a predictor of high-risk behavior. Thus, programs that report they have raised participants’ self-esteem levels are not likely to be addressing underlying problems (Dryfoos, 1991).

Adolescent Transitions Program

The Adolescent Transitions Program offers training for parents and youth, peer consultants, and family consultation sessions. Once a week for 12 weeks, small groups of parents gather to learn and practice techniques for problem solving, communication, limit setting, supervision, and discipline. The training is step by step and based on developing skills. The parent curriculum parallels the youth program, and exercises frequently involve parent-child activities. Six 10-minute videotapes demonstrate relevant skills and practices (Dishion et al., 1995).

Programs for youth are designed to help them learn to self-regulate problem behavior. The program teaches at-risk adolescents to set realistic behavior change goals, develop appropriate small steps toward their attainment, develop and provide peer support for prosocial and abstinent behavior, set limits, and learn problem-solving skills. Goal setting is the first step, and the goal selected is negotiated with the parents and adolescents. Sessions address the adolescents’ self-interest as much as possible.

Gathering high-risk youth together for interventions using scare tactics may glamorize inappropriate activity so that participants eagerly adopt it.

Peer consultants for both parents and teens are a key feature of ATP. The consultants typically have completed the program or are experienced in successfully negotiating the problem behaviors. Consultants model appropriate parenting or self-regulation skills, offer support for successes, and suggest coping strategies for difficult situations.

Four consultations help fine-tune skills with each family. The sessions let families discuss their strengths and talk about what barriers keep them from implementing the new skills.

Evaluation of ATP in Community-Based Study

The research began with a community-based study of the four ATP components as compared with a control group. There were separate groups focused on just parents, just teens, parents and teens combined, and a self-directed study group. The control group participated in no programs. In a second phase, the ATP program was implemented in a school setting.

The researchers hypothesized that joint parent-teen programs would be most effective and that the school-based implementation would be more effective than the community-based one.

Using newspaper ads, school postings, and counseling services, the researchers recruited 158 high-risk families for the community-based study: 119 assigned to one of the four groups and 39 as controls. Parents first were interviewed by phone about the presence of 10 areas of early adolescent risk. Those reporting 4 or more as current concerns were accepted. The interview uses risk-factor research by Bry and colleagues (Bry, McKeon, & Pandina, 1982).

Study families were randomly assigned to one of four components: parent focus, teen focus, parent and teen focus, and self-directed materials only. Group sessions were generally well attended. Parents attended an average of 69% of the sessions; youth attended an average of 71% of the sessions. Retention was also high (90%); 143 of the original 158 families participated in the evaluation. These families generally liked the program, were engaged, and were learning. This is important for the prevention effort to be effective.

How parents and youth interact while discussing and solving a problem is an important measure of the success of an intervention like ATP. Participants were filmed in a 25-minute problem-solving task, and their behavior was coded. Negative interactions declined significantly for those in the parent-focus-only and teen-focus-only groups, compared with those in the self-directed and control groups. Interestingly, in contrast to our hypothesis that working with the youth and parents together would produce better results, the combined parent-teen group showed the same reduction in negative interactions as the single-focus groups.

Youth problem behaviors at school were improved at the end of the program only for the parent-focus group as compared with the control group. However, one year later the teen-focus groups were actually smoking more and exhibiting

How parents and youths interact while discussing and solving a problem is an important measure of the success of an intervention like ATP.

worse problem behavior at school than the control group. Analysis showed that the smoking behavior was directly affected by participation in the teen-focus group. There was a modest but significant beneficial effect on smoking and marijuana use for youth whose parents received the parent-focus program, compared with the control group. No such effect occurred for the combined parent-teen group.

In summary, parent focus is the best intervention strategy for producing positive outcomes and minimizing the unintended negative effects of grouping high-risk youth together. Bringing high-risk youth together in groups can actually worsen substance use and problem behavior at school. Teens participating in the combined program showed neither an increase nor a decrease in problem behavior, suggesting that the two conditions were working against one another.

Parent focus is the best intervention strategy for producing positive outcomes and minimizing the unintended negative effects of grouping high-risk youth together.

Evaluation of ATP in School-Based Program

The ATP program was implemented for sixth graders in four middle schools located in neighborhoods with high rates of juvenile arrests. Teacher ratings, which have consistently proven accurate in other studies, helped identify families to involve in the study. The study compared 63 families randomly assigned to the school-based implementation of ATP and a community-based implementation. All families received both the teen-focus and parent-focus interventions because the study was planned before the negative results of teen grouping were known.

