In recent years a sea change has occurred in thinking about interventions for families with adolescent children. A perception that adolescence was “too late” for family intervention has gradually shifted as evidence has accumulated suggesting that interventions through this period can contribute to healthy youth development. This paper explores the evidence for family-focused adolescent health promotion.

hat adolescence is a distinct phase in human development is a relatively recent historical observation. This shift can be related to social conditions characterised by technological advancement, requiring longer periods of specialised training, and the move to democratic, free-market economies, emphasising tolerance and requiring higher levels of social and emotional skill than previously (Fend 1994).

The notion that working with families may be an important means of promoting healthy adolescent development has been slow to emerge in Australia. The Freudian location of sexual pathology within the family, a rights perspective in youth work, and a focus on early bonding and childhood amongst family specialists have all contributed to a lack of enthusiasm for working with the adolescent’s family. The dramatic social changes for women, families, and society since the 1970s may partly explain an increased interest in working with the adolescent’s family. Bronfenbrenner’s ecological view predicted that close family relationships would play a more influential role in healthy youth development during times of social instability.

In recent years, reviewers have presented evidence that interventions delivered to the families of adolescents can reduce social problems, such as crime and alcohol and drug abuse (Ashery et al. 1998; Toumbourou et al. 2000). A range of intervention strategies has been proposed, including parent education (involving the delivery of information or a curriculum to one or more parents or guardians), adolescent education (targeting the adolescent), family therapy (including both the adolescent and one or more family members), and community change (modifying broader factors that impact the family).

This article reviews research relevant to family-based adolescent health promotion. The research has emerged out of a concern to prevent problems such as substance abuse, crime, youth suicide, and from a broader developmental research focus. In what follows, the term “health promotion” refers to interventions aimed at both preventing problems and encouraging healthy development.
Health issues in adolescence

The Australian Institute of Health and Welfare recently completed a report examining the health of young Australians, aged 12-24 years (Moon et al. 1999). The report demonstrated a number of very positive trends. Two-thirds of young people perceived their health to be excellent or very good, and youth death rates have declined from 85 per 100,000 in 1979 to 60 in 1997, partly attributable to a decline in vehicle accident deaths. Rates of new HIV and syphilis infections have declined since the early 1990s. Teenage fertility has declined from 55 births per 1,000 women in 1971 to 20 in 1988, and has been stable over the remaining decade.

Nevertheless, the sexually transmissible disease chlamydia has more than doubled in prevalence during the 1990s from 71 to 196 per 100,000 notifications. Rates of youth mental illness (particularly depression) are higher than for any other population group, and represent the major burden of disease for young people. Youth suicide, self-harm, tobacco use, harmful alcohol use, and illicit drug use each demonstrated significant increases in the youth population over the early 1990s. The National School Survey conducted in 1999 found that by the final year of secondary school (Year 12), 78 per cent of Australian students had tried tobacco, 33 per cent were smoking on a weekly or more frequent basis, and half had tried cannabis (Drug Policy Expert Committee 2000).

Existing information affirms the inter-relationship of health and behaviour problems emerging during adolescence. For example, re-analysis of 1999 Victorian school survey data (Bond et al. 2000) revealed that 26 per cent of Year 9 students reported recent cigarette use. Compared with other Year 9 students, recent smokers were more likely to have: engaged in binge alcohol use (consumed five or more drinks) in the previous fortnight (7 per cent compared to 44 per cent); used one or more illicit drugs (3 per cent compared to 19 per cent); reported some level of unprotected sexual intercourse (4 per cent compared to 13 per cent); reported more than ten symptoms of depression (17 per cent compared to 30 per cent). This “problem behaviour syndrome” (Jessor and Jessor 1977) appears to be due to common determination through both individual characteristics and experiences within the family and the broader community.

Families differ in their capacity to support the adolescent transition. Family breakdown, economic disadvantage, and vulnerability amongst family members (due to mental illness, substance abuse, or disability) can make the transition more difficult. A number of studies has found sole-parent families to be associated with higher rates of youth substance use (for example, Selnow 1987) and mental health problems (for example, Silburn et al. 1996). These associations arise, in part, from a higher likelihood sole-parent families will experience traumatic conflict around family breakdown, lack of supervision due to the parent’s work pressures, and limited family income resulting in higher exposure to community risk factors. Over the past two decades, low-cost housing has tended to aggregate sole-parent families in low-income neighbourhoods, where crime and drug use are higher (Gregory and Hunter 1995).

