Intervening with Troubled Youth and Their Families: Functional Family Therapy and Parenting Wisely

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I. Overview

Both the need for and availability of empirically-validated interventions for families in crisis and at risk has never been greater. The great majority of service providers to these children and families are not using effective methods, while the number of effective interventions has substantially increased in the past half decade. This conundrum, although deeply frustrating, inspires creative solutions and drives governmental funding to bridge the gap between research and practice. The past decade has seen a consensus among behavioral scientists that parent and family interventions should at least be included (if not the sole focus) when children exhibit behavioral or adjustment problems. Carr (2000) presents a recent review of all of the interventions for children and adolescents included only studies with comparison groups and pre- and post-treatment measures. Included are treatments for child abuse, enuresis and encopresis, attention deficit disorder, oppositional defiant disorder, adolescent conduct disorder, depression, anxiety disorders, drug abuse, and anorexia and bulimia. The most effective treatments for these disorders usually involved the parents or family, and were included as principal components of effective treatment in all.

Among the most effective treatments for adolescent behavior problems in general and conduct problems in particular are family therapy (Carr, 2000; Gordon & Arbuthnot, 1988). Those models with the greatest empirical support are Multisystemic Therapy and Functional Family Therapy (FFT). Currently, these approaches are enjoying strong governmental support for dissemination. In this chapter, I will describe the FFT model based upon the experiences of my students trained to use this model with young offenders over a 20-year period. I will also describe the development of a parent training programmme on CD-ROM to both augment the FFT approach, and to reach greater numbers of families who could or would not receive FFT or did not need FFT. I also present the research on both programmes, and the important issues relating to their dissemination.

II. Family-related risk factors.

The view that the family is the cause of criminality has surged and faded and now resurged in the history of the study of criminal behavior. It is now accepted as fact that the roots of adult criminal behavior can be traced to hostility and aggression in childhood, which along with other antecedents of criminal behavior, are socialized in and controlled by the family (Lorion, Tolan, & Wahler, 1987). Travis Hirschi, in his extensive study of the causes of delinquency, found that the number of children's self-reported delinquent acts was powerfully influenced by their attachment to their parents, communication with the father, and supervision by the mother. Social class and the influence of peer groups, long thought to be predictors of delinquency, pale in comparison to family factors. A variety of thorough investigations have supported these findings, which point to discipline, problem solving, monitoring, and support as central to parenting skills related to delinquency (McCord, 1982; Snyder & Patterson, 1987; Farrington, 1995).

The most compelling demonstration of the causative role of the family in delinquent behavior comes from the efforts to change family (particularly parent) behavior. Most of the studies (Gordon & Arbuthnot, 1987; Tolan et al., 1986) showed reductions in delinquent behavior such as rearrests, recidivism, and truancy following family therapy. All studies in Tolan et al.'s (1986) review that included measures of family functioning, and those few that included recidivism and family functioning measures reported improvement. However, weaknesses in experimental design limit the strength of a conclusion that family therapy leads to improved family functioning and reduced delinquency. The many studies of FFT and Multisystemic Therapy attest to this causal role.

Adolescent substance abuse is also associated with delinquency and behavior problems, and the risk factors for substance abuse are very similar to risk factors for delquency. Low parental involvement with children (St. Pierre & Kaltreider, 1997), poor family communication (Glynn & Haenlein, 1988; Kumpfer & DeMarsh, 1986), and low family cohesion/attachment (Kumpfer & DeMarsh, 1986; McKay, Murphy, Rivinus, & Maisto, 1991; Malkus, 1994) are related to adolescent substance use. McKay et al. (1991) found

that a direct relationship between levels of family dysfunction and levels of adolescent substance abuse.

Regarding peer group influences, Brown, Mounts, Lamborn, and Steinberg (1993) pointed out that parents have an indirect influence. Parent behaviours impact adolescent characteristics, which predict what type of peer group a child will associate with. If the parent-child relationship is poor (little communication, high conflict, and little support), the child is more likely to become involved with deviant peers and consequently to become involved in drug and alcohol use or delinquency (Brown et al., 1993; Patterson, 1986).

In our work with families of delinquents over the past twenty years, we have observed those characteristics that are well established in the literature. Discipline is ineffective, being either erratic and overly harsh, or permissive. High levels of parent-child conflict, and the blaming and anger that accompany this conflict, and low levels of parental supervision and monitoring communicates parental disinterest and distrust of the child. When children learn coercive social interaction patterns from their parents, they often transfer these to their peer group and are rejected by normal peers, as Patterson's research has demonstrated. When high conflict is associated with low family cohesion and parental affection and support for the child, the child's susceptibility to deviant peer group influence grows.

III. Description of FFT

FFT combines social learning, cognitive behavioural, interpersonal theory, and family systems theories. It was developed in the 1970s primarily for a behavioural-adolescent population whose parents were unable to control their acting-out behaviour. The adolescent's behaviour was viewed in the context of the interpersonal needs of various family members, as well as the teen's own developmental needs. The developers paid attention to family members' thoughts of each other's behaviour, and determined via observation and interview, the meaning which recurrent interaction sequences held for each family member, and the needs these sequences met. Methods of changing these sequences are first cognitive-behavioural, accomplished by therapists' relabeling patterns to change their meaning, followed by didactic instruction, modeling, role play, and feedback to teach new skills. Many of the behaviour change methods arose from the parent training methods developed by G.R. Patterson and others, reviewed by Serketich & Dumas (1996). The primary contributions of the FFT approach were the evaluation of family interaction patterns from a family systems perspective, the conceptualization of repetitive sequences from an interpersonal need for distance or closeness position, and the standardization of methods for conceptualizing and dealing with family members' resistance to change.

Description of the Functional Family Therapy Approach. The initial structure of the FFT model delineated five phases (introduction/credibility, assessment, therapy, education, and generalization). In the past few years, since the Blueprints for Violence Prevention were developed to disseminate effective programs (Alexander, Pugh, Parsons, & Sexton, 2000), these five phases were reduced to three: engagement/motivation, behavior change, and generalization. In the initial sessions, therapists focus on building alliances with family members and reducing negativity and hopelessness. Listening and eliciting family members' goals substitutes for advice giving, as therapists lay the groundwork for a motivational context for change. Assessment in the recent version of FFT continues throughout each of the phases. It consists of the evaluation, by observation and interview,

of family behavior patterns, cognitions, and feelings and the reinforcers maintaining those patterns. Repetitive relational styles for each dyad are assessed as meeting basic interpersonal needs for contact or connectedness, distance or autonomy, or something in between (midpointing). Assessing these interpersonal functions is critically important to understanding which behaviors will be more resistant to change, as interpersonal functions are seen as relatively enduring. In our implementation of the FFT model, within the first and second sessions, the therapists interviewed members in detail about problem behaviors. We attempted to take a snapshot of daily family life by focusing in detail on the major transition points each day: getting up and preparation for school, arrival of children after school, dinner arrangements, after dinner activities, and bedtime routines. Among the delinquent populations we have served, the most common problem behaviors parents identified were curfew violations, in about two-thirds of the families; frequent noncompliance with parental requests, in over three-fourths of the families; and daily parent-child conflict, in all of the families. When two parents were present, parental inconsistency in providing consequences was present in virtually all of the families. Serious marital discord was present in less than half of the intact families. The therapists also gathered information on problem behaviors from school personnel, county caseworkers, and court personnel. Just before and after the first session, the therapists met with their supervisor to decide on the initial focus of therapy.

The therapy phase (now called the engagement/motivation phase) was designed to alter attitudes, expectations, cognitive sets, labels, emotional reactions and perceptions of relationships between family members in such a way as to reduce blaming and to portray each member as an unwitting victim of a poor learning history. Therapists substituted benign motives for the more malevolent motives family members assigned to each other's behaviors. Reframing is a powerful technique used to change the meaning of an interaction or a behavior. Its value lies in its ability to initially confuse family members, then to have them see each other in a more compassionate light. Therapists must be able

to empathize with family members' frustrations and anger and hurt, but also be able to get them to see a different meaning behind the frustrating behavior. Novice therapists have more difficulty learning to reframe problematic interactions than most other skills, so I have emphasized this skill in training. Appendix B lists common problem behaviors and reframes that apply, and Alexander lists a number of reframes in his Blueprint (Alexander et at., 2000, p.30).

Consistent with a systems framework, the family was viewed as a dysfunctional unit. Thus, the goal of treatment was to resolve problematic interactions among family members, recognizing that more than a dyad was involved in the problems. This goal was attained through focusing attention away from the juvenile as "the problem," and toward other family relationships and the contributions of the "noncombatants" before and after disruptive episodes (Alexander & Parsons, 1982).