Recruitment

To counter the anticipated problem of getting parents involved, the researchers designed a very successful parent-driven recruitment system. A letter from the school principal to families of at-risk students used neutral language with phrases such as the following:

“As you know, the teenage years involve changes and challenges to both parents and teens.”

“I am pleased that this program is available to families in our community and believe that it will help your child be more successful at home and in school.”

“Your family will benefit from this free program.”

“Because of limited resources, only some families can be offered ATP this year.”

“Your family’s full involvement in the 12-week program will help prevent substance abuse, problem behavior, and emotional turmoil in your teenage son or daughter.”

More than 50% of the participating families volunteered within a week of receiving the letter. The remaining families were telephoned and invited to review the program during a home visit. At these visits the program was described in detail, and youth and parent concerns were addressed.

School Liaisons and Behavioral Consultants

Two liaisons from each school, selected from volunteers by the principal, proved to be a valuable link between participants and the school. In addition to helping with details of space allocation, information gathering, and teacher communication, liaisons met weekly with students, for whom they became advocates. They also attended parent groups, reporting weekly on each student's academic and social behavior in school. Behavioral consultants, ultimately used for only three or four students during the study, helped teachers develop behavior change plans for students.

Integrating High-Risk and Low-Risk Youth

After the first 12 weeks of the program, students in the program were mixed with low-risk youth to create a video project on substance use and other pressures facing middle school students and families. Goals were to produce a video with an "antiproblem behavior" message, to integrate high-risk youth into prosocial groups and activities, to reinforce skills taught in the 12-week sessions, and to inform students of the risks of substance use and other problem behaviors.

Conclusion

The hypothesis that implementing ATP through schools would be superior to doing so through the community was not supported by a majority of the data. There was no reliable difference between the two.

Summary and Future Directions

Parent training and involvement in schools and communities were once again supported as effective strategies to improve behavior and slow increases in drug use. The basic components of ATP's parent and teen focus effectively engaged students and their parents and improved parent-child relations. The parent-focus curriculum had a short-term effect on reducing aggressive and delinquent behaviors in young teens.

The teen-focus curriculum improved parent-child relations but did not influence problem behavior in the short term. Further, we need to look closely at any effort to bring high-risk youth together because problem behavior escalated after they participated in these groups.

The school implementation of ATP demonstrates the need to alter the school environment to

- further increase parent involvement and home-school communications, and
- develop more heterogeneous peer environments to help counter the effects of deviant peer groups.

Future work should concentrate on building on the parent training component of ATP.

The basic components of ATP's parent and teen focus improved parent-child relations.

The specific processes associated with escalating problem behavior (deviant peers, school failure, and antisocial behavior) must be identified early and interrupted before they unfold.

Interventions must be designed to maximize parent satisfaction and engagement. The first step is enhancing the motivation to change.

The authors propose regular, brief interventions, called family checkups, to enhance at-risk parents' motivation to change. This is based on a study that showed a drinker's check-up reduced problem drinking as much as a 28-day inpatient program (Miller & Rollnick, 1991). The process involves improving motivation to change through a realistic appraisal of risk status in the company of a knowledgeable and supportive professional. It also enhances motivation to use appropriate intervention resources.

Comprehensive systems of prevention must focus on both families and communities. Effective parent training programs must be institutionalized for young parents and parents of challenging youth. Successful prevention is relevant to developmental stage and context and keeps parents and teens engaged in the process. Regular check-ups can be a useful, nonstigmatizing mechanism for prevention with families. Communities must continue to develop formal and informal organizations promoting overall development of their youth. This joint focus will result in the most significant and sustainable impacts.

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This article is based on the following:

Dishion, T. J., Andrews, D. W., Kavanagh, K., & Soberman, L. H. (1997). Preventive interventions for high-risk youth: The Adolescent Transitions Program. In R. D. Peters & R. J. McMahon (Eds.), *Preventing childhood disorders, substance use, and delinquency* (pp. 184-214). Newbury Park, CA: Sage.

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Strong Beginnings: Promoting Resiliency Through Secure Parent-Infant Relationships

Martha Farrell Erickson

As the facilitator leads the five young moms and their 6-month-old babies through a series of games, Susan holds her baby, Brian, at arm's length with his back to her, avoiding all opportunities for eye contact or cuddling. Susan begins to toss Brian roughly in the air, bringing a startled look and then a cry. The facilitator, speaking through the baby, says: "Hey Mom, I need to slow down and have a hug." Silently, Susan turns Brian toward her, but Brian places stiff arms between himself and his mother and screams a piercing cry.

