

Community Based Multi-Family Groups* and Mental Health Disparities: A Randomized Controlled Trial with Low-Income, African American Children

***Families and Schools Together (FAST) is one of 50 Evidence Based Models identified by the National Registry of Prevention Programs; Substance Abuse and Mental Health Services Administration (SAMHSA)**

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For the complete Abt Assoc. federal research report on Family Support (including FAST), please go to website: <http://www.abtassoc.com/reports/NEFSP-VolB.pdf>)

Multi-Family Groups (FAST)* and Disparities in Mental Health: A Randomized Control Trial with Low-Income, African American Children

***a SAMHSA Model Program (Substance Abuse and Mental Health Services
Administration)**

***Abstract**—Participation rates of low-income, African American children in traditional mental health services are low; yet, minority children are disproportionately served in juvenile courts, special education, and child welfare. A non-traditional engagement process is introduced which re-distributes power to parents through community based multi-family group (MFG). Stages of the MFG are: 1) active outreach with home visits; 2) 8 weekly, school based, MFG co-led by a team of parents and professionals, with parent-led, developmentally appropriate, “generic family enactments” and parent support groups; and 3) 20 monthly, community based, parent-led, MFG. Teams support parents to lead familial processes informed by theories of family systems, family stress, and learning theory, without specified content. Weekly repetitions produce family laughter, build relationships, and increase protective factors for children against risks for mental health problems, substance abuse and delinquency. Developed in 1988, FAST (Families and Schools Together) was identified as one of 50 Evidence Based Models by the National Registry of Prevention Programs for Substance Abuse and Mental Health Services Administration (SAMHSA). An independent rigorous study conducted by Abt Assoc. on FAST as a family support program is reported. Teachers from 9 elementary schools in New Orleans identified 400 children (ave. age 7) with behavioral problems (45% had clinical levels of aggression) whose parents agreed to be in the study. Their families were low-income (75% had incomes <\$15,000), African American (90%), and primarily single mothers (60%) with more than 3 children. Families were randomly assigned to control vs. MFG and were interviewed three times with standardized instruments (CBCL, SSRS) at baseline, post FAST, and at one year follow-up. If they came once, 78% completed 6+ MFG and graduated. The “intent to treat” research design with hierarchical regression analyses of 1 year data showed significant impact on aggression and social skills favoring FAST children (effect size .26) and on parent community leadership favoring FAST. Engagement rates of low-income parents are consistently 80% across 800 FAST sites in 45 states and 5 countries. Disparities can be addressed with community MFG.*

The U.S. Office of the Surgeon General identified a national crisis of health disparities, by contrasting the lack of available mental health services for children compared to the high mental health needs of children, especially for children from low-income, minority families (US Department of Health and Human Services, 2001). The Coalition for Juvenile Justice documented the disproportionate representation of low-income, minority children in the juvenile courts, the prisons, special education services, in school suspension rates, school drop out rates, and in child welfare services (Coalition for Juvenile Justice, 2001). The National Institute on Drug Abuse (NIDA) recently hosted a national conference to showcase research which addresses disparities in substance abuse prevention and treatment. Healthy People 2010 has two priorities for the next decade: eliminating health disparities is one of them (U.S. Dept of Health and Human Services, 2000). What contributes to this crisis?

Are mental health disparities a problem of traditional services, i.e. individually-oriented, one-to-one, office based services vs. community based services? Are disparities a result of the lack of prevention (stress reduction, peer groups) and early intervention programs? Or the lack of fit between the client and the personal characteristics of therapists, i.e. attitude, style, training, gender, or ethnicity? Do societal structures provide unequal access to economic, education, housing and health benefits, which in turn leads to disparities in health? Are scarce funds funding ineffective services in communities with low-income, diverse families?

Recent policy is to identify science based practices (Schinke, et al, 2003) and to use tax dollars for programs that are proven to work. The National Registry of Prevention Programs reviewed over 1000 programs with an independent peer review process for the US. Substance Abuse and Mental Health Services Administration (SAMHSA). Explicit standards include

randomized control trials; 50 programs now have been designated with the highest status of being a Science Based Model (see www.samhsamodels.org). These 50 Models are being recommended to state and local governments for replication with federal dollars substance abuse and mental health dollars. Only a few of the SAMHSA Models are applying family systems theory (e.g. Szapoznick, J.: Brief Strategic Therapy and Family Effectiveness Therapy; Gordon, D.: Positive Parenting; Henggeler, S.: Multi-systemic Therapy; and McDonald, L.: Families and Schools Together, in Schinke, et al, 2003)). Perhaps another standard which could be used to identify a science based Model, would be effectiveness in engaging low-income minority children and parents. Success in addressing disparities in mental health and substance abuse should be a critical standard for recommending “what is proven to work” to communities.

Low-income, African American families, for example, might become more engaged in mental health services if the therapeutic strategies used were informed by clinical research conducted with low-income African American families? Minuchin’s original work (1979) involved direct observation of hundreds of low-income, single parent families interacting with their incarcerated delinquents, most of whom were African American. Structural family therapy evolved from the repeated patterns he identified, patterns related to the importance of hierarchy in families, the impact of cohesive relationships rather than disengaged families, and effective strategies for resolving conflicts of daily living. Coding both verbal and non-verbal communication, he observed the importance of clear family boundaries of sub-systems within the family unit. In recent years, Szapoznik (2001) who developed a family coding system based on Minuchin’s theory, has successfully engaged low-income minority families into mental health outpatient clinics with systemically informed processes and has retained them in family therapy

services (Szapoznik, 1989). Henggeller also built on Minuchin's work to form his own multi-systemic, intensive, in-home intervention (Henggeller, et al, 1998), Henggeller's rigorous research on community-based family therapy demonstrates successful engagement and treatment of court-involved delinquents to reduce recidivism, with low-income, often African American youth.