The education or behavior change phase was designed to either teach family members skills they lacked or prompt them to use skills they had more frequently. This phase is similar to parent-training procedures used by Patterson's group. Thus, the education phase consisted of teaching communication and problem solving skills, providing technical aids to assist in reinforcing functional behavior, and instituting interpersonal family tasks. Among the communication skills taught to the families via modeling and prompting were active listening, source responsibility, "I" messages, directness, and feedback. The technical aids, designed to provide concrete ways of reinforcing the new functional family interaction patterns, included contingent reinforcement, contingency contracting, time-out, charts and graphs, and note and message centers. Considerable emphasis was placed on these parenting techniques; particularly contingency contracting, since most parents showed substantial skill deficits in these areas. Later sessions were devoted largely to ensuring that family members were generalizing newly developed problem-solving and communication skills across varied situations. Handouts with instructions for using the various methods, along with

homework exercises, were usually given to the families. Interpersonal tasks, such as asking a mom to set up a homework routine with her child, were designed to provide families with the opportunity to practice communication skills, reinforce positive interaction patterns, engage in conflict management, and spend enjoyable time together. In two-parent families, parents were prompted to verbally support each other's use of new skills with their children, particularly applying immediate consequences for changes in deviant child behavior. Interparental support of skill practice has been shown to increase the persistence of treatment gains.

Because a majority of the adolescents lived in families where there was no father, one therapeutic goal was either to establish (especially when the child was a boy) the child's contact with the father, to increase the frequency of contact, or to establish a supportive relationship with an adult male in the community (relative, neighbor, church member). When the mother had a boyfriend who was responsible and interested in the children, positive contact between that boyfriend and the delinquent (especially the male) was monitored and encouraged.

The final phase, generalization, focuses on the generalization of the skills the family has learned to a variety of naturally occurring situations, with the therapist assigning homework requiring progressively more independence. The frequency of sessions declines, with sessions often scheduled every 2-3 weeks for the last two or three sessions. Therapists support the maintenance of change, and warn the family that occasional setbacks are to be expected, but that they should rely on the new skills they learned rather than regress towards earlier (ineffective) methods. Therapists often take on the role of case manager to access community support for the family, such as school consultation to increase support for the delinquent, financial support, job placement services, and advocating for the family with the juvenile court. Court advocacy usually involves recommending against out of home placement, unless that is clearly indicated

based on the therapists knowledge of the family. We routinely schedule booster sessions with the family two to three months after termination.

Case Example

A case example of functional family therapy that is fairly typical of our population of low income families with a delinquent follows (reprinted from Gordon (1995)):

> Larry is a 16-year-old referred for family therapy by the juvenile court following his third theft, as well as gang fights after school, as an alternative to institutional placement. Mr. G, Larry's stepfather,. is physically disabled and stays home where he does household chores. Mrs. G. works in a paper plant. They also have a daughter, Heather, 14 years old. Two therapists recently trained in the FFT model meet with most of the family weekly in the family's home.
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> Over three sessions, their assessment of the family reveals that communication is defensive with much blaming and little listening. Members believe the worst of each other's motives and small problems don't get resolved, often escalating into severe conflict after which one person leaves the house. Larry is frequently criticized by both parents, often for his temper. He seeks distance from his mother but wants contact with his father. Both parents want distance from Larry. They often pick at him until he loses his temper and leaves to be with his delinquent friends. Heather is her father's favorite, and reliably gets both parents' attention by tattling on Larry. Her poor compliance with chores and homework is not noticed by Mr. G. and is only sporadically targeted for criticism by Mrs. G. Mr. G. loosely

monitors the children while Mrs. G. is at work, and does not carry out Mrs. G.'s restrictive policies with either child. The children have no input into rules or consequences, and the parents complain of irresponsible academic, peer, and sibling behavior.

During the therapy phase, covering much of the next five Sessions (as well as part of the first three sessions), the family's resistance to each other and to the therapists is lessened through reframing and pointing out strengths. (Supervisor requirements were greatest during this phase to provide ideas for handling resistance and to support the therapists.) The therapists explained how each family member unwittingly got locked into defensive patterns, and how the parents' lack of support for compliance and appropriate behaviors was a result of their own parents' teaching. Larry's motives for acting-out with his friends, seen by his parents as lack of respect for them, was portrayed as seeking approval from peers that he was missing at home, and as wanting his parents to be proud of his independence and ability to make decisions that weren't disastrous. Mr. G.'s distancing of Mrs. G. was relabeled as respecting her need for privacy after a tiring day at work . Heather's tattling on Larry was relabeled as her desire for her parents' approval and to get Larry's attention. Mr. G's not carrying out mom's restrictive policies with the children was relabeled as not wanting to hurt his relationship with the children. The presence of family conflict was repeatedly tied to poor communication

skills and the lack of a specific conflict resolution plan rather than ascribing them to negative personality traits and motives of family members.

The education phase, covering most of the next four sessions, included teaching and prompting the parents to use reinforcement (verbal, granting privileges) for the children's compliance. Larry was also taught stress reduction techniques such as taking a walk outside when he noticed that he was getting angry, telling himself that he was strong enough to withstand provocation by immature peers, and taking several deep breaths while telling himself that he could keep his "cool". Heather agreed to report only on Larry's improved behavior (thereby allowing her to continue to get parental attention). Mr. G. relayed these messages to Larry via notes placed on his bedroom door, allowing him to maintain his distance from Larry. Family members practiced active listening and "I" messages during therapy sessions and also with weekly homework assignments (which they completed about 50% of the time). The therapists structured a problem-solving format for the family to follow and led them through several rehearsals. The family worked out a contract on their own between sessions, which were spaced out to twice per month in preparation for termination. In their contract, Larry agreed to report to Mr. G. when he was going to be late coming home from school (or be grounded the next day) and Mr. G. agreed to refrain from criticizing Larry when he brought his friends home. Improved homework and chore

compliance led to Larry's being allowed to have friends stay overnight, which increased the supervision he received from his parents. With the decrease in conflict, Mrs. G. and Mr. G. spent more time discussing improvements and started some family activities, such as trips to a local skating rink and renting movies selected by all. Two follow-up therapy sessions four weeks and three months after termination revealed minimal conflict and confidence that the family could resolve future problems on their own.

Adaptations of the FFT Model

In the early 1980s, I adapted the FFT model for low-income high risk families of delinquents, as evidenced from the example above. The graduate students in my family therapy course sequence began seeing families of court-referred delinquents in their homes, and we collected data on these families and those in a probation only control group. These studies, explained in more detail in the next section, demonstrated substantial reductions in recidivism for the delinquents receiving FFT (Gordon, Arbuthnot, Gustafson, & McGreen, 1987; Gordon, Graves, & Arbuthnot, 1988; Gordon, 1990). These findings were similar to or more striking than Alexander's results (Alexander & Parsons, 1973; Alexander, Barton, Schiavo & Parsons, 1976), in spite of the fat that we worked with families who were lower income than Alexander's samples and who also were non-Mormon. While following the model as outlined in Alexander and Parson's (1982) treatment manual on FFT, I increased emphasis during several of the five phases of intervention on a behavioural approach. During the assessment phase, I stressed a behavioural assessment of daily interactions of family members which appeared, from a social learning perspective, to promote or maintain problem child behaviour. Detailed interviewing of family members followed the style of Peter Falk in the Columbo television programme. In the Therapy or Motivational phase, I emphasized not only reframing motives and problematic family interactions, but using a salesperson's approach to motivate the family to try new skills when interacting. In this approach, the therapists point out the costs the family (primarily the parent(s)) is paying for using their current methods (coercion, stonewalling, ignoring, shaming). Such costs include chronic stress, exhaustion, depression, self-medicating through substance abuse, alienation, and disengagement. Many parents believe their methods are "good enough" and do see the need for change. The therapists try to raise the family's awareness of these hidden costs. Then the therapists specify the advantages to learning "new" methods, and how the new methods will help them reach their goals more efficiently even though the initial investment of time and energy seems high. During the educational or behaviour change phase, therapists give very specific instruction in teaching communication skills, problem

solving, and contingency management. This instruction is combination of didactic instruction, demonstration, role playing, and coaching. An empowerment approach is used to motivate the family to make the changes for themselves, using skill practice and psychoeducational aids. These aids seem to be powerful to help the families learn and implement the new skills. They include handouts, videotapes, and, in the past five years, use of the Parenting Wisely CD-ROM. Homework assignments are regularly given. During the generalization phase, as in the FFT model, therapists focus on motivating the family to implement the new skills for a greater variety of situations, and providing technical assistance to do so. Booster sessions are added to improve generalization and provide additional support to the family.

IV. Research

Alexander et al (2000) report effects of FFT on recidivism in 14 studies (three of which are ours). About half the studies involved random assignment to control or treatment as usual groups. Recidivism rates for FFT treatment varied from one sixth to two thirds of the comparison groups, with a variety of risk levels and multicultural backgrounds of offenders. The average reduction in recidivism or out to home placements was 34.6 percent. Follwup periods ranged from one to five years.