Despite public perceptions to the contrary, Australian research generally suggests that young people born overseas and from at least some non-English-speaking backgrounds are less likely to use drugs (Rissel et al. 2000; Coffey et al. 2000) and are more likely than other young people to complete secondary school and participate in higher education (Marks et al. 2000). These findings from research with community samples stand in contrast to the observations of those working with street drug abusers who observe high proportions of youth from recently migrated families (Louie et al. 1998). The difference may be explained by the fact that many migrant families have a high achievement emphasis, low tolerance for norm violation, and an authoritarian approach to discipline. Youthful transgressors may find themselves cut off from family contact, and therefore particularly vulnerable to recruitment into drug-involved peer groups. Guiding families to a less reactive approach to youth transgression offers an important direction for assistance (Szapocznik et al. 1986; Jenkin and McGuiness 1999).

Family processes through adolescence

In the sections that follow, some of the underlying processes which appear central to healthy adolescent functioning, and which can be addressed through family intervention, are examined.

Family attachment in adolescence

The importance of strengthening attachments to both parents and other adults has been widely emphasised in the development of interventions. Although infant bonding appears important in explaining aspects of pathology, a considerable body of work suggests that bonding and attachment to the family remain fluid through childhood and adolescence, and are influenced by ongoing relationship experiences (Catalano and Hawkins 1996).

Attachment processes through adolescence are distinguished by the growth of the child towards cognitive and physical maturity and the re-negotiation of family relationships towards greater reciprocity. Communication processes that enhance attachment through this phase avoid blame and criticism, explore mutual needs, and solve problems constructively. Positive social relationships within the family are considered to increase the parental influence on developing adolescent attitudes and behaviors, and thereby reduce rebellious identification with disaffiliated peer sub-cultures (Jessor and Jessor 1977).

Attitude and behaviour development

The family appears to be an important context for the development of attitudes and behaviours through adolescence. Kandel and Andrews (1987) noted that parents’ values are of particular influence in shaping fundamental adolescent beliefs relevant to education, work, and social relationships. Parents’ behaviours also matter: for example, Australian research has tended to be consistent with overseas studies in finding parental substance use to be an important predictor of adolescent substance use (Williams et al. 2000).

Attitudes to health behaviours may be particularly malleable in late childhood and early adolescence, when decisions relevant to involvement in behaviours such as drug use are being made (Dielman 1994). Catalano and Hawkins (1996) summarised evidence
suggesting that adolescent identification and modeling of parent attitudes and behaviours are typically mediated by family attachment, although not all studies concur (for example, Kandel and Andrews 1987).

**Encouraging healthy adolescent separation**

With the emergence of independent thinking and physical maturity, new horizons open for the adolescent, and parents may be seen as part of the childhood past. Parents often experience the adolescent's separation as a loss, and some level of parental grief is common. Family systems theorists have emphasised the interrelationships in family emotions through this transition in their explanations of the genesis of some adolescent behaviour problems.

With decreasing influence of organised religion and little consensus in social values, sources of social integration outside the family can become more precarious than in the past. Adolescent separation from the family may be more difficult where the parent or adolescent has few social supports, is emotionally vulnerable, is unemployed, or has a lower capacity for independent functioning. By redoubling assistance to the adolescent, some parents temporarily avoid separation, but the consequence may be inhibited opportunity for the adolescent to develop independence. In other families, the adolescent may develop "problems" that require parental assistance (Stanton et al. 1982). Acknowledging the increasing complexity of the adolescent transition and providing social support for parents and adolescents are each important.

**Reducing disharmony and family conflict**

The adolescent is still developing coping strategies to manage the physical and social changes occurring through this period, and the consequence can be an increasing level of conflict within the family.

Conflict resolution skills can make an important contribution to family harmony and adolescent health through this phase. The parent's response through the early adolescent period represents a critical developmental transition factor. Acrimonious conflict with parents can undermine adolescent self-confidence, increase stress, and distance the adolescent from an important source of social support. For example, Brody and Forehand (1993) demonstrated that mother–adolescent conflict predicted early initiation of adolescent substance use.

In their management of the adolescent transition, parents model emotional and relationship skills that can influence the adolescent's approach to later social relationships and challenges. A number of parenting programs encourage parents to examine their own adolescent transition in understanding their response to the adolescent (for example, Jenkin and Bretherton 1994). Specific competencies developing through adolescence that appear to exert a later protective effect include anxiety management (Williams et al. 2000), problem solving (McCubbin et al. 1985), and conflict resolution (Paul et al. 2001).

**Setting limits, enforcing consequences, encouraging responsibility**

Typically, the process of adolescent separation is graded around small "first-time" events, such as going to town or visiting a friend alone. In making judgements, parents balance the requirement to encourage independence against that of ensuring safety. Parental monitoring and supervision are important factors influencing adolescent problem behaviour (Barnes et al. 1994).