Engagement of low-income minority populations into mental health services may be enhanced if the approach recognizes the issues of social exclusion, the daily challenges of living in a majority dominated social context, as well as the chronic and acute stressors of living in poverty. Dr. Nancy Boyd-Franklin, an African American family therapist, has a multi-systemic approach which integrates assessment of contextual stresses with the social ecological child development model with family systems (Boyd-Franklin, 1989; Boyd-Franklin & Bry). She recommends non-traditional, informal settings for the application of her approach in treating African American children's mental health needs. Boyd-Franklin also discusses the benefits of multi-family groups (MFG) for African American families, because of the importance culturally of systemic values concerning the centrality and importance of the family.

Unfortunately, MFG are often not recognized as a legitimate form of family therapy by family therapists. In a national survey of marriage and family therapists asking for a description of a primary treatment modality, MFG was a notable omission from the list (Northey, 2002). However, MFG have been in the family therapy literature since the 1950s (Laqueur, 1969). MFG have been reported being used in a range of settings with a range of mental health and health problems: institutional settings (MacFarlane, 2002) and in outpatient clinics with people with serious mental illness (Anderson et al, 1986); outpatient medical settings for diabetes and other chronic medical conditions (Steinglass, 1998), including breast cancer (2004); correctional

settings and group homes for juvenile delinquents (Keiley, 2002; Belsky, 1995) and outpatient mental health clinics (Howe, 1994).

Community based MFG are introduced here as a non-traditional approach for engaging low-income minority children into mental health services; this approach is an effort to address disproportionality of low-income, minority children, by respectfully engaging the parents into partnership in an early intervention process. This paper presents a study of community based MFG, working with 7 year old children with behavior and emotional problems who were identified in elementary schools by their teachers. In this non-traditional approach, low-income, urban, African American parents were engaged by teams to attend MFG; activities promoted social inclusion, built cohesive relationships, and redistributed power and hierarchy within families, across families, and across the systems of school, community and families. Called FAST (Families and Schools Together), this paper presents a randomized control trial on FAST in New Orleans, which was independently conducted by Abt Associates (2001) for the federal government on the effectiveness of family support legislation.

Families and Schools Together (FAST) FAST was developed in 1988 as an early intervention outreach process to engage marginalized, low-income, single parents into mental health services for their “at-risk children” before behavior problems led the children into special education, alcohol and drug abuse, the court system, or child welfare placements (McDonald et al., 1991; McDonald et al, 1997). An outpatient mental health counseling center in Madison, WI, collaborated with a local school, and an alcohol and drug counseling center to start the first community based MFG. The MFG engagement process includes: 1) active outreach with personal home visits; 2) 8 weekly, school based, MFG, co-led by a trained team of parents and

professionals who represent the culture and ethnicity of the invited families; 3) 20 monthly, community based, parent led MFG, with support for appropriate referrals into mental health services. The 8 weekly sessions last 2 ½ hours, with a fixed lottery for every family, a family meal cooked each week by the lottery winner of the week before, and free transportation and child care are provided. The four goals are 1)to strengthen the family, 2)to increase school success, 3)to reduce substance abuse of child and of the parent, and 4)to reduce stress of daily living. Families come because they laugh together and have fun; parents like FAST because they meet and talk each week with other parents; kids like FAST because they get “quality time” with their own parent. Community-based MFG have been developed for babies, pre-school, middle school, and high school students (www.fastprogram.org) The FAST program has been replicated and evaluated in 800 schools, 45 states and 5 countries (McDonald et al, 1991; McDonald et al, 2003; and Moberg et al, 2004). The national average completion rates for FAST if a family which comes once, is 80%.

FAST provides a safe and supportive setting for parents to practice taking the lead on “generic family enactments” that build multiple relationships important in the social ecology of their child’s life (Bronfenbrenner, 1979). Rather than providing family therapy interventions based on individual family diagnoses after a child’s mental health problems are serious enough for referral into a mental health clinic, community-based MGF are offered through elementary schools to parents of children about whom teachers have expressed concerns. MFG activities are based on clinical assumptions made about (1) the developmental stages of children on family relationships, (2) the common stresses experienced by all families of children at a certain age, combined with (3) generic formulations of often-observed, age specific, systemic family

dynamics of children with behavior problems. Based on these assumptions, interactive exercises were created for parents to lead with their own children. The parents also meet in peer groups to build support networks of other parents of same aged children from the same community.

For example, common family systems interactional sequences that could maintain out-of-control aggressive behaviors of a child at the developmental stage of ages 5-8 years are: (1) the **parent-child dyad** is disengaged, or has unresolved conflicts; (2) the **executive sub-system** has unresolved marital conflict (overt or covert) and is disengaged, or a single parent has hierarchical distortions, shifting the power to the child; and (3) the **family unit** has loose boundaries, or is highly stressed, either chronically by poverty or acutely by sudden loss, and the family unit is socially isolated. Multiple rehearsals for 8 weeks of standard, generic family enactments focusing on each issue without any individual family assessments, in a positive, respectful public setting is designed to systematically strengthen each relationship in participating families.

Teams are trained with manuals, videos, and rehearsals, in the specified processes of each “generic family enactment”, and then they coach the parents to lead these interactions each week. Multiple rehearsals of the “standard” enactments strengthen the relationships of any participating family. For eight weeks, parents practice clarifying boundaries of subsystems, reinforcing hierarchy with multiple embedded compliance requests to their child, and organizing turn-taking with personal inquiry. The parent leads family games to build cohesion in which the child is asked to speak and is listened to, and the family laughs together. Each parent plays for 15 minutes alone with the focal child, and “attends” to the child’s initiative, rather than directing, teaching, or criticizing (Kogan, 1979). (Of the 50 SAMHSA Models, about five disseminate this strategy of parent child “special play” time for 15 minutes (Schinke, et al, 2003)).