I will summarize the evaluations we conducted in Ohio. The first evaluation, reported elsewhere (Gordon, Arbuthnot, Gustafson, & McGreen, 1988 and Gordon Graves, & Arbuthnot, 1995) was a home-based program of family therapy conducted in a rural southeastern (Appalachian) Ohio county. The court selected 27 delinquents for the treatment who were likely to recidivate, and/or be placed out of the home. Most of the delinquents were 14-16 years old who had committed status offenses (57%), misdemeanors (30%), and felonies (13%). The participants in the comparison group were 27 delinquents with fewer offenses but a similar breakdown of types of offenses. Both groups were similar in family income (very low), divorced/intact, and schools attended. The court selected 27 delinquents for the treatment who were likely to recidivate, and/or be placed out of the home. Most of the delinquents were 14-16 years old who had

committed status offenses (57%), misdemeanors (30%), and felonies (13%). Both groups were similar in family income (very low), divorced/intact, and schools attended. After a two to two-and-a-half year follow-up period, recidivism (court adjudications) for the treatment group was 11 percent versus 67 percent for the controls. These delinquents were followed for another 32 months into adulthood, with the family therapy group showing a 9 percent recidivism rate for criminal offenses versus 41 percent for the probation-only group (Gordon, Graves, & Arbuthnot, 1995).

The second evaluation was conducted on a court-run program using paraprofessionals hired by the court to do home-based functional family therapy. The setting was a suburban county outside Columbus, Ohio, having a mixture of social classes and a variety of social services. The 40 juveniles referred to the treatment program were the most serious, chronic offenders in the county. They were referred for family therapy after release from a state institution for juvenile offenders. Most had had three to four prior institutional commitments. The treatment group averaged 7 offenses prior to treatment, and started offending at age 13, and were 17 to 18 years old at the time of referral. There was no comparison group, other than a statistical one, because the judge referred all delinquents upon institutional release.

After an average of 18 months following the end of treatment, for the 40 delinquents receiving treatment, 30% had a new offense (status, misdemeanor, or felony), while 10% required another institutional commitment. As no comparison group at similar high risk for reoffending from the county could be obtained, a statistical group was constructed, based upon risk for recidivating (age at first offense, number and type of offenses, age at referral). Such a group would be expected to have a 60 to 75% recidivism rate, and a recommitment rate of 50 to 60%.

The third evaluation was conducted on a program of aftercare treatment similar to the second evaluation. In five counties of southeastern Ohio (Appalachia), delinquents were referred to the home-based functional family therapy program (delivered by graduate

students at Ohio University) after release from state institutions for juvenile offenders. The five counties were very similar in demographics to that described in the first evaluation (rural, low income families, high unemployment, poor social services). The 27 referred delinquents came from lower to lower middle income families where the biological father was rarely in the home. They had an average of two prior institutional commitments, four prior juvenile offenses, and were 16 to 17 years old. The comparison group was matched for risk for reoffending, age, and social class. The 25 comparison delinquents received standard probation services, with many being referred to mental health centers. After an average of 16 months following the start of treatment, the recidivism rate for the treatment group was 33% being recommitted to a state institution for delinquents. The comparison group had a recommitment rate of 64%, which is the rate expected given their risk for reoffending.

V. Dissemination

Since 1998, the U.S.. Government has funded several investigators to identify the most effective interventions that reduce violence, delinquency, and substance abuse. Two of these, Delbert Elliott at the University of Colorado and Karol Kumpfer at the University of Utah, identified FFT as among the most effective. Elliott's Blueprints for Violence Prevention, mentioned earlier, have been widely requested by communities seeking federal funding to implement those identified, evidence-based interventions. Similarly, Kumpfer's Strengthening America's Families project identified and promoted family-focused programmes for treatment and prevention of substance abuse. The result has been a growing demand for training in FFT. Another family therapy intervention, Multisystemic Therapy (MST) was identified by both Elliott and Kumpfer and has enjoyed explosive growth. The challenges of widely disseminating these complex interventions to communities distant from the programme developers are daunting. The FFT and MST groups are paying careful attention to details of community preparation, training, supervision, treatment integrity, monitoring process and outcome, and ongoing technical support.

My experience with training practitioners in community settings to deliver FFT in a consistent fashion faithful to the model was humbling compared to training graduate

students. In the course of training graduate students, I relied on teaching the model over a 6-10 week period (12-20 hours), close supervision of therapy sessions through having therapists complete checklists of activities for each family session, listening to audiotapes of the sessions, and group discussions of each family weekly (20-30 minutes per family). The caseloads were very small, with students carrying one to three families at a time. Part of the reason for our impressive outcomes for recidivism is probably the more intensive nature of the supervision, as well as the use of graduate students in clinical psychology. These students are an elite group selected from a large pool of graduate school applicants. They are very personable, diligent, intellectually curious, and quite intelligent. They are also aware that they know little about working with families and subsequently are eager to learn. For all these reason, it was not difficult to maintaining treatment integrity.

When I trained experienced professionals in FFT, I ran into obstacles similar to those Barton noted in his replication of FFT (Alexander et al, 2000). The behavioral specificity required in FFT was opposed by psychodynamic and humanistic therapists, and by eclectic therapists unwilling to put in the organized, disciplined work required in behavioral approaches. Many were not knowledgeable about behavior change methods to be taught to parents and resisted learning these without insistence from the supervisor. Cognitive behavioral therapists were quite comfortable with the model. Many therapists objected to the accountability required (filling out session checklists, making regular supervision meetings, measuring outcomes). Another challenge for therapists was accepting the FFT model's view that it was the therapist's responsibility to engage difficult families. These therapists are used to blaming a failure to engage on the families rather than on their methods.

These challenges are not unique to implementing FFT. Resistance to change is endemic to governments, agencies, therapists, as it is with parents. Introducing innovations, regardless of how logical and cost effective they may be (as are family interventions), meets with resistance. Many policy makers and administrators lack information about effective practices. Agencies often have limited abilities to plan and implement new programs, as well as limited start-up funds. The operational changes

required of agencies to train, monitor, evaluate, motivate and maintain changes for practitioners are wrenching (Mendel, 2000).

Bickman & Noser (1999) express concern about therapists' likelihood of following a defined treatment protocol if ongoing close supervision and consequences are not in place. We need to implement continuous quality improvement systems to give service providers feedback about their procedures and outcomes. Supervisors must have effective consequences at their disposal to motivate practitioners to adhere to the treatment protocols. Implementing these procedures has been a very difficult challenge because service providers resist attempts to limit their autonomy, and are unused to receiving feedback about their effectiveness. As Chambless (1999) notes in her discussion of the problems with disseminating empirically validated treatments, practitioners are hampered by time, distance, and money in getting supervised training. The recent availability of state and federal funds is helping agencies afford the training and supervision. Another challenge is recruiting and retaining providers with personal attributes and skills to benefit from training. When the practitioners do not have strong science-based academic training, they are more skeptical of empirically-validated interventions when certain procedures conflict with their usual practices, their clinical experience, and personal beliefs. A prominent Canadian psychologist who, along with Don Andrews, helped start the movement towards evidence-based treatment, Paul Gendreau warns about the common sense revolution (Gendreau, 2001). This revolution is manifested by the disregard for empirically validated treatments, an anti-empirical bias of those with personal experience with the topic (crime, family relations, problem child behaviour). To these practitioners, administrators, and policy makers, if a certain treatment practice if it makes common sense to them, there is no need to look for evidence to support such treatments or to evaluate them. The tragedy of this attitude is shown by the widespread use of individual counseling or therapy for troubled children and adolescents with behaviour problems, in spite of research reviews and large scale well-designed studies showing that such community interventions do not lead to positive outcomes for children (Weiss Catron, Harris, & Phung, 1999; Bickman ,1996; Bickman and Noser, 1999).

Another hindrance to the dissemination of effective treatments is the poor marketing and packaging of these programmes, which compete against the well-financed and expert marketing of ineffective or unevaluated programmes. Most programme developers who have conducted thorough research are academics with little knowledge of marketing, and their universities either discourage or do not provide the incentives for them to take the time to learn or finance such ventures (Gordon, 2000). Many developers do not want to limit their research activities in order to focus on dissemination.

When the target population are young offenders, most practitioners and juvenile courts have an individual responsibility orientation which focuses rehabilitative and punitive efforts primarily if not exclusively on the delinquent. It is easier for courts to mandate the delinquent to treatment, and it is easier for service providers to focus on one person than on a family, school, or community. When the treatment occurs outside the community, as in regional institutional settings, it is often impossible to meaningfully include other important social systems. The problem of informing providers and courts about effective family interventions is compounded when politicians call for tougher sanctions for the delinquent as the principal method of reducing juvenile crime.

Both the MST and FFT groups are addressing the challenges of improving compliance with implementation standards in innovative ways. After extensive training in FFT, therapists must complete checklists after each session that guide them as to the appropriate activities for the session and provide the supervisor with evidence of adherence to the model. These checklists are often supplemented with audio or videotapes. Weekly telephone conferences between a team of FFT-trained therapists with a supervisor at FFT headquarters

Resistant families. Families of young offenders, substance abusing and behaviour problem adolescents, are often low income, poorly educated, with a history of unpleasant experiences with schools and public service agencies. Parents of these teens may have disengaged from active involvement with them due to a history of feeling defeated and ineffective (Spoth & Redmond, 1995). These parents are in the precontemplation stage of change, as they do not see a need for parenting interventions. Other parents do not have

the resources to attend multiple session family interventions or parent education classes (reliable transportation, funds to pay for or public transportation, child care providers, or a flexible schedule to mesh with the therapists schedule). For other high-risk families, parents will avoid mental health clinics or therapists because of their fear of the stigma such services have among low-income areas. Attendance and retention of family therapy is enhanced when the treatments are delivered in the homes using a flexible approach that works with whomever is present at each session. We have had success among such high-risk families with a very pragmatic and practical application of the FFT model, and with the much briefer Parenting Wisely programme.