Early relationships lay the foundation for a child's later development. A secure attachment in the 1st year of life helps the child develop working models of others as caring and responsive, and of the self as worthy of being loved and capable of getting positive response.

This article describes Project STEEP—Steps Toward Effective, Enjoyable Parenting. The program is designed to promote healthy parent-infant relations and help prevent social and emotional problems among children born to first-time mothers who are at risk for parenting problems. The sources of this risk are poverty, youth, lack of education, social isolation, and stressful life circumstances.

In this paper we describe a high-risk family involved with the program, review the importance of establishing a secure parent-child attachment, review the prevention strategies used in STEEP, summarize the effectiveness of the program, and draw implications for policies and programs.

The Challenge

Intervening with high-risk mothers and babies is a significant challenge. Susan, the mother described earlier, was neglected as an infant. She moved through a series of 10 foster homes during her childhood. Now a 21-year-old single mother, she is struggling to overcome her own history in order to care for Brian. It is not an easy task for Susan, or for those who work with her and her son.

Unlike many high-risk mothers, Susan got regular medical care during pregnancy and was careful about diet and chemical use. Brian was born a robust, alert baby. However, meeting the needs of a young infant is overwhelming for Susan. Brian is already lagging in motor and social development, which is not surprising given his mother's emotional unavailability and insensitivity. He is also beginning to resist his mother's attempts to hold him. This could push Susan further away.

Brian is on a track that will likely lead to learning problems, poor social and emotional functioning, and probably costly interventions later in life. Furthermore, the

interaction patterns between Susan and Brian are likely to reinforce her low self-esteem and her conviction that she will fail at everything she attempts.

There will be no quick fixes for Susan and Brian. However, being involved in Project STEEP during these crucial early months of their life together has the potential to begin a change for the better.

Why Intervene? Attachment Theory

The STEEP program is based largely on findings from the Mother-Child Interaction Project, a 14-year study at the University of Minnesota. The project helps define what promotes healthy outcomes in the face of poverty and the stressful life circumstances that often accompany it.

Mother-infant attachment in the first year of life is a powerful predictor of the child's future social development. For example, the Mother-Child Project showed that the quality of attachment at 12 months can predict preschool teacher ratings, behavior problems, and quality of relationships with peers (e.g., Erickson, Egeland, & Sroufe, 1985). Attachment also relates to social competency in a summer day camp setting when children are 10 and 11 years old (Sroufe & Jacobvitz, 1989; Urban, Carlson, Egeland, & Sroufe, 1991). Although not an inoculation against later problems, secure attachments in infancy lay the foundation for healthy development.

Although all children are powerfully inclined to become attached, many children do not receive care that encourages secure attachment. These children are described as being anxiously attached. Researchers estimate that at least 20% of all children are anxiously attached. Tragically, among families encumbered by poverty, highly stressful life circumstances, and lack of support, nearly half of the children develop anxious attachments.

Depending on the particular pattern of care they received in infancy, children who are anxiously attached are likely either to be overdependent on teachers for help and attention or to behave in ways that keep others at a distance. They lack confidence, self-esteem, and motivation to learn. They have difficulty forming friendships and often are socially withdrawn. Many of these children tend to be disobedient and aggressive. Their behavior makes them vulnerable to becoming either a victim or victimizer. And, as their behavior drives others away, this reinforces their negative models of self and others.

Several reports also suggest that the quality of care received as a child influences how a parent responds to and rears his or her own child. Early history is not destiny, however. Mothers who were maltreated as children but were not abusive toward their own children usually had a positive additional relationship with an adult as a child or a significant positive relationship in their adult life (Egeland, Jacobvitz, & Sroufe, 1988).

Furthermore, researchers have identified what beliefs, attitudes, and behaviors in the parents are important to developing a secure attachment (e.g., Egeland & Farber, 1984). For example, research shows that caregiver sensitivity to the

The quality of the mother-infant attachment at 12 months can predict preschool teacher ratings, behavior problems, and quality of relationships with peers.

child's cues and signals is the major factor. Children learn to trust the caregiver will meet their needs and, equally important, to trust their own ability to solicit care.

Attachment theory and supporting research form the framework for the STEEP program.