Many whole families are personally welcomed at the door by team members trained to be respectful of parents as leaders of their families. The public venue implicitly provides a feeling of safety while also blocking family conflict. Team members are trained to be proactive, to watch for signs of conflict, and to directly intervene to block family conflict by distracting, interrupting, or offering explicit support. Families learn new possibilities through repeated positive family experiences, and the child sees the parent as the initiator of these “new” ways.

Table 1

Weekly and Monthly Community Based MFG Activities and Parent Leadership

Weekly MFG (8-10 sessions) Co-Led by Parent and Professional Team	Parents Direct Generic Family Enactments	Protective Factors	Research Base
Flag: The team welcomes parents of each family, asks parents to select a family table and create a family flag to set on their family table for eight weeks. Team gives direction to parents only, and support parents to be in charge of table.	Parent(s) sits with family at a table and gives instructions about activities; child sees parent being in charge. Parent sees team members offering respectful help: adults acting as allies.	Family School Community	Alexander & Parsons (1982); Boyd-Franklin (1989); Minuchin (1979), Satir (1983); Szapocnik (1989).
Greetings and Music: Team moves from table to table to quietly ask parents to publicly introduce their whole family by name; every family has a turn, and is greeted as a family unit, which supports the family boundary. Team asks each parent quietly to ask their children to select a song to lead the crowd in singing. Music, a FAST theme song, special greetings are rituals. Team acts like “waiters” at restaurant.	Parent(s) explain to the children that there will be family unit greetings; the parent stands and introduces the family to the crowd of people; people clap and smile. Parent explains to child that each family will have a turn; parent explains to family the activity of choosing a song; family leads the whole group in singing.	Family School Community	Alexander & Parsons (1982); Boyd-Franklin (1989); Minuchin (1979), Satir (1983); Szapocnik (1989).
Meal: Team insures that families eat a meal together at a family table without interruptions; other families are blocked from visiting across tables, protecting the boundary of the family unit. If a team member sits with a family to eat, they must ask the parent for permission. If a child leaves the table and runs around the room, the team asks the parents how they can support the parent in bringing the child back to the family table; parent experiences family support. Team selects Lottery winning family to maximize retention, and next week that family reciprocates and hosts the meal for all MFG. Team provides money, advice, transportation, home visit and support to insure success in hosting meal. Rotating family pot-luck is recognized with praise.	Parent, as head of the family table, leads the meal time discussion in home language; each week the parent(s) selects one child to go to get the parent a meal and serve the parent; (e.g. one of many imbedded compliance requests); parent practices asking for obedience in a positive way; parent requests this small, positive task which lets the child pay respect to their parent, while the parent sits; the child is praised. The public setting & available team support, helps parent host a conflict free, family meal, without TV. Each family hosts one MFG meal, cooks and plans.	Family School Community	Dunst, Trivette, & Deal (1988); Minuchin (1979); Wolin & Bennett (1984).
Scribbles: Team supports parent to keep family at the family table for one hour; without conflict, by visiting the table, giving parent ideas for fun activities, with equipment; supporting parental hierarchy and authority, for parent to build family cohesion; practice conflict resolution skills with turn-taking; building relationships in public positive setting with supportive team members visiting the family tables.	Parents organizes a drawing and talking game at the family table; parent asks a child to go get papers and pencils, and gives instructions to family members; parent directs turn taking in conversation re: drawing, thoughts, and ideas (with team support). Families laugh, and practice reciprocal listening and talking.	Family School Community	Alexander & Parsons (1982); Egeland (1980); Minuchin (1979); Schedler & Bloch (1990).
Feelings Charades: Team supports parent to keep family at the family table for one hour, without conflict, by visiting the table, giving parent ideas for fun activities, with equipment; team supports parental hierarchy and authority, so parent delegates and leads the fun to build family cohesion; team supports practice of conflict resolution skills with turn-taking, in public positive setting with supportive team members visiting the family tables.	Parent practices leadership skills within the family unit. Parent directs a feelings identification game at the family table: parent directs each family member to go and select a “feeling” card, then organizes taking turns play-acting, guessing and talking about seven basic feelings. (in the fourth week, parents change the game into one they create).	Family School Community	Alexander & Parsons (1982); Egeland (1980); Goleman (1995); Satir (1983); Schedler & Bloch (1990).