VI. Parenting Wisely

Several years ago we developed a family-centered intervention which is not dependent upon social service personnel for its delivery, which is inexpensive, and which can be replicated and sustained in communities without training for service providers. In addition it minimizes the barriers to low income families of cost, accessibility, and social stigma. The intervention is a self-administered CD-ROM, Parenting Wisely (PW), which teaches parents and their children and teens important skills which have been implicated in the cause of delinquency and substance abuse (communication, support, supervision, and discipline). The programme's development was based on two premises, which are well supported in the literature. One premise is that interactive videodisk programmes increase knowledge and performance more efficiently than do standard methods of instruction and produce mean effect sizes of .53 (Fletcher, 1990, McNeil and Nelson, 1991; Niemiec & Walberg, 1987). The other is that videotaped modeling of parenting skills is as effective in producing improvements in child behaviour as are parent education discussion groups and parent training with a therapist (Webster-Stratton, Hollinsworth, & Kolpacoff, 1989; Webster-Stratton, Kolpacoff, & Hollinsworth, 1998). The programme requires and invites interaction by presenting nine live-action scenarios of common parent/child problems followed by three possible solutions for each one, along with explanations of why each solution is or is not the most effective. Problems include homework, sibling conflict, defiance, chore avoidance, disrespectful talk, and associating with undesirable peers. After the problems are played, the parent has an opportunity to choose one of three solutions that

is most similar to the way they would handle that particular situation. A video clip of that solution is then played on the screen. Following the presentation of the solution, a series of question and answer screens deliver a critique of the solution they just viewed, providing feedback to the parent on positive and negative consequences of dealing with the problem in that particular manner. If the solution that the parent chose is not the best possible solution choice, the computer will instruct the parent to choose another solution. After the correct solution is chosen, an on-screen quiz is provided to give the parent an opportunity to see how well he or she learned the techniques taught in the programme thus far. In the context of normal family interactions, effective parenting skills are demonstrated, such as active listening, I messages, contracting, supervision, assertive discipline, contracting, and contingency management. Parents and children can use the programme together, prompting helpful discussions. The programme uses a family-systems, cognitive behavioural, and social learning approach. The FFT model was influential in the design of the programme. For instance, the interrelationships among family members leading to different outcomes for children was emphasized, as well as attempts to discourage scapegoating or triangulating. Developmental changes in children's need for contact and distance is also part of the instruction, and parental needs for those two functions are acknowledged. The PW programme also teaches parents and teens the connection between making malevolent attributions and conflict, or benign attributions and cooperation. Each family/parent using the programme receives a workbook containing the text of the programme, and skill-building exercises for the skills taught in the programme. The use of these exercises provides skill practice that facilitates implementation of the skills.

The use of this technological format, where parents get information about good parenting practices from a computer program rather than a person, has advantages over services delivered by a trained professional or paraprofessional. Not only is defensiveness minimized, but also the interactive and multimedia format facilitates learning. Table 1 lists the advantages of this approach over traditional therapist-delivered parent training or family therapy.

[INSERT TABLE 1 ABOUT HERE]

The goals and outcomes of the PW programme are increased knowledge of good parenting skills and principles, improved parenting practices, improvements in child problem behaviour, and improved family interactions. Another goal is high parental satisfaction, and improved confidence parents can deal with child problem behaviour using the skills taught in the programme. Also we sought to increase the number of parents who would use PW who refuse to attend parent education classes or family interventions.

Controlled research demonstrates high parental satisfaction, increased access of high-risk families to parenting interventions, improvements in knowledge and use of skills, improvements in family relations, and large improvements in child problem behaviour. For difficult children and teens, behaviour improved by more than 50% (Lagges & Gordon, 1999; Kacir & Gordon, 1999; Gordon, 1999). Because of this research evidence, the PW programme was rated Exemplary II by the Center for Substance Abuse Prevention (CSAP) and the Office of Juvenile Justice and Delinquency Prevention.

In a study using participants referred from outpatient clinics and a residential treatment center for juvenile delinquents, Segal, Chen, Gordon, Kacir, & Gylys (1995) found significant decreases in the number and intensity of child problem behaviours. Parents also reported an increased use of effective parenting skills and showed greater knowledge of parenting skills taught in the programme. They also reported very high satisfaction with the programme and high confidence they could use the parenting skills taught to improve their children's behaviour.

Using randomly assigned control and treatment groups, Kacir and Gordon (1999) investigated the effectiveness of the PW programme with parents of adolescents recruited through local public schools. At a one-month follow-up, parents in the treatment group demonstrated significantly greater knowledge of parenting skills than did parents in the control group. At one- and four-month follow-ups, parents in the treatment group also reported greater decreases, from 14 to 6, than control subjects in the number and intensity of child problem behaviours on the Eyberg Child Behaviour Inventory (ECBI, Eyberg & Ross, 1978, Eyberg & Robinson, 1983). Most teens in the treatment group showed clinically

elevated scores on the ECBI prior to their mothers using the programme. Four months after programme use, 50% of the teens were classified as recovered on the ECBI (scoring in the normal range). Average effect sizes for all measures were .46, similar to those in Segal et al (1995).

While prior research focused on individual administration of the programme to parents of adolescents, Lagges and Gordon (1999) investigated the effectiveness of using the PW programme with teenage parents. Their children were infants and toddlers. Compared to control subjects, teenage parents in the treatment group demonstrated greater increases in their knowledge of adaptive parenting skills at a one-month follow-up. Parents in the treatment group were also more likely than control subjects to endorse the effectiveness of adaptive parenting practices over coercive practices at follow-up. This study demonstrates the flexibility of the PW programme, and its potential for use in a variety of contexts.

Gordon and Kacir (1998) examined the effectiveness of the PW programme when used with court-referred low income parents of juvenile delinquents. These parents were often resistant to treatment, unmotivated, and had repeatedly demonstrated poor parenting practices in the past. Nevertheless, these parents also showed improvement, in comparison to a no-treatment control group, on both the Eyberg Child Behaviour Inventory Total Problems scale (Eyberg & Ross, 1978) and on a parenting knowledge test. These improvements were demonstrated at three- and six-month post-treatment. Additionally, the children of parents who used the PW programme showed decreases in negative behaviours as reported on the Parent Daily Report (Chamberlain & Reid, 1987) collected one week, one month, three months, and six months following treatment. Effect sizes ranged from .49 to .76, indicating a robust treatment effect. Tests of clinical significance showed that 82% of children in the treatment group showed reliable change, with 71% being classified as recovered (scoring in the normal range) on the Eyberg Child Behaviour Inventory. No children in the control group recovered.

A recent study of PW as a family intervention has found that family functioning, as measured by the Family Assessment Device (Miller, Epstein, Bishop, & Keitner, 1985), improved after parents and children used the programme (Woodruff, Gordon, &

Lobo,2,000). High risk, disadvantaged families with a fourth-to sixth grade student were randomly assigned to receive in their homes either the PW programme (on a laptop computer) or parent education booklets covering similar content. The PW group showed larger effect sizes for reductions in child problem behaviour (on the Eyberg Child Behaviour Inventory) and improvements in family functioning.

These studies are summarized in Table 2, along with their effect sizes for child problem behaviour. When compared with interventions producing similar effect sizes (Webster-Stratton's and Patterson's programs), the modest time commitment required of families for the brief PW approach is well-compensated.

[INSERT TABLE 2 ABOUT HERE]

When the PW programme was implemented with at risk families through urban schools, the programme reduced family violence (Rolland-Stanar, Gordon, & Carlston, 2001). Spousal conflict showed a significant reduction, as well as conflict and aggression between parents and children (via child report). General violence scores, as well as verbal aggression and severe violence subscores, all improved. Children reported that their hyperactive behaviours declined, relative to an untreated control group.

In all the studies conducted on PW, parents who used the programme reported overall satisfaction and found the teaching format easy to follow. They also found the scenarios realistic, the problems depicted to be relevant to their families, and the parenting skills taught reasonable solutions to those problems. The parents felt confident they could apply the skills in their families. These findings may help explain why parents were willing to spend two to three hours in one sitting using the programme, and why improvements in child behaviour were evident as soon as a week after parents used the programme.

The size of the treatment effect is highly unusual, given the very brief duration of the treatment. Although effect sizes for other studies using interactive video were also moderately large (McNeil & Nelson, 1991, Niemiec & Walberg, 1987), high-risk families have not, until now, been exposed to this technology, nor has CD-ROM or interactive video been applied to parenting and family living skills. These large treatment effects are probably due to a combination of at least three factors: videotaped modeling of excellent

and highly relevant content, a very high level of required user interaction, and the privacy, self-paced, and nonjudgmental format of a computer (Gordon, 2000).