Strategies for Promoting Optimal Child Development

A second foundation for the STEEP program is strategies that have proven effective in supporting and empowering families and promoting optimal child development. STEEP follows a model that combines support, education, and what Selma Fraiberg has called "therapy in the kitchen" (Fraiberg, Adelson, & Shapiro, 1974).

Research shows that although no one can change the parent's history, what is most important is how a parent thinks now about that history. Therapeutic interactions aim to help the mother

- face her own developmental history,
- examine how it affects her parenting,
- express the pain associated with her past and present circumstances,
- look at current choices and actions and decide what to repeat and not repeat from her own childhood, and
- consider how she can move forward to a more empowered way of living.

The literature of intervention also helped us determine such things as the timing of enrollment in the program, incentives for participation, and logistics of service delivery. For example, the birth of the first child is a time of dramatic change, and usually anxiety, which in our experience encourages receptivity to intervention. This is a special window of opportunity to affect the prospective mother's view of herself, her child, and their relationship. Recruiting these women during pregnancy also means the mother does not yet feel she has "failed" at parenting in any way.

The STEEP Program: Steps Toward Effective, Enjoyable Parenting

Project STEEP, a 4-year randomized evaluation of the effectiveness of the STEEP program, served 74 first-time pregnant women, with the first recruited in 1987, and compared them over time with a control group of 80 families. All were below the poverty level, which was the primary risk factor, and were recruited through Minneapolis area obstetrics clinics. All were at least 17 years old, and the average age was just over 20. The average education was 10.9 years. Forty percent were black, 92% were unmarried, and 88% were unemployed at intake

The birth of the first child is a time of dramatic change, and usually anxiety, which encourages receptivity to intervention.

to the obstetrics clinic. Many had a history of being abused or neglected, and many were currently in abusive relationships. An additional 80 women were recruited and assigned to a control group for evaluating the program's effectiveness.

During the participants' second trimester of pregnancy, the program began both home visits and group sessions, which continued until the baby was a year old. Prenatal visits focused on the mother's feelings about pregnancy and preparation for parenting. Our previous research indicated that mothers most at risk are those who feel totally positive or totally negative about becoming a parent, rather than experiencing a more realistic ambivalence (Brunnquell, Crichton, & Egeland, 1981). This is also a critical time for the family life facilitator to build a relationship with the participant.

Home visits continued every other week until the child's first birthday and were tailored to the unique needs, strengths, and interests of each family. Also, about the time the babies were born, approximately eight mothers with similar due dates were brought together for 3-hour group sessions that continued biweekly through the year. To build trust and ensure continuity, the staff person who conducted the home visits also led the group.

Using demonstration, discussion, and participatory activities, the facilitator

- taught child care skills,
- provided basic information about infant development,
- helped the mothers learn to understand and respond to their infant's cues and signals, and
- guided mothers in recognizing their own infant's special characteristics and needs.

The interactions were videotaped. Guided viewing of those tapes helped promote the mother's perspective taking and sensitivity. Again, previous research highlighted the importance of sensitive, contingent response to infant cues. This sensitivity is the major factor leading to a secure attachment.

"Mom talk" time and a free meal followed the baby-centered time. The mothers were encouraged to build supportive relationships with each other and to talk about their own emotional issues in relationships, personal growth, education and work, and general life management. The goal was to help empower the mothers to deal effectively with other aspects of their lives and to use existing community resources. The program promoted increasing responsibility for group activities by the participants to decrease their dependence on the facilitator and encourage initiative and cooperation within the group.

Sensitive, contingent response to infant cues is the major factor leading to a secure attachment.

Therapy and Learning New Models

Home visits between group sessions focused on psychological therapy as well as more general life management and social support. The staff person explored with the mother how her own developmental history and current life events were influencing the way she interacted with her child. Other family members or friends were encouraged to participate in the home visits to the extent the mother wished.

For many parents, the demands of caring for a new baby may trigger their own feelings of sadness, loss, and anger because they have never really felt cared for. In our experience, some parents will (if given permission and acceptance from the facilitator and/or other group members) acknowledge some resentment, really a kind of jealousy or rivalry with the baby. Bringing such emotions into conscious awareness can be the first step toward letting them go so they don't interfere with the parent's ability to respond to the baby.

Accessing these feelings can help a parent see things from the baby's perspective. One technique is "talking for" the baby, using a small voice to put the baby's cues into words. Another very effective strategy is writing letters to the parents from the baby. One letter from an 8-month-old who always wanted mom in sight said, "You are the most important thing in my life right now. . . . I'd crawl for miles on my hands and knees just to see your face. . . . Sometimes even just hearing your voice is enough to make me feel okay."