<p>Kid's Play Time: Team respects parent needs for respite, and organizes positive peer activities for all the kids which are developmentally appropriate. Local adaptations include acting projects, arts and crafts, sports, reading buddies, elders telling cultural history; active or quiet, but no TV.</p>	<p>Parents explain to their children to go and play and return in one hour; and behave. Parent clarifies adult vs child subsystems, supports peer group needs of children, and delegates child care to shows parental trust in the team.</p>	<p>Child Peers School Community</p>	<p>Minuchin (1979); Rutter (1983).</p>
<p>Parents Talk Time: Team shows respect for the parents wish to have non-directed talk time with one another; team structures 15 minutes of dyad time. Parent partner on team hosts 45 minutes of small group time (8-10 parents) without interruption from children. No didactics or agenda.</p>	<p>Parents meet 1 to 1 (with spouse or two single mothers) to process the day. Mutual aid parent group discusses life, shares advice, builds interdependent relationships with other local school families of the same life cycle stage.</p>	<p>Parents School Community</p>	<p>Belle (1980); Egeland(1980); Freire (1995); Gilligan (1982); Hill (1958); Wahler (1983).</p>
<p>Parent-Child Special Play: This is the heart of the MFG prevention program: Research supports a parent delivered version of play therapy, in which parent follows the child's lead in play, as an effective intervention for children with emotional problems. Team structures 15 min. uninterrupted play time for each parent with one child; team moves table to table to support parent in responding to child-initiated play with full attention, without judging, directing or teaching. Team trained to observe micro-sequences of parent child interaction, and respectfully gives parent feedback: praises and coaches parent to be successful. Non-directive materials provided; team sees the changes happen.</p>	<p>Parent takes one child and finds a place to sit together; parent asks child to select toys to play; parent explains the game: for 15 minutes, the child is in charge and will lead the parent. Parent practices delegation of power to child, with time limits and support from team. Clarifies boundary of parent-child dyadic sub-system within family unit. Parent does not use power, but attention to support child's self-efficacy; builds intimate trust and connection of the parent with focal child; parent practices tuning in; child is enthusiastic</p>	<p>Child</p>	<p>Hanf (1969); Kogan (1980); Kumpfer (1994); Forehand & McMahon (1981); Schedler & Bloch (1990); Webster-Stratton (1991).</p>
<p>Lottery: Team provides incentive for retention in the MFG program: a Fixed lottery: each family wins once. Team asks parents to tell their children to trust the parent, that they are sure that their family will win once and that it will be fair. Team supports parent to help the children learns to delay gratification, and celebrate other families when they win. When the family finally has its turn to win, the child turns to the parent with respect, because they knew this would be fair. Team showcases the whole winning family with applause. Winning family reciprocates with team support and program money, to plans & cook the next week's meal.</p>	<p>Parents tell their children that they are certain that their family will win once, and to actively congratulate other families when they win, and be patient and wait for their turn. Parent shows trust that it will be fair; and expects child to rely on parent, and to display impulse control. Parent sets boundaries of family unit; displays parental hierarchy; has fun and build family cohesion; parent practices conflict resolution skills, i.e. impulse control, with turn-taking of families over time;</p>	<p>Family School Community</p>	<p>Dunst, Trivette, & Deal (1988); Hill (1958); Minuchin (1974).</p>
<p>Closing Circle: Team supports parents to bring children in large circle for closing ritual: announcements, birthdays, etc. Team leads the closing routines, including nonverbal movements passed around the circle in silence, making sounds of rain followed by a sun emerging in the group.</p>	<p>Parent leads children into the circle for closing ritual; parent listens and talks in large group setting; parent models clapping for others' accomplishments; child experiences social inclusion of family with community members</p>	<p>Family School Community</p>	<p>Imber-Black, Roberts, & Whiting (1989), Satir (1983), Wolin & Bennett (1984).</p>
<p>Daily Homework for Parents, Special Play: Team gives parents weekly charts and stickers to parents and gentle reminders to do Special Play every day at home as "home-work." There are no contingencies for not doing it; parents who do it are praised and asked to share their stories.</p>	<p>Parents practice doing special play at home every day for 15 minutes; often parents also do this with their other children. Parents hear from other parents the benefits of this 'special play' intervention; parents see child change.</p>	<p>Family School</p>	<p>Barkley (1987) Kogan (1978) Patterson (1975) Webster-Stratton (1985)</p>
<p>Serious Topic (e.g. Substance Abuse) 5th Week: Team makes a didactic presentation to the family tables; then they ask parents to lead a table based family discussion on the serious topic with their own children. This topic breaks the "no-talk" rule in families about drugs; violence, or depression; often parents self-refer for therapy after this.</p>	<p>Parents lead their children in listening to a brief lecture on a serious topic; then parent leads a discussion of the serious topic at the family table, with support from the team. Parents practice their leadership skills within the family unit, with increased self-efficacy.</p>	<p>Family Community and Family Norms</p>	
<p>Graduation (8th Session): Parent partner (during the parent group) reads personal affirmations to each parent from the whole team, with behaviorally specific observations of positive parenting. Team encourages parents to plan the graduation event and to invite guests; Parents may do skit, give speeches. Team helps children make graduation hats. Principal speaks and gives framed certificates to each whole family; Pomp and Circumstance music and formality foreshadow high school graduation.</p>	<p>Parents as an interdependent group take on first planning function: the FAST graduation ceremony. Decisions are made and informal parent leadership emerges; delegation of responsibility and team work is practiced. These parent leadership skills which were at first practiced within the family unit, are now being developed in the trusting network of the mutual aid parent group, with support.</p>	<p>Family School Community</p>	<p>Minuchin (1974) Patterson (1975) Wahler (1983) Werner (1989)</p>
<p>Monthly MFG (20) Parent Graduates Led: Teams recede in their leadership role with MFGs; not as facilitators, but can continue to attend without providing the agenda; role shifts to support as a resource to parents, with ideas for speakers and supporting referrals. Monthly MFG meetings for two years are offered with a stipend to the interdependent parent graduates receive a small budget and</p>	<p>Parents and their families who attended 5+ weekly MFG sessions, graduate, and now shift to a monthly dosage of MFG. In addition, to being the authority and leader within their own family, they now take charge of the MFG agenda, and practice parent leadership within the structure of relationships with parents of</p>	<p>Families Community</p>	<p>Alinsky (1971); Boyd-Franklin & Bry (2000); Freire (1995); Putnam(2000); Werner & Smith (1992).</p>

support from school with space, transportation for meetings; ideas for speakers; parents set MFG agenda.	same aged children, staff from school and community; MFG community development .
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Research Design The Abt study involved random assignment of about 400 children and their families into the experimental vs. control condition, with assessments conducted before and after a FAST cycle and one year later. Family Services of New Orleans (a respected outpatient mental health clinic) collaborated, organized and implemented the MFG, and led Abt to the nine New Orleans Parish and St. Bernard Parish elementary schools recruited to participate in the study. The schools served low-income, urban, predominantly African American, families; all students and families assigned to the FAST condition were compared with those assigned to the control condition, regardless of exposure to FAST, in a conservative medical-model research design called “intent to treat.” Those assigned to FAST were compared to the control group who received 8 weekly mailings to their homes of commercially available behaviorally oriented parenting pamphlets.