VII. Dissemination of Parenting Wisely

The PW programme is being used in over 200 locations in the U.S. and in dozens of communities in England, Ireland, and Australia. It has enjoyed a fairly rapid dissemination, due to a number of factors. The programme is packaged as a stand-alone programme requiring no training of practitioners. The time and expense agencies must devote if they want to ensure and maintain treatment integrity is not an issue, since the PW programme is a computer-CDROM programme. Its brevity and non-threatening nature increases its access to families, particularly high-risk families. It also lends itself to evaluation since most families complete outcome measures when they first use the programme, and most families complete the programme in a short period of time. The programme includes a range of good pretest and posttest measures, with simple instructions on how to conduct programme evaluation. The effectiveness of the programme has contributed to its popularity. Publicity from CSAP and the Centers for Application of Prevention Technology has stimulated interest. A more detailed analysis of factors contributing to successful implementation of the programme, following a survey of sites implementing PW, has just been completed (Gordon, 2001).

In order to market the programme, I formed a company through Ohio University's business incubation center. This center exists to assist faculty members in taking their inventions to market and to create jobs for the area. The company, Family Works Inc., developed a professional look for the programme, integrated new research findings into upgrades of the programme, and conducted marketing activities to make the programme known to service providers who deal with at risk children and families. Elsewhere, I discuss the advantages and disadvantages to programme developers in forming companies to market their programmes are discussed in (Gordon, 2000). While we must be careful not to let the business aspects of these companies influence our focus on continuously evaluating and enhancing effectiveness, the dissemination of these programmes leads to

independent evaluations. We know of at least a dozen independent evaluations of the PW programme currently underway.

VIII. Integration of FFT with Parenting Wisely

The idea to use these two programmes in tandem as a routine practice came after anecdotal feedback from several families of offenders who had used PW either before or after receiving FFT. These families reported that they had a much clearer understanding of the skills we were attempting to train during the educational phase of FFT once they used the PW programme. For those who used PW first, the parents were less resistant to discussing their parenting practices and practicing the skills needed to improve.

When FFT is implemented first with a family, an appropriate time to introduce PW is during the education or behaviour change phase. The skill training the therapists do during the sessions will be reinforced by the PW programme, as well as giving the family a different format for learning (more interactive, private, multimedia presentations (video, audio, text, graphics). Therapists can spend less time with skill training, instead working more on motivating and prompting parents to practice skills between therapy sessions. It may be a better use of therapists' time and skills to focus on other matters while letting the technology handle much of the skill training. Similarly, therapists can use videos, audiotapes, and instructional handouts to teach parenting skills during this phase.

We have also used PW as a follow up or booster treatment a month or two after terminating a family. Most families are very receptive to recommendations of their therapist at that point. We have found PW to be useful as a recruitment method for families for FFT. In our programme targeting the highest risk families whose young offenders have had several institutional placements, most parents refuse to participate in family therapy. More than half of these treatment refusers will allow someone to bring a laptop computer into their home and will use the PW programme with their adolescent. Of those who do, some of them subsequently agree to participate in FFT. One effect of the PW programme is to convince parents that their parenting techniques are related to their child's misbehaviour, and that they can improve such behaviour by changing their methods. The programme gives them some confidence that they will be able to do this.

However, with the severe problems they face with their children, some parents then are open to receiving more help.

Continuum of services. Some agencies have developed a continuum of parenting/family interventions to serve families with varying needs and abilities to engage in treatment. For those families with children with mild to moderate behaviour problems, or for those who are unwilling or unable to commit to more than one or two appointments, the PW programme is used without other services. Most families are advised to use the PW programme several times to absorb more information in the programme. Other families receive PW, then participate in ongoing parent education groups. The more dysfunctional families, who are motivated, receive PW and family therapy.

Recently I developed a curriculum/treatment manual for four sessions of family intervention (Appendix A). This very brief programme is based on my adaptation of the FFT model and is intended for use in the following three circumstances: 1) families who use PW and either do not need more than several consultations with a therapist to resolve most of their problems; 2) families who will not engage for more than several sessions; 3) a shortage of family therapists cannot meet the demand for full length family therapy. This model is more psychoeducational than psychotherapeutic, and focuses on empowering families to use the skills they were exposed to in the PW programme and its workbook. Rather than telling families how to resolve problems, the therapists prompt parental recall of programme scenes and skills that might resolve current problems. Therapists motivate parents to practice and implement the skills presented in the PW programme. In this way, the families' dependence on the therapist as a problem solver and crisis interventionist is minimized. During some of the sessions, parents are encouraged to apply the skills they have learned to a greater variety of challenging child behaviour problems (substance abuse, theft, aggression and violence, self-harm, hygiene problems).

This four session family consultation model is being implemented and tested in locations in Ireland, England, and the U.S. Evaluations will determine any additive effect of these consultations upon changes produced by the PW programme alone.

Where do we go from here? The challenges to disseminate these effective parent and family intervention are plentiful. We cannot rely upon recent evaluations showing that these approaches are more effective and cost-effective than traditional approaches and the rational acceptance of this information to continue. Educating legislatures and policy makers about the need to adequately fund and maintain these training programs is paramount. Accountability at the local level of implementation must be established to avoid practitioners rejecting the training or drifting away from the manualized treatment models.

The families who can benefit from these interventions must be recruited and engaged more effectively. Early exposure to parenting training will increase later acceptance, so parents should be enticed to receive such training when their children are very young, preferably before they enter school. If we can set the expectation that receiving this training is expected of all parents throughout the child's development, the stigma attached to parenting help will diminish. As more programs are disseminated, we will be better able to offer a continuum of effective services that are matched to the families' needs.

Table 1. Comparison of Therapy and Interactive CD-ROM

Therapy	Interactive CD-ROM
1. Verbal descriptions of parenting	detailed verbal and visual examples of parenting
2. Judgment by therapist	no judgment by computer
3. Client defensiveness main obstacle to progress	minimal client defensiveness
4. Client discloses parenting errors	client recognizes parenting errors by actors
5. Feedback on parenting errors infrequent and indirect	client actively seeks feedback on parenting errors performed by actors in program
6. Client rarely asks for repetition of unclear advice	client can repeat any part of program any time
7. Often pace selected by therapist	pace always selected by client
8. Infrequent reinforcement of good parenting practices	frequent reinforcement of good parenting practices
9. Focus on therapist-client relationship	exclusive focus on teaching good parenting
10. Majority of therapy time and cost	little of program time devoted to resistance

devoted to resistance

11. Difficult to improve therapist skills relatively easy to improve program content

Alexander, J. F., Barton, C., Schiavo, R. S., & Parsons, B. V. (1976). Systems behavioral intervention with families of delinquents: Therapist characteristics, family behavior, and outcome. Journal of Consulting and Clinical Psychology, 44, 656-664.

Alexander, J. F., & Parsons, B. V. (1973). Short-term behavioral intervention with delinquent families: Impact on family process and recidivism. Journal of Abnormal Psychology, 81, 218-225.

Alexander, J. F., & Parsons, B. V. (1982). Functional family therapy. Monterey, CA: Brooks/Cole.

Alexander, J.F., Pugh, C., Parsons, B., & Sexton, T.(2000) Book three: Functional Family Therapy. In D.S. Elliott (Ed.) Blueprints for Violence Prevention. Golden, CO: Venture Publishing.

Bickman, L. (Ed.) (1996) The Fort Bragg Experiment. (Special Issue). Jounal of Mental Health Administration, 23, (1).

Bickman, L, & Noser, K. (1999). Meeting the challenges in the delivery of child and adolescent mental health services in the next millennium: The continuous quality improvement approach. Applied & Preventive Psychology, 8, 247-256.

Brown, B. B., Mounts, N., Lamborn, S. D., & Steinberg, L. (1993). Preventing childhood disorders, substance abuse, and delinquency (pp. 215-240). Thousand Oaks, CA: Sage Publications.

Carr, A. (Ed.) (2000) What Works for Children and Adolescents: A critical review of psychological interventions with children, adolescents, and their families. London: Routledge.

Chamberlain, P., & Reid, J.B. (1987). Parent observation and report of child symptoms. Behavioral Assessment, 9, 97-109.

Chambless, D.L. (1999). Empirically validated treatments—what now? Applied & Preventive Psychology, 8, 281-284.

Eyberg, S. M., & Robinson, E. A. (1983). Conduct problem behaviour: Standardization of a behavioural rating scale with adolescents. Journal of Clinical Child Psychology, 12, 347-354.

Eyberg, S. M., & Ross, A. W. (1978). Assessment of child behaviour problems: The validation of a new inventory. Journal of Clinical Psychology, 16, 113-116.

Farrington, D.P. (1995) The twelfth Jack Tizard memorial lecture: The development of offending and antisocial behavior from childhood: Key findings from the Cambridge study in delinquent development. Journal of Child Psychology and Psychiatry and Allied Disciplines, 360, 929-964.