STEEP staff often videotaped parents and babies in a variety of play, feeding, and child care situations at home and in the group sessions. They then watched the tape with the parents, using comments and questions to encourage them to discover what the baby was experiencing and communicating. They might say, for example, "Look at that expression on his face. I wonder what he was feeling then." Or perhaps they would comment, "You knew just what she needed there. How did you know?"

Nearly all the young mothers had a history of abuse or neglect, and their working models of others and self reflected this. It was through experience with a predictable, sensitive facilitator that many of the young mothers began to modify those working models.

There are several ways the STEEP program tried to help the mothers experience a new way of being in a relationship. First and most basic was to be consistent and predictable with the mother. This is easy to say, but sometimes hard to do. For STEEP staff it meant promising no more than they could deliver and always showing up when they said they would. This was true even if the mother herself had failed appointments or was not ready when the van arrived to take her to the group session.

As a policy, STEEP staff kept going back for a mother, assuming she would keep her commitment to the program unless she specifically said she did not want to participate. Some mothers said this was their first experience with someone who

Some mothers said this was their first experience with someone who "hung in there" with them.

“hung in there” with them, and some even admitted later that they tested their facilitator early on to see what she would do.

Personnel: The Critical Variable

Developing a caring, trusting relationship between the facilitator and participant is at the heart of the STEEP program. It takes skill to build such a relationship and deliver the complex services the mothers need. Facilitators must have well-developed problem-solving skills and a degree of psychological sophistication and therapeutic savvy. In Project STEEP the directors hired facilitators who had no professional license of any type, but had at least a bachelor’s degree in education or the social sciences plus hands-on experience with young children—usually their own.

Evaluation

A rigorous evaluation of the STEEP program, funded by the National Institutes of Mental Health, showed a positive impact overall. Researchers administered a variety of assessments during pregnancy and when the babies were 12, 19, and 24 months old.

Mothers who participated fully in STEEP had more appropriate play materials in their homes; were more responsive; and scored higher on quality, organization, and stimulation in the home environment than mothers in the control group and those who participated only to a limited extent. The STEEP mothers had a better understanding of their child and their relationship with their child.

It was disappointing to find no significant differences on the quality of mother-infant attachment at 13 months. However, by 19 months mothers and infants were moving toward more secure relationships, while relationships in the control group were moving in the opposite direction.

On measures of social support, mothers in the treatment group reported significantly more support than those in the control group. Mothers in the treatment group also showed higher scores on community life skills, indicating they were better able to manage their household and child-care responsibilities. In addition, the treatment group was significantly less depressed than the controls.

A major goal of STEEP was to help mothers become more sensitive to babies’ signals. The program did appear to help the mothers buffer their interactions with their children from the effects of stress and depression. In the control group the researchers found a strong connection between stress, depression, and the mother’s sensitivity. However, for mothers in the intervention group, sensitivity was not linked to depression and stress. Mothers in the STEEP group seemed to have learned to more effectively separate the effects of life stress on themselves from their interactions with their children.

Mothers who participated fully in STEEP had more appropriate play materials in their homes, were more responsive, and scored higher on quality of the home environment.

Parents must have emotional support for themselves to be able to care for their children sensitively and consistently.

Moreover, within 2 years of the birth of their first child, mothers in the treatment group had significantly fewer repeat pregnancies than mothers in the control group (Egeland & Erickson, 1993b).

Based on the research findings and clinical observations during implementation of the program, the developers of STEEP concluded that the program would be more effective if it continued through the child's 2nd year or longer. And, in fact, subsequent implementations of the program have lasted for at least 2 years.

Many mothers lived in chaotic, disruptive, and, for some, violent home situations. These stressors needed to be dealt with before STEEP staff could focus on the parenting and personal goals of the program (see Egeland & Erickson, 1993a). Also, many mothers had psychological problems that interfered with focusing on the actual intervention (see Egeland, Erickson, Butcher, & Ben-Porath, 1991).

Policy and Program Implications

Our children are the hope of the future, but they are in trouble. Over 14.3% live in poverty; 2.7 million are neglected or abused; more and more are dropping out of school and out of life.

When we look for ways to make a difference for our children, research points to a relationship with a caring, supportive adult as being the most critical factor. It is best when that begins in the first months of life because a child's early relationship with a caregiver becomes a prototype for later interactions and relationships. Society must support children's opportunities to develop strong, secure attachments.