Participants in the project were identified by second, third and fourth grade teachers at nine schools who were asked to refer students with behavioral or emotional problems. Names on the student lists were randomly assigned to FAST or the control condition by Abt staff; then, the parents were recruited into the study. This deviation from the standard random assignment procedure, in which families are recruited to the study without knowing their assignment, was chosen because the outreach process for FAST is part of the intervention. The families assigned to FAST were visited by the team members and were asked to attend FAST at least once to be a part of the study. Fifty four percent of those approached for FAST agreed to be in the study (n=194); of these 25% never actually attended a session; of those families who did attend one

MFG, 78% attended six or more and graduated. In contrast, the families assigned to the control condition were visited by an Abt staff person. Seventy three percent of those families approached to be in the control group were recruited into the research study, which involved three paid interview sessions.

Table 2

MFG Program Participation by 194 Families Assigned to FAST Condition

Number of Sessions Attended	Number of Families
0	50
1 – 2	19
3 – 5	22
6 – 8	103
Total	194

Data Collection Data were collected at three different time points for each child’s family from 1997-99. The program integrity of the implementations was checked three times during each FAST cycle by a certified FAST trainer. The teams were culturally representative (i.e. predominately African American) and had at least one parent from the school on each team. All assessment interviews with the primary caregiver (usually the mother) were conducted by Abt staff in each family’s home, at a time convenient for the family. The field work yielded high response rates for the retention of the parents in the study: 98% at the initial interview, 96% at the 8 week follow-up, and 94% at the annual follow-up. Data were also collected from teachers over two school years; the teachers at follow-up were blind to condition.

Measurement In the initial interview with parents, descriptive information was gathered about the child, the family, and the community. This information included: Child age, ethnicity, and gender; child’s physical health and special needs; household composition; parent education level and family income; and community resources. At each data collection point, information was

also gathered about aspects of child and family behavior. Domains for which data were collected included: children's social activities, social skills and behavior; children's school experience and academic progress; family environment and parenting; learning environment and literacy activities; parent's social support and connectedness; parent mental health; school-family connection; and community participation.

Two widely used measures, with established validity and reliability, were selected to evaluate the child's psychosocial functioning pre, post and at one year follow-up. The Child Behavior Checklist (CBCL) (Achenbach, 1991) is the most respected instrument in the children's mental health field, and is a broad band rating scale with 120 items used to assess problem behaviors either at home (parent form) or at school (teacher form). Two main CBCL scales measure acting out, aggression, impulse control problems, cruelty, delinquency, etc. (Externalizing) and withdrawn, somatic complaints, anxious/depressed behaviors (Internalizing). With a three point range, parents and teachers indicate the extent to which each item describes a child's behavior within the past six months (0=not true, 1=sometimes or somewhat true, 2=very true or often true). T Scores are reported with 50 as normal, 57 as high-risk, and >60 as clinical. The Social Skills Rating System (SSRS) (Gresham and Elliott, 1990) is an instrument which measures children's social skills and behavior problems at home and at school, as well as academic competence (by teacher only). Ratings on 52 items are combined for a total score in social skills, including cooperation, assertion, responsibility, and self control. Higher scores indicate better social skills. The SSRS has been standardized with various groups, including African American, and has documented reliability and validity (Powless & Elliott, 1993). (The Abt study only reported on the Total Scores of the Social Skills of the SSRS.)

Analyses A hierarchical linear modeling analysis was performed for outcome variables for which data were available at each of the three points and which were continuous in nature. This approach estimates individual growth curves on each outcome for each person in the sample, and takes advantage of the three time points of data that were available. The model is hierarchical in that multiple observations on each student are nested within-students. This within-student level of the model addresses the question: How do children and families change over time? A second between-person level of the model builds upon the first level and addresses the question of whether a pattern of change is related to other systematic differences between families in the study. In this study, the second level of modeling is the analysis of greatest interest, because it allows us to examine whether there are differences in the outcome between the groups assigned to FAST and the control condition.

For each outcome variable, a number of covariates were included in the analysis. This was done primarily to control for any potential effects the covariates could have on the outcomes. Demographic covariates included child age at the initial interview, child gender, whether the parents had a high school diploma, and whether the family was above the poverty level. We included variables indicating which school the child attended and which cycle they were in. A variable of time was also created. The final variable included was assignment to the FAST condition; this variable indicated whether there were significant program impacts.

Initial Characteristics of Families and Children (The term focus child is used to refer to the child whom the teacher referred to the study.)

Family Characteristics: The families in this urban study in New Orleans had extremely low incomes (with 75% having incomes under \$15,000). More than 90% were African American, and the families were primarily single parent families (64%) with more than three children per family. In addition, parents listed a number of problems in their local community such as high unemployment, delinquency, guns, and drug dealing. Parents in both groups reported relatively high levels of involvement with their children; and only 15% had moved in the past six months, a relatively low mobility rate in the urban setting. The families assigned to FAST and control conditions did not differ statistically on family characteristics.