Weatherburn and Lind (1998) predicted crime trends in Australian communities by modeling youth availability for delinquent peer activities as a function of parenting neglect. Assisting parents to develop age-appropriate methods of supervision, and establish a basis for reciprocity in providing material and other support, are important aims for intervention.

A further important role for parents through this period is the establishment of appropriate demands for an increasing contribution to family and household responsibilities (Baumrind 1991). In this context, Azrin et al. (1994) demonstrated adolescent substance abuse was influenced by the way in which parents supported and rewarded adolescent behaviour.

**Evaluated family interventions**

Interventions designed to support the adolescent transition years span a broad age range from around ten to 24 years. Programs have been based on a range of theories, including ecological and systems theories, cognitive-behavioural theories, and developmental theories. Many evaluations have built on the pioneering research of Stanton et al. (1982) and Alexander and colleagues (for example, Klein, Alexander and Parsons 1977). The body of knowledge is perhaps most advanced with respect to adolescent family intervention. More recent work has demonstrated the potential success of less intensive parent education strategies.

The selection below, which includes only a few of many interventions, mirrors the historical development of the field by beginning with more intensive programs (designed for families with multiple risk factors) and then generalising to less intensive whole-population prevention and early-intervention applications. A principal but not exclusive focus of the interventions included here is on the prevention and/or treatment of substance abuse; delinquency and crime are among other foci.

The interventions included were evaluated using a design that enabled a causal relationship between intervention exposure and outcomes to be inferred. Such designs typically require randomised assignment or adequate matching to a control group and longitudinal follow-up.

It should be noted that although the "evidence-based" approach offers a practical strategy for measuring effectiveness, the moderating effect of client and context differences has received limited attention. Furthermore, while many evaluations appear promising, it remains unclear whether these positive findings can be generalised beyond the original study teams or to wider population impacts.
Recruiting and engaging families

There are real challenges recruiting families into interventions. Typically, between 10 per cent and 50 per cent of families can be encouraged to enrol in interventions when invitations are extended to all parents within a defined population (universal interventions). Participating parents in early adolescent interventions tend to have higher levels of education (Spoth et al. 1997). Santisteban and Szapocznik (1994) described active recruitment methods that can be successfully employed in interventions aiming to attract disadvantaged families or youth with specific problems such as substance abuse.

Once parents enter interventions, a further challenge is that of engagement (of encouraging interest and retention). Typically, around 60–80 per cent of parents can be retained through all sessions of universal parent education interventions (Spoth et al. 1999).

Family interventions for those with multiple risk factors

Interventions targeting multiple risk families are typically conducted in settings such as drug treatment, juvenile justice and school welfare. Family therapy is often approached reluctantly by government, due to perceptions of undefined length and expense. However, considerable work has been done to better quantify the investment required. A number of research teams has presented evidence supporting the effectiveness of manualised forms of family therapy in the treatment of youth drug abuse (Szapocznik et al. 1988; Liddle and Dakof 1995).

The Addicts and Families Project was historically important in its use of a well-controlled evaluation to demonstrate the effectiveness of family therapy as a treatment for youth substance abuse (Stanton et al. 1982). The study demonstrated that, after six months, supplementing methadone treatment with family therapy reduced drug use in around two-thirds of cases.

Functional Family Therapy has provided leadership in the movement to disseminate brief family therapy using a clearly staged (readily taught) family counselling program involving as few as eight hours of therapist contact. Evaluations have demonstrated reductions in juvenile justice expenditure and prevention of offending amongst the younger siblings of targeted offenders (Klein et al. 1977).

The family is only one of the important social systems impacting on adolescent development. The Multisystemic Treatment program is based on family systems principles, but extends assistance to serious juvenile offenders by including effective intervention strategies to enhance individual competence, tackle peer relationship issues, and ensure access to work, education and community resources. Exposure to the program reduced offending and re-arrests (Cunningham and Henggeler 1999) relative to usual juvenile justice practices. The program appeared more effective than individual counselling in reducing antisocial behaviour for serious adolescent offenders (Borduin et al. 1995), and was effective in engaging families with multiple and complex problems (Cunningham and Henggeler 1999).

The successful application of multisystem casework has inspired applications for younger adolescents. The Targeted Adolescent/Family Multisystems Intervention program uses an individual-focused intervention for high school students and parents. The program is designed for late primary/early high school students evidencing poor school performance and substance misuse or abuse. Bry et al. (1998) reported reduced substance use in the second year. The Families and Schools Together program also targets families where students are identified to have behaviour, learning, or attendance problems in late primary school (McDonald et al. 1991). The program has been successfully trialed in Victoria, beginning in 1997 (Grima 2000).