Fletcher, J. D. (1990). Effectiveness and cost ofe. interactive videodisc instruction in defense training and education (Report No. P-2372). Institute for Defense Analysis.

Kacir, C., & Gordon, D.A. (1999) Parenting Adolescents Wisely: The Effectiveness of an Interactive Videodisk Parent Training Programme in Appalachia. Child and Family Behaviour Therapy, 21 (4), 1-22.

Glynn, T. J., & Haenlein, M. (1988). Family theory and research on adolescent drug use: A review. Journal of Chemical Dependency and Treatment, 1(2), 39-56.

Gordon, D.A. (1995) Functional Family Therapy. In R.Ross and D. Antonowicz (ed, & G. Dhaliwal (Eds.), Gair oing strainght: Effective delinquency prevention and offender rehabilitation. Ottawa, Ontario: Air Training and Publications, 163-178.

Gordon, D. A. (2000). Parent training via CD-ROM: Using technology to disseminate effective prevention practices. The Journal of Primary Prevention, 21 (2), 227-251.

Gordon, D.A. (2001). Factors predictive of successful implementation of a parent training program. Unpublished manuscript, Ohio University.

Gordon, D.A., Jurkovic, G., & Arbuthnot, J. (1998). Treatment of the juvenile offender. In R. Wettstein (Ed.)Treatment of offenders with mental disorders. New York: Guilford Press, 365-428.

Gordon, D.A., Arbuthnot, J., Gustafson, K, & McGreen, P. (1988) Home-based behavioral-systems family therapy with disadvantaged delinquents. American Journal of Family Therapy, 16, 243-255.

Gordon, D.A., Graves, K., & Arbuthnot, J. (1995) The effect of functional family therapy for delinquents on adult criminal behavior. Criminal Justice and Behavior, 22, 60-73.

Kumpfer, K. L., & DeMarsh, J. (1986). Family Environmental and genetic influences on children's future chemical dependency. Journal of Children in a Contemporary Society, 18(1-2), 49-91.

Lagges, A., & Gordon, D. A. (1999). Use of an interactive laserdisc parent training program with teenage parents. Child and Family Behavior Therapy, 21, 19-37.

Lorion, R. P., Tolan, P. H., & Wahler, R. G. (1987). Prevention. In H. C.Quay (Ed.), Handbook of juvenile delinquency. New York:: Wiley, 383-416.

Malkus, B. M. (1994). Family dynamic and structural correlates of adolescent substance abuse: A comparison of families of non-substance abusers and substance abusers. Journal of Child and Adolescent Substance Abuse, 3(4), 39-52.

McCord, W. M. (1982). The psychopath and milieu therapy. New York: Academic Press.

Snyder, J., & Patterson, G. R. (1987). Family interaction and delinquent behavior. In H. C. Quay (Ed.), Handbook of juvenile delinquency. New York: Wiley.

McKay, J. R., Murphy, R. T., Rivinus, T. R., & Maisto, S. A. (1991). Family dysfunction and alcohol and drug use in adolescent psychiatric inpatients. Journal of the American Academy of Child and Adolescent Psychiatry, 30(6), 967-972.

McNeil, B. J., & Nelson, K. R. (1991). Meta-analysis of interactive video instruction: A 10 year review of achievement effects. Journal of Computer-Based Instruction, 18 (1), 1-6.

Mendel, R.A. (2000). Less hype, more help: Reducing juvenile crime, what works—and what doesn't. Washington, D.C.: American Youth Policy Forum.

Miller, I. W. Epstein, N. B., Bishop, D. S. & Keitner, G. I. (1985). The McMaster Family Assessment Device: Reliability and validity. Journal of Marital and Family Therapy, 11, 345-356.

Niemiec, R., & Walberg, H. J. (1987). Comparative effects of computer-assisted instruction: A synthesis of reviews. Journal of Educational Computing Research, 3 (1), 19-37.

Rolland-Stanar, C., Gordon, D.A., & Carlston, D. (2001). A school-based parent training intervention to reduce family violence. Unpublished manuscript, Ohio University.

Serketich, W. J., & Dumas, J.E. (1996). The effectiveness of behavioural parent training to midify antisocial behaviour in children: A meta-analysis. Behaviour Therapy, 27, 171-186.

Spoth, R., & Redmond, C. (1995). Parent motivation to enroll in parenting skills programs: A model of family context and health belief predictors. Journal of Family Psychology, 9, 294-310.

St. Pierre, T.L., & Kaltreider, D.L. (1997) Strategies for involving parents of high-risk youth in drug prevention: A three year longitudinal study in Bosy and Girls Clubs, Journal of Community Psychology, 25(5)473-485.

Webster-Stratton, C., Hollinsworth, T., & Kolpacoff, M. (1989). The long-term effectiveness and clinical significance of three cost-effective training programmes for families with conduct-problem children. Journal of Consulting and Clinical Psychology, 57, 550-553.

Webster-Stratton, C., Kolpacoff, M., & Hollinsworth, T. (1988). Self-administered videotape therapy for families with conduct-problem children: Comparison with two cost-effective treatments and a control group. Journal of Consulting and Clinical Psychology, 56, 558-566.

Weiss, B., Catron, T., Harris, V., & Phung, T.M. (1999). The effectiveness of traditional child psychotherapy. Journal of Consulting of Consulting and Clinical Psychology, 67 (1), 82-94.

Woodruff, C., Gordon, D.A., & Lobo, T. R. (2000). Reaching high risk families through home-based parent training: A comparison of interactive CD-ROM and self-help parenting programmes. Unpublished manuscript, Ohio University.

Appendix A

MANUAL FOR INDIVIDUAL CONSULTATION WITH FAMILIES WHO HAVE USED PARENTING WISELY

Objectives and Philosophy: The purpose of this manual is to teach family intervention skills to service providers to effectively extend the skill training of Parenting Wisely (PW) and address other risk factors in only four sessions with family (mother and at least one child).

This very brief family intervention model presents basic effective components of family therapy and parent training, and should be accompanied by the use of psychoeducational aids such a pamphlets, videos, handouts, and homework assignments from the PW workbook. The purpose of these four sessions is to empower family members to transfer the skills learned from the PW programme to all parenting challenges. As the PW model relies upon pscychoeducation rather than a client-therapist relationship, the consultant's main role will be motivating parents to use these psychoeducational resources rather than relying on the consultant for emotional and functional support.

Prior to working with families service providers must have used the PW programme and be familiar with its operation and content, as well as read the PW parent workbook carefully. This is necessary since prompting parents to recall specific parts of the PW programme and refer to the workbook is a central feature of the family consultations. In addition, rapport is improved when the providers disclose their experiences with the programme and implementation of the skills with their own children.

Practitioners or service providers come from a variety of backgrounds. This manual focuses on teaching very basic skills for working with families. With increasing experience, practitioners will make use of the more advanced material in this workbook. Each of the four sessions of consultation with the families is outlined as to the basic tasks to be accomplished. As trainees gain experience and effectiveness, they will react more dynamically to the families needs. They will be able to change the order of material covered in the four sessions and supplement the basic tasks as needed, with additional interventions (such as guidance for dealing with depression or marital conflict).

This model of family interventions is briefer than others, and different in focus. Since families (at least the primary parent) will have used the PW programme prior to these four

sessions, most will be more able to focus on the objectives of these sessions instead of requiring many sessions of rapport-building and preparations to begin discussions of parenting issues. The objectives of these four sessions is to encourage practice of the PW skills, to help parents use the skills learned from PW in different situations, and to increase the number of PW skills they use in their daily lives. Thus, we are trying to get parents (and other family members) to transfer, extend, and generalize what they learned or started to learn in the PW programme. In time these skills should become second nature and will be integrated into the day-to-day behaviour of the family.

Basic steps

Session 1

A. Build rapport and trust: Various methods of building trust may be intuitive to many trainees. These include pleasant discussions of issues the trainee and parent or child have in common, such as the trainees being parents themselves to objects in the family's home the trainee can relate to. These pleasantries should not take more than a few minutes (10-15) before getting down to the objectives of the first session. Length of the session should be between 45 and 90 minutes, depending upon your availability and the family's ability to maintain their attention.
B. Objectives: Establish family goals, review effects of PW use on family relations, help parents recall their use of skills, and promote recall of skills demonstrated in PW programme applicable to current concerns about child behaviour.
    1. Establish family goals. Parents will buy into taking your advice on using better parenting skills if they understand how this advice connects to goals they have agreed to. Common goals most parents will agree to are: increased respect among family members, decreased conflict, increased cooperation, increased support, increased maturity and trust. For instance, if the mother resists practicing Active Listening (by not doing workbook exercises or role plays with you), you need to tell her how using this skill with her children will increase the respect she wants from them. If parents deny any problems with their children and cannot endorse any of the goals mentioned above, they will agree with the goal of keeping the court off their backs (ie, by not giving them any more Parenting Orders).
    2. Review effects of PW programme. Ask family members what changes they noticed after using the PW programme. Get them to be specific. If they cannot verbalize changes, review the different skill areas and ask them specifically (communication, discipline, compliance with parental requests, problem solving, using charts, etc.). Be very supportive of changes and look for opportunities to empower family members. If they report increased problems, empathize with their frustrations, then get more information which will allow you to remind them of specific scenarios in the PW programme that would be most relevant to solving the current problems.
    3. Discuss the parents' most pressing current concern regarding the children's behaviour. If the offender is not a concern, focus on other children's behaviour as skills the parent uses with these problems can be applied later to the offender. The reason for focusing on the most current concerns is to engage the parents as soon as possible. When several behaviour problems of the children are mentioned, focus on those that are most frequent and susceptible to improvement following the use of good parenting skills. For example, if the parent mentions sibling arguments, occasional stealing from stores, substance abuse, and getting to school late in the mornings, focus on the sibling arguments and getting to school late. It is important

that parents experience initial success when they try new parenting skills, so problems that are likely to be more responsive to better discipline, communication, contracting, etc. should be chosen.