Table 3

Family and Child Characteristics

	Total Sample (n=403)	FAST Group (n=206)	Control Group (n=197)	Difference between FAST & Comparison Groups ^a
<i>Child Characteristics</i>				
Mean age in years at start of study (s.d.)	7.52 (1.43)	7.37 (1.42)	7.67 (1.45)	t=2.07, p=.04
Proportion males	.62	.62	.61	$\chi^2=.03$, p=.87
Focus child ethnicity	90% black	92% black	88% black	$\chi^2=3.99$, p=.41
Mean overall health status ^b (s.d.)	3.11 (.63)	3.10 (.65)	3.12 (.62)	t=.25, p=.80
Have special needs	.32	.31	.32	$\chi^2=.04$, p=.84

a For continuous variables, difference between groups is indicated by a t-test value and an associated probability level; for categorical variables, difference between groups is shown with the chi-square and an associated probability.

b A composite of four variables (overall health, resistance to illness, etc); 1=poor health and 4=excellent health.

Child Characteristics: The study sample was about two-thirds boys, 90% African American, average age 7 ½. Children assigned to FAST were very similar to those assigned to the control group across multiple measures in terms of their baseline physical health status, health habits, and socio-emotional development as rated by both their parents and teachers. The baseline parent

and teacher questionnaires indicate that a substantial number of children assigned both to FAST and to the control condition, had special needs or a learning disability (32%) and severe socio-emotional difficulties. On the CBCL the children in the FAST condition had average scores of 61 on Externalizing behaviors (clinical level), and 57 on Internalizing behaviors (at risk), compared with is considered a normal score of 50. Nearly half (45%) of the parents in both groups rated their children as having a clinical level of externalizing problems (aggressive behaviors), and nearly a third (33%) of the parents rated their children as having a clinical level of internalizing problems (anxious). Parents rated their children more negatively than did teachers across both conditions. Study children were rated as displaying significantly more emotional disturbance behavior problems than children from the standardization sample for this measure.

Table 4

Initial Parent and Teacher Ratings^a of Children's Socio-Emotional Behavior

Child's Social-Emotional Behavior	Total Sample	FAST Group	Comparison Group	Difference between FAST & Comparison Groups ^b
Parent Ratings	n=400	n=206	n=194	
SSRS^c : Total				
Mean score (s.d.)	86.92 (17.38)	89.28 (18.04)	84.43 (16.35)	t=2.77, p=.01
CBCL^d : Internalizing Behavior				
Mean score (s.d.)	57.16 (12.60)*	56.93 (12.56)	57.40 (12.67)	t=.37, p=.71
Proportion in clinical range	.33	.33	.34	$\chi^2=2.09$, p=.35
CBCL^d : Externalizing Behavior				
Mean score (s.d.)	61.31 (12.35)	61.10 (12.46)	61.53 (12.26)	t=.35, p=.73
Proportion in clinical range	.45	.45	.44	$\chi^2=1.92$, p=.38

Teacher Ratings				
	N=352	n=184	n=168	
SSRS^c : Total				
Mean score (s.d.)	84.38 (15.74)	84.57 (15.62)	84.17 (15.90)	t=.23, p=.81
CBCL^d : Internalizing Behavior				
Mean score (s.d.)	54.61 (12.18)	53.98 (12.35)	55.29 (11.98)	t=1.01, p=.31
Proportion in clinical range	.24	.22	.26	$\chi^2=1.96$, p=.38
CBCL^d : Externalizing Behavior				
Mean score (s.d.)	55.79 (16.30)	54.73 (16.67)	56.91 (15.87)	t=1.21, p=.23
Proportion in clinical range	.33	.31	.34	$\chi^2=.41$ p=.82
<hr/> a Ratings are reported as standard scores. b For continuous variables, difference between groups is indicated by a t-test value and an associated probability level; for categorical variables, difference between groups is shown with the chi-square and an associated probability. c Social Skills Rating System (Gresham & Elliott, 1990) d Child Behavior Checklist (Achenbach & Edelbrock, 1986) * Significant cohort difference <hr/>				

RESULTS Interviews were held one year after the implementation of the 8 week MFG, enabling examination of the long-term impact of the program. Twenty-eight percent of those assigned to FAST attended no sessions; 78% of those families in this study who went once to FAST, attended six or more MFG and graduated. The conservative ‘intent to treat’ model, including all families assigned to either condition regardless of exposure to the treatment, is a way of managing issues of attrition in large clinical studies. This method enables the researchers to explore impacts sustained over time, beyond the end of the program.

The FAST program drop out rates for the low-income, urban, primarily single parent, African American families, if they came once, were 22%. Although a wide range of variables were measured (the full Abt report is **Online**<http://www.abtassoc.com/reports/NEFSP-VolB.pdf>) **for the family support study,**

only a few significant results were found that distinguished the two groups. The one year results showing statistically significant change are reported here: mental health of the child, (aggression and social skills) and parent leadership in the community, favoring FAST.

Significant group differences in parent ratings of problem behaviors on the CBCL emerged over time, particularly with Externalizing Scale, which is comprised of aggressive behavior and delinquent behaviors. (See Table 6). Parents assigned to FAST described their children as displaying statistically significantly fewer aggressive behaviors and delinquent behavior (Externalizing Scale: $p < .001$) one year after the eight week multi-family group sessions. Whereas the parents assigned to the control condition, reported that their focal child was still showing aggressive behavior at above clinical levels, the FAST children decreased their symptoms to the at-risk level. The effect size was .26, despite the “intent to treat” design. Close to significant differences ($< .08$) were also reported by parents on the Internalizing Scale,

referring to a cluster of anxious and depressed behaviors, FAST vs. control. On a measure of social skills, the SSRS, significant group differences in parent ratings at one year follow-up as well, favoring children assigned to FAST compared to control ($p < .05$). The positive behaviors which improved on the standardized instrument included cooperation, assertion, and self-control.