Several critical factors that help parents and children develop a secure attachment are identified by research. These sound relatively simple, but are often *not* basic to our programs and policies.

- To have the physical and emotional energy to meet their children's needs, parents must have their own needs met for housing, food, clothing, transportation, and health care.
- Parents must have emotional support for themselves to be able to care for their children sensitively and consistently.
- Parents need basic child development knowledge. Understanding certain key child behaviors, such as separation anxiety or negativism, lets them be more realistic in what they expect from their child and "see the world through the eyes of the child." Knowledge, understanding, and perspective taking are fundamental to the sensitive care needed for secure attachment.
- Parents need to deal with their own childhood history: facing its pain, acknowledging its influence, recognizing the option of making new choices, and mustering the resources to help them live up to those choices.

There are no quick, easy answers, but we must consider how we can ensure that children have the best possible chance to develop a secure attachment with at least one caring, supportive adult. Across all studies of vulnerability and resilience, such a relationship is the single most important factor accounting for good outcomes for children in the face of high-risk circumstances. A few actions that can help accomplish this goal include the following:

- Supporting natural neighborhood caregivers like churches and youth centers.
- Providing additional support for new parents (home visits, parenting classes, training service providers to identify and address the psychological issues that can undermine a parent's best intentions).
- Offering family life and child development education in middle and high school and assessing its effectiveness.
- Supporting workplace policies sympathetic to family and attachment issues.
- Establishing ways to identify early which families have potential attachment problems and offer extra support and intervention.
- Incorporating knowledge of attachment more effectively into adoption, foster care, and child custody decisions.
- Providing long-term mentorship programs through schools to let more children form meaningful relationships with caring adults.
- Assessing how policies and practices in child-care facilities help or hinder attachments.
- Disseminating the relatively unknown research on adult-child attachment to educators, health care professionals, human service providers, policymakers, the judicial system, and the general public.
- Investigating effective ways to prevent and/or treat attachment problems, linking the results to ongoing practice and program development and determining what additional research is needed.

Understanding child-adult attachment must become a lens through which we consider all decisions that touch the lives of children. This is not a political issue; it is a universal human issue.

Despite ongoing depression and limited capacity for insight, Susan participated regularly in the STEEP program, making slow progress in learning basic caregiving skills. Brian's father, who was involved in the home visits, actually gained much from the program and was the more emotionally invested parent. STEEP staff helped the family secure good quality child care for Brian while mom and dad were at school or work, and that outside care and stimulation was important to Brian's well-being. It will continue to be a long and challenging journey for this

Attachment with at least one caring, supportive adult is the single most important factor accounting for good outcomes for high-risk children.

family, but hopefully their positive experience with this program will make it easier for them to continue to seek and use the support they need.

The STEEP program currently operates at St. David's School for Child Development and Family Services in Minnetonka, Minnesota; Community-University Health Care Center in Minneapolis; and Health Start in St. Paul. A program is just getting started at Marybridge Hospital in Tacoma, Washington. STEEP strategies are also formally incorporated into the home-visiting work of public health nurses in Ramsey, Dakota, and Scott counties in Minnesota.

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This article is based on the following:

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National Network for Family Resiliency

www.agnr.umd.edu/users/nnfr

This website offers a wide range of resources aimed at fostering family resiliency.

Strengthening America's Family Project

www-medlib.med.utah.edu/healthed/ojjdp.htm

This website provides program descriptions of top parenting and family programs selected for dissemination by the U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP).

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Editors: Karen Bogenschneider, Director, Wisconsin Family Impact Seminars, Professor, Human Development & Family Studies, UW-Madison, and Family Policy Specialist, Cooperative Extension, UW-Extension, and Jonathan Olson, Research Assistant, Wisconsin Family Impact Seminars. Authors: Karen Bogenschneider, Professor, Human Development & Family Studies at the University of Wisconsin-Madison; Tena St. Pierre of the Institute for Policy Research and Evaluation, The Pennsylvania State University; David W. Andrews, Assistant Director of Extension, 4-H Youth Development at The Ohio State University; and Martha Farrell Erickson of the Children, Youth and Families Consortium at the University of Minnesota. Produced by the Center for Excellence in Family Studies, School of Human Ecology, University of Wisconsin-Madison. Lynn Entine, editor; Elizabeth Ragsdale, designer.

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