4. Look for opportunities to relabel or reframe negative motives that parents and children attribute to each other. See Appendix B for common relabels you can use for different kinds of parental and child behaviour.
5. Before the end of the first session, choose a parenting skill most relevant to solving one or more of the problems you discovered in Step 3. Assign as homework the workbook exercises for that skill. Mention that you will go over the homework with them on the next session. It is better if they do the homework on their own rather than have you go through it with them (which may be necessary if they are having trouble or are unmotivated to do the homework). In this way they can take more credit for the improvement and be empowered to solve problems on their own after you stop working with them.
6. As part of normal procedures, the parents will need to use the PW programme a second time, preferable with another family member who has not used the programme. During the first and subsequent sessions, be prepared to recommend this second use. The rationale for a second use is that all families are recommended to do this as the information in the programme cannot be absorbed totally after only one use. Generally, allow 2-4 weeks to elapse before the PW program is repeated.

Session 2

1. Build rapport for several minutes before beginning to go through the content.
2. Review homework. Use your judgment about how firmly to deal with any failure to do the homework. Inquire about application of the skills practiced in homework to family life, being very supportive of any attempts to implement these skills.
3. Review family goals identified in the first session. The purpose of this review is to remind the family they have goals that can be met with the use of the skills in the programme (and you will often need to show them the link between their goals and specific skills). At any point in the four sessions you meet with resistance to working on developing skills, discuss the link between their goals and the skills. It is important that the family not feel you are trying to get them to do something which is not in their acknowledged interests.
4. Inquire about child behaviour problems since the last session. [Be careful that while you empathize you do not get sidetracked for too long. Many of these single parents are hungry for social contact, as they are often isolated and depressed. The social support you provide, while important, will have only short-term benefits. Try to steer the single parent to ongoing sources of social support, such as developing friendships with other single parents, contacting relatives, becoming active in a church or community organization, or seeking counseling (and or medication) for depression.] Prompt parents to think about the parenting skills from PW that may help resolve the recent behaviour problems. You may need to take a longer view and suggest improving communication rather than only implementing assertive discipline or contracting. Ultimately, the relationship between parent and child can be improved and deepened through the positive attention that accompanies good communication skills.

   5. Continue to look for opportunities to recall specific scenarios from the programme that are relevant to current parental concerns. You can help them generalize the problem areas and skills from the programme to different problems they are experiencing with their children. See Appendix C, PROBLEMS NOT COVERED IN PW AND APPLICABLE SKILLS. Your goal is to promote the learning of core parenting skills which are applicable to most parenting challenges they will face. You should avoid being too direct with advice giving such that you are solving their problems for them.

6. Assign homework from the workbook that seems to be most relevant to the areas the parents are most motivated to address.
7. If parents used the programme a second time since the first session, review their reactions and what they learned from the second use.

Session 3

1. Review homework, and focus on family members' (particularly parents') implementation of the skills. Suggest new opportunities to implement the skills practiced during homework. If family members are struggling with communication (active listening, I statements) skills or problem solving, use the suggestions and exercises in the Therapist Manual for Communication and Problem Solving Skills to provide additional practice.
2. Repeat steps 4 and 5 from Session 2. That is, inquire about child behaviour problems since the last session. Then ask parents about which parenting skills might help. As in step 5, help the parent generalize these skills to problems not covered in PW.
3. Again, as in the earlier sessions, be alert for chances to recommend the family use PW again. They may be more motivated to consider doing this by the third or fourth session than they were in the first or second session. For convenience, you could lend them the PW video series to view at home.
4. If parents have younger children or less mature teens, and if they have not learned how to use point systems and charts, you should motivate them to begin using this skill. Review the workbook exercises with them, or give this as a homework assignment. This is a powerful tool that most parents can learn and succeed with quickly. For parents of teens and pre-teens, contracting is a skill they need to learn. Prompt parents to think about situations where contracting would be helpful, then go over the steps in contracting (problem solving
5. If the parents are practicing and understanding the parenting skills, discuss the basic processes present in the core parenting skills. For instance, point out the sequence of listening, making I statements, and problem solving, contracting, or using point systems and charts. Discuss with the more highly functioning parents how this increases mutual respect and promotes responsibility among all family members.
6. Assign homework from the workbook exercises. If you have not done so, assign the contracting exercises for review in the next (last) session.

Session 4

1. Review homework, and recommend continued practice of the skills that are most difficult for the family to use. Reassure them that the awkwardness they experience is normal and will gradually diminish the more they use the skills.
2. Repeat steps 4 and 5 from Session 2. That is, inquire about child behaviour problems since the last session. Then ask parents about which parenting skills might help. As in step 5, help the parent generalize these skills to problems not covered in PW.
3. If you have not discussed school issues, and if they are relevant, discuss the following:

a. Importance of increasing child's self-confidence for school work, reduce criticism

b. Developing good homework habits: set up a predictable routine, using a collaborative rather than authoritarian approach

c. Parental monitoring, limit setting (preferably by contracting)

d. Using point systems to motivate

e. Communicating with teachers

(1) need for parental advocacy

(2) effective strategies for discussions with teachers
(3) promoting continuity between home and school—notes, phone, in person
(4) supporting teachers and encouraging their involvement with the child

4. Repeat step 5 from session 3, on core parenting skills and basic processes underlying them, if there is time and if the parents seem able to understand.
5. Assign homework. Focus on the skills most needed for continued improvement.

If contracting or family problem solving has not been learned, assign this as homework.

6. by reviewing the family's accomplishments, giving their effort and use of new skills credit for positive changes. This is the essence of empowerment. Avoid taking credit yourself, but be aware of the crucial role you played.

Appendix B

Problem Behaviours To Be Reframed

Child behaviours to be reframed to parents:

***sibling conflicts**: seeking attention, kids are bored, or jealous*

***curfew violations**: wanting to be with friends, parents are upset because they are worried*

***not doing homework**: too difficult, child lacks confidence, low on priorities, embarrassed to ask for help, peers pressure child not to do homework*

***child talks back to parent**: need for independence, child showing they can think on their own, practicing their debating skills, may be imitating an argumentative parent*

***child curses parent**: does not know how to put their feelings into words, wants some space or privacy, seeks attention, imitation of others in the family who curse, immature impulse control*

child avoids being at home: feels more comfortable with peers, trying to reduce family conflict
child hits parents: poor impulse control, does not know how to put feelings into words, afraid
child hangs out with peers parents don't like: wants to make own decisions, seeking approval from others

Parent behaviours to be reframed to children:

***parent nags children to be more responsible:** wants them to succeed later, may have unrealistic expectations for child's maturity or age, wants children to feel sense of pride*

***parent is uninvolved with children:** parents needs space, is under pressure, parent does not know how to be involved without being controlling (did not learn how from own parents), respects children's privacy*

***parent yells at children:** parent is tired or frustrated, parent cares too much, takes their job to give guidance and teach maturity too seriously, has learned that yelling works to get things done*

parent hits children: *does not know other methods, believes children need spanking, parent is frustrated and does not know how to put their feelings into words, learned this from their parents and never questioned it*

marital conflict: *parents unaware it is upsetting to children and not paying attention*

parent is overly controlling: *parent tries too hard to make sure child is safe or behaves properly, learned this from their parents, parent is too attached to child, cares too much, parent has hard time trusting*

parent calls child names: *temper control problems, hopes to shock child into behaving well, learned to do this growing up*

Appendix C

Problems Not Covered in PW Programme and Applicable Skills

General theme: apply previously learned skills to new problems, emphasizing listening. Apply only enough discipline to solve problem

1. Verbal and physical aggression (anger control problems)

- child threatens parent with force or assault: defuse situation (i.e.,by leaving or asking child to take a time out), meet and make I statement, state you want to hear what the child was feeling and thinking that led to the threat, using active listening. Call family together at convenient time to problem solve about ideas to prevent such threats, make agreement to try a particular method and reevaluate later. Specify what kinds of verbal aggression are permitted and which are not. . When problem solving, first define the problem specifically, then brainstorming possible solutions, evaluating the suggestions, reaching consensus, then writing down agreement.
-

Problem Solving

- Regulates family communication
- Involves all family members—teens buy into process when they have a say
- Control of conflict, accountability established
- Expectations become specified, consequences are established
- A process of mutual respect is established

Problem Solving Steps

1. Problem definition—specificity, actively listen, solicit each perspective
2. Brainstorming—everyone adds at least one possible solution, suspend evaluation
3. Evaluation—pros and cons for each; which will "fly"
4. Consensus—combination of solutions all can live with
5. Establish consequences and write down
6. Identify a regular family meeting time to review the agreement

- child hits parent: parent makes I statement and using assertive discipline state a consequence immediately. Later, parent states expectation that force is not permissible, and encourages child to participate in discussion of future consequences for hitting. Discuss alternative forms of expressing anger and relieving stress.