At one-year follow-up, teachers rated the children's psycho-social functioning in the classroom, without knowing the assigned condition in the research study. Their reports were not significant; however, their scores showed a trend supportive of the direction of change observed by the parents: i.e. better social skills at ($p < .13$) favoring FAST vs. control, and fewer Externalizing Behaviors in the classroom ($p < .13$) favoring FAST vs. control. There were no reported differences by teachers of the Internalizing score between the two groups.

Table 6

One-Year Outcomes for Parent and Teacher Ratings^a of Children's Socio-Emotional Behavior

Child's Social-Emotional Behavior	Total Sample	FAST Group	Control Group	Difference between FAST & Control Groups ^b
Parent Ratings	n=382	n=194	n=188	
SSRS^c : Total				
Mean score (s.d.)	88.55 (16.61)	90.22 (16.61)	86.80 (16.49)	F=3.78, p=.05
CBCL^d : Internalizing Behavior				
Mean score (s.d.)	56.88 (12.01)	55.94 (12.06)	57.84 (11.92)	F=3.02, p=.08
CBCL^d : Externalizing Behavior				
Mean score (s.d.)	59.05 (12.77)	57.19 (12.40)	60.99 (12.89)	F=10.71, p=.001
Teacher Ratings	n=309	n=161	n=148	
SSRS^c : Total				
Mean score (s.d.)	86.00 (15.72)	87.39 (16.62)	84.53 (14.61)	F=2.36, p=.13
CBCL^d : Internalizing Behavior				

Mean score (s.d.)	54.52 (15.26)	54.22 (14.81)	54.63 (15.79)	F=.01, p=.94
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CBCL^d : Externalizing Behavior

Mean score (s.d.)	54.55 (14.68)	52.83 (14.31)	56.49 (14.89)	F=2.29, p=.13
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- a Ratings are reported as standard scores.
 - b For continuous variables, difference between groups is indicated by an F-test value from either a hierarchical linear model or a linear regression and an associated probability level; for categorical variables, difference between groups is shown with Wall chi-square from the logistic regression and an associated probability.
 - c Social Skills Rating System (Gresham & Elliott, 1990)
 - d Child Behavior Checklist (Achenbach & Edelbrock, 1986); lower scores indicate more positive ratings
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The Abt report also reported on parental participation levels in the community at one year follow-up in New Orleans. The parents in the study were interviewed about their volunteer work and their community leadership roles. When comparing the families assigned to the FAST condition vs. the control group, statistically significant differences were noted in favor of FAST. Specifically, more parents assigned to FAST became involved in volunteer activities and held leadership positions in community. Both of these differences were at a significant level of $p < .05$. In addition, two other variables indicated a trend in the same direction ($p < .10$ and $.12$) favoring parent involvement over time (see Table 7).

Table 7

One-Year Outcomes for Parent Community Participation

	Total Sample (n=386)	FAST Group (n=197)	Control Group (n=189)	Difference between FAST & Control Groups ^a
Community Participation				
Proportion of neighborhood resources used by family	.59 (0.25)	.58 (0.24)	.60 (0.26)	F=.04, p=.84
Hours/month of community participation	11.33 (17.66)	11.78 (19.80)	10.86 (15.19)	F=.18, p=.67
Proportion of families who do volunteer work ^b	.21	.22	.19	$\chi^2=4.02$, p=.05
Average hours/week of volunteering	1.96 (5.96)	2.26 (6.43)	1.66 (5.41)	F=2.71, p=.10

Proportion who have held any higher level leadership positions ^c	.13	.15	.12	$\chi^2=2.39, p=.12$
Proportion who held any lower level leadership positions ^c	.18	.19	.16	$\chi^2=3.91, p=.05$

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- a For continuous variables, difference between groups is indicated by an F-test value from either a hierarchical linear model or a linear regression and an associated probability level; for categorical variables, difference between groups is shown with Wall chi-square from the logistic regression and an associated probability.
- b Adapted from “Prospects: The Congressionally Mandated Study of Educational Growth and Opportunity”, Parent Interview (1990).
- c Adapted from “National Evaluation of EvenStart: In-Depth Study”, Parent Interview (1990).
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DISCUSSION

The strengths of this large, rigorous, independently conducted study by Abt Associates are that Abt 1)created working relationships and respectful collaborations over time with the local mental health agencies, the multiple local schools, and the program developer; 2)co-created a classic, randomized control trial in the community with an “intent to treat” research design; for example, Abt accommodated to the program components which included home visits for recruitment; 3)retained the large sample of about 400 very low-income, stressed families with minimal attrition from the research project, and 4)conducted every step of the research process with a high level of professionalism.

In light of mental health disparities crisis for youth and the underutilization of traditional mental health services, the most important finding of this Abt study is the high rate of parent engagement and retention rate of low-income, African American families with children who had clinical level problems on the CBCL. Across the sixteen cycles of MFG at 9 different elementary schools: if the family attended once, 78% graduated; graduation required attending six or more of the eight weekly MFG.

To better understand the meaning of these program retention rates, consider the context of child mental health services literature (Kazdin, 2001). Kazdin reported that if a child or youth attends one session at an outpatient mental health clinic, his drop out rate before completion of treatment would be between 40-60%. If that child is from a low-income, minority, or single parent family, the drop out rates will be even higher. In contrast to these estimates which are based on clinical research, FAST in New Orleans had an average 22% drop out rate. These retention rates are consistent with another randomized control study on the impact of FAST MFG with rural, low-income, Native American children and families: their rates across 7 MFG cycles were 80% (Kratochwill, Levin, & McDonald, in press). Further research should be done on variables which contribute to retention rates for minority children in mental health services.

The impact of the community based MFG on the mental health of the FAST children in New Orleans was significant. Statistically significant outcomes of the Abt study were 1) child mental health functioning as measured by the parent reports on the CBCL and the SSRS, and 2) parent involvement and parent leadership in the community, all favoring FAST. The moderate findings on children's mental health, included reduced aggressive and delinquent behavior (Externalizing scale) and increased social skills, (self-control, assertiveness, cooperation). Both the decrease of problem behaviors and the increase of positive behaviors were outcomes of central importance to the mental health community, the schools, and to the FAST parents. High aggression levels of 8-year-old boys are the single most significant predictors in longitudinal studies of adult incarceration, substance abuse, under-employment, lack of family stability, and school failure. Having good social skills can reduce the long term impact of elevated aggression

levels. The scores of both of these critical features of children's functioning were affected by being assigned to the FAST condition.

The community based MFG engaged and retained marginalized parents, the children assigned to the FAST condition improved and maintained those mental health and social skills gains a year later, and the FAST parents reported increases in parent involvement and parent leadership in the community. However, as stated in the Abt report, the other measures in this family support research project showed no significant differences between FAST and control. The interviews focused on the family environment, family routines, parenting, social support, and the school-family relationships. None of them differentiated between assignment to the two conditions. Thus, the important one year outcomes of the MFG were not explained by the data on the other instruments selected to measure the family support processes. Either the "intent to treat" design was too rigorous for the difficult to measure process changes, or the family processes did not change at all, or the instruments used were not sensitive enough to changes in the family processes, or the parents were poor reporters about what had changed.

Direct observation and coding of over 40 couples' interactions in a laboratory apartment and a path analysis reported in a recent study (Driver and Gottman, 2004) led the investigators toward a new respect for the positive daily exchanges in a couple's routine. They suggested comic exchanges and enthusiastic responses were correlated with conflict resolution success. They concluded that perhaps therapists have underestimated the positive impact in a family of laughing together and having fun, on reduced negativity and ability to survive conflicts. Additional research is needed to better understand and record in valid and reliable ways the changes in family processes, i.e. the dyadic micro-sequences in families, which are taking place

in FAST sessions. Direct observation and coding of individual family processes over time who are participating in the MFG is recommended to better understand how the FAST MFG is linked to improved child mental health outcomes; these are continuous challenges to family systems researchers.

Several site visits with program integrity checks were made for each of the 16 MFG cycles. Although core components were implemented, local adaptations of the MFG processes varied the quality of the implementations considerably. Significant inconsistencies in the quality of implementations were observed, in part because of the economic hardships. This variability is expected in “real world” research and in communities and schools with extremely limited resources. Extra analyses by Abt determined that the site variability did not affect the outcomes. However, Abt discussed the poor implementations as an explanation for the “lack of results”.

On the other hand, the selection of this particular social context for a rigorous test of a family support program for Congress by an independent evaluator can be discussed. Could the setting of inner city schools, extreme poverty and high mental health needs of the children have compromised the overall results? Was this too hard a test for a mere family support program?

The 400 children and families participating in the Abt research had very high needs. Over 1/3 of the children were receiving special education services for emotional disabilities and about 45% of the children were assessed by teachers as having clinical level symptoms. The children’s mental health needs were compounded by social, economic, and contextual struggles of their primarily single parent families: Seventy-five percent had incomes under \$15,000 a year with an average of 3.5 children and they lived in dangerous neighborhoods with high crime rates, murder rates, and drug trading rates. New Orleans at that time had the highest urban violence and

homicide rates in the US. Social inclusion and social support for families are helpful in stressful times as they raise their children. With FAST, there were high levels of engagement, a significant reduction in child mental health problems, an increase in child social skills, and an increase in parent involvement in the New Orleans community, holding one year later.

In a less extreme context, the experimental study on family support of FAST MFG might have shown more effects. However, family support programs cannot substitute for jobs with “a living wage”, for decent housing, for good schools, for safe neighborhoods, and for good medical care. Fair social policies should be instituted which better support families to raise their children.

Conclusion: It is time to consider non-traditional strategies to address the crisis of children’s escalating mental health needs, especially in low-income communities. This study demonstrates the benefits of community based multi family groups, with the values of shared governance and parent empowerment, as an outreach and engagement strategy. Broad implementation of community-based MFG could help with the mental health disparities for our youth by building sustainable relationships within and across families. The disproportionate representation of low-income, minority children with emotional problems combined with the lack of mental health services might be addressed. Benefits include: 1) all families can be strengthened by participating in the “generic” family enactments – it is like getting a “family tune-up;” 2) many whole families can simultaneously receive the “generic” mental health services; 3) the delivery of these “generic mental health services” to 8-30 families at a time can be delivered by trained team, with only one mental health professional present; 4) screening for serious mental health problems can take place in an informal and positive setting; 5) relationships built in 8 weeks across the child’s social ecology are maintained then over time; 6) relationships with a mental

health professional from a community agency helps to facilitate appropriate referrals for more intense, individualized mental health services; 6) MFG might be cost-effective for achieving significant outcomes with child mental health problem reduction, without the use of prescription drugs or intensive, individual therapy; and finally, 7) society benefits from informal social networking between parents of same age children living in the same community, i.e. building social capital in the community.

With the increased social capital that is built through MFG, the need for formal mental health services may be diminished. Both economical and respectful of the strengths of parents as partners in the prevention process, the integration of family systems research and theory with an egalitarian team-led service-delivery process may very well be the road map to future interventions that result in strengthening all families. More research should be done to better document the underlying family processes leading to the children's mental health outcomes, and to further examine the possible benefits of investing in community-based MFG.

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