2. Theft

- parent discovers child has stolen property (shoplifting) in community: parent asks child why the theft occurred, using active listening to determine underlying motivations, then states own feelings about stealing with I statement. Family problem solving discussion should follow, with focus on consequences the family thinks will be most effective, as well as alternative methods for child getting needs met. Restitution should be emphasized.
- parent discovers child has stolen property from someone in the family: If first time, parent uses I statement and then assertive discipline (stating consequence for the current theft and consequences for future thefts).. If recurring problem, parent calls family meeting and states expectations regarding privacy and security of each family members' belongings. Parent solicits others' thoughts on this issue. Proceed to problem solving, first defining the problem specifically, then brainstorming possible solutions, evaluating the suggestions, reaching consensus, then writing down agreement.

3. Substance abuse

- child returns home and is drunk: using an I statement, parent tells child of their concern and wish to discuss the situation when the child is sober. If a first offense, discuss the circumstances leading to the inebriation and other decisions the child could have made. Active listening enables parent to learn of peer pressure, stress, curiosity, etc. as reasons for getting drunk. Discuss parental expectations about substance use. Explore alternatives to getting into unsafe situations (i.e., driving under the influence) and reach agreement (contract, if necessary). If a repetitive problem, use problem solving strategy leading to a formal agreement (contract) spelling out consequences for success and failure. Be very specific.

4. Curfew violations

- child returns home an hour later than permitted: parent begins by using I statement, then reflects response by child, usually a reason for the delay. Rephrase I statement if necessary. Give child choice of discussing consequence for curfew violation now or at a specific time within the next day. Ask child their recollection of consequence. If consequences for curfew violation had not been specified in advance, problem solve around the issue of current and future consequences. Involve other family members when appropriate in the problem definition, brainstorming, and evaluation of solution phases.

5. Self harm

- child lacerates part of body, or hits head on hard object: parent asks child to desist if caught in the act, or restrains child if necessary. Parent states worry with I statement, invites child to talk about feelings, reflecting whatever child says with active listening, especially underlying feelings. Involve other family members if appropriate in subsequent family discussion. Use problem solving format, stressing supervision, safety and alternate methods of child expressing feelings. Develop method for increasing support for appropriate child behaviour to increase child's feelings of self-efficacy. Consider point systems or contracts for child earning increased freedom from close supervision.

6. Poor hygiene

- child goes for days without bathing or brushing teeth: parents tell child they would like to sit down and discuss ways to encourage child to show better hygiene, and gives child choice of times to do this. Parents begin with I statements, then listen actively to child's point of view. Parents present their reasons for improved hygiene. Problem solve inviting child to make suggestions about improvements and decide issue of reminders from parents. Be specific. Consider using contingency management,

point systems for younger children. Let child monitor progress, with regular supportive feedback from parents when improvement occurs.

Contingency Management

--Systematizes objectives and feedback
--Specifies goals and consequences
--Breaks down goals into component parts
--Tracks performance
--Increases parental monitoring
--Reduces conflict

Principles of Contingency Management

Goals consistent with abilities
Frequency or duration
Reward menu varied
Child input
Establish trade-in times
Regular review at family meetings

FFT Chapter Outline

I. Overview of chapter
II. Risk Factors for delinquency: CSAP paper, Lochman paper
III. Description of FFT
    IV. Theoretical model—cognitive behavioural family systems, social learning
    V. 5 phases: (Ross chap)
    VI. Interrelationship of phases

    IV. Research on FFT
    V. Dissemination issues: supervision, barriers (CSAP, Wettstein)
    VI. Resistant families

    VII. Parenting Wisely—based on FFT, goals for use
        VIII. Description (CSAP)
        IX. Implementation (Kirby)
        X. Research (CSAP)

VIII. Integration of PW and FFT, recs.for each, include 4 session treatment manual & where being implem. And eval.

V. Dissem. Issues
Supervision strategies: obs., tapes (Chambless recs as necessary), grp. Disc., th. Self ratings, lng to relabel & exercises & affectr-behav. Integration, session checklists; initial focus on 1-2 families W/ tapes, 12 mos., limiting # families seen.
Barriers to dissem:a) th. Integrity—effort and expense of maintaining, getting experienced service providers to change, accurate, objective mechanisms to monitor not in place, inadequate consequences for provider change and maintenance of change; Bickman & Noser (1999) express concern about therapists' likelihood of following a defined treatment protocol if ogoing close supervision and consequences are not in place. Because they conclude that there is insufficient scientific evidence that treatment for children and adolescents is effective (as it is delivered in community (as opposed to research) settings, we need to implement continuous quality improvement systems to give service providers feedback about their procedures and outcomes. This has been a very difficult challenge because service providers resist attempts to limit their autonomy. As Chambless (1999) notes in her discussion of the problems with disseminating empirically validated treatments, practicing clinicians are hampered by time, distance, and money in getting supervised training.b) recruiting and retaining providers with personal attributes and skills to benefit from training (i.e.); c) common sense revolution (Gendreau)—anti-empircal bias of those with personal experience, if it makes sense, no need to look for evidence or evaluate (ie., individual th. For troubled kids—cite Weiss & Weis, 1999); d) poor marketing and packaging of EV programmes, great marketing of ineffective or unevaluated programmes (DARE, Active Parenting); e) inability of providers to evaluate research, trust in opinions of peers, limited access to research (don't subscribe to research journals, little time to go to libraries to read them, applied journals not research oriented and emphasize case studies). The APA's Div. 12 (clinical psychology) Task Force on Interventions has a website listing manuals and training in EVTs: www.sscp.psych.ndsu.nodak.edu Many providers and juvenile courts have an individual responsibility orientation which focuses rehabilitative and punitive efforts primarily if not exculusively on the delinquent. It is easier for courts to mandate the delinquent to treatment, and it is easier for service providers to focus on one person than on a family, school, or community. When the treatment occurs

outside the community, as in regional institutional settings, it is often impossible to meaningfully include other important social systems. The problem of informing providers and courts about effective methods of intervening which usually include the family is compounded when politicians call for tougher sanctions for the delinquent as the principal method of reducing juvenile crime.

VI. Resistant families: poverty, suspiciousness, external attributions, messages from school reinf attribs., poor school rels., Ps disengage due to hopelessness, history of defeats (Spoth, Temple ref.—Lagges); Ps dislike being told how to parent—either defensive or ignorant of the rel. betw parenting and child behaviour; substance abuse—focus on strengths, resiliency (Arnolds); Patterson & Forgatch—resistance linked to therapist teaching—this has implications for parent education as well as therapeutic approaches. In groups of mandated parents attending classes, group leaders will not have good methods for detecting the reasons for resistance nor individualized responses for dealing with it. Factors which enhance treatment of resistant families have been studied by Szapocnik (see Utah eval materials) Therapist attributes necessary for engaging and retaining high risk families include intelligence, warmth, nonjudgmental attitude, maturity, enthusiasm, creativity, and openness to learning.

VII.

VIII. PW—from CSAP, Kirby, OCJS proposal—descr., implementation, research

IX. Integration: pre-FFT (changes attributions), educ phase—concurrent, followup boosters. Cols. Project; Deciding on cases for FFT vs. PW. Adding svcs to PW (UK proposal). Channeling therapist activities to non skill training (assessment, relabeling, helping families see applications for skills, motivating).

X. poverty, suspiciousness, external attributions, messages from school reinf attribs., poor school rels., Ps disengage due to hopelessness, history of defeats (Spoth, Temple ref.—Lagges); Ps dislike being told how to parent—either defensive or ignorant of the rel. betw parenting and child behaviour; substance abuse—focus on strengths, resiliency (Arnolds); Patterson & Forgatch—resistance linked to therapist teaching—this has implications for parent education as well as therapeutic approaches. In groups of mandated parents attending classes, group leaders will not have good methods for detecting the reasons for resistance nor individualized responses for dealing with it. Factors which enhance treatment of resistant families have been studied by Szapocnik (see Utah eval materials) Therapist attributes necessary for engaging and retaining high risk families include intelligence, warmth, nonjudgmental attitude, maturity, enthusiasm, creativity, and openness to learning.

XI.

Summary—what we know works, challenges for large scale implementation, parental participation (set expectations early for parent ed, destigmatize, involve parents continually thru their kids dev.), increase info about effective programmes, improve dissem.