Intensive family competence training

Young people are at particular risk of substance abuse where their parents abuse substances. Intensive programs that deliver home-based case management and skills training for both parents and children have been developed, targeting families in drug treatment. Successful examples of this approach include the Focus on Families program (Catalano et al. 1999), which demonstrated reduced parental drug use and improved family management, and the Strengthening Families Program, which demonstrated increased children’s protective factors, reduced substance use in both adolescents and parents, and improved parenting behaviours (DeMarsh and Kumpfer 1985).

Universal family interventions

A smaller number of programs has evaluated universal (whole-population) family intervention strategies. These programs used a range of strategies to encourage healthy family communication. The more intensive programs of this type provided professionally-led, sequenced groups for parents and children. Amongst rural families in Iowa, the benefits of these programs delivered in late primary (middle) school included reductions in youth hostile and aggressive behaviour four years later (Spoth et al. 2000).

Less intensive strategies involved providing families with “homework”. The Slick Tracy Home Team program was developed for late primary school and involved a set of activity books completed as homework tasks requiring parental assistance. In the context of broader community mobilisation efforts, delivery of the program was associated with increased communication regarding

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alcohol use, lower initiation of youth smoking, and less regular youth alcohol use (Perry et al. 1993).

Parent education

The above evidence demonstrates that positive improvements in adolescent functioning have been documented through a range of family intervention strategies. In attempting to understand these changes, theorists have suggested that a critical program element may involve changing parent behaviours (for example, Dishion and Andrews 1995). Some evaluated programs have worked only with parents. Parent education may range in intensity from the distribution of one-off messages, using social marketing strategies, through to sequenced curriculum packages that may involve professional contact over multiple sessions.

Much of the research examining parent intervention focuses on efforts to prevent escalation or persistence in problem behaviours. One of the more intensive interventions used social learning principles to develop a training curriculum for parents. Parents targeted for this intervention had adolescent children younger than 16 years who had at least two previous convictions. Evaluation of this small trial demonstrated faster reductions in offending and reduced reliance on incarceration, compared with standard juvenile justice contact (Bank et al. 1991). Bank et al. also reported that an average of 44 hours of professional contact yielded savings estimated in excess of $US100,000 over three years.

Using a similar strategy within an early-intervention framework, Dishion and Andrews (1995) evaluated a 12-week parenting skills program aimed at families where youth had exhibited behavioural problems as children. Exposure to this parent group intervention reduced youth initiation to tobacco use one year later. Reduced parent-adolescent conflict was associated with these positive changes. In a small trial of an interactive, computerised parent education program that presents options for potential parent responses to common dilemmas faced in parenting adolescents, exposure to the package improved effective parenting responses (Kacir and Gordon 1997).

An Australian program was designed to provide a cost-effective method of assistance to parents of a substance-abusing adolescent. Blyth et al. (2000) developed an eight-week, professionally led group intervention. High rates (87 per cent) of depression among participating parents at pre-test reduced to 24 per cent after eight weeks, and further improvements were reported for parental mental health, parental satisfaction and assertive parenting behaviours (Toumbourou et al. 2001a).

Interventions targeting all parents

A growing range of programs aim to provide training and information to all parents with early adolescents in a given population. For example, Preparing for the Drug Free Years is a school-based, five-session, professionally led program aimed at enhancing positive parent-child interactions, parent-child bonding and effective child management. The program was demonstrated to be effective in increasing young people's intention to abstain from alcohol and in enhancing family bonding. Follow-up revealed that benefits in the form of reduced youth alcohol use were sustained two years after the intervention.

Toumbourou and Gregg (2001) reported an evaluation of an Australian program, Parenting Adolescents a Creative Experience (PACE), for parents of early adolescents. Designed as a universal intervention, facilitated groups based on an adult learning model used a curriculum that included adolescent communication, conflict resolution, and adolescent development (Jenkin and Bretherton 1994). Evaluation investigated the impact of seven-week PACE groups on a national sample of 3000 parents and Year 8 adolescents. Although only around 10 per cent of parents were successfully recruited into PACE groups, pre- and post-intervention findings demonstrated that benefits extended more broadly across families in the schools where PACE was offered. Parents and adolescents reported a reduction in family conflict. Adolescents reported increased maternal care, less delinquency, and less substance use (the odds of transition to alcohol use were halved).

The evaluation demonstrated that the parents recruited into the intervention were more frequently sole parents and their children reported higher rates of family conflict and substance use. Four months later at post-test, family conflict and youth substance use had reduced markedly in these families. Evaluation suggested that the substance use of respondents was influenced by their best-friend's substance use. Thus improvements in troubled family relationships appeared to have an impact on a wide group of families linked through peer-friendship networks (Toumbourou and Gregg 2001).

Teaching families to control peer influence

Evidence that peer attachments may be risk factors for youth substance abuse has led to interventions to assist parents to better manage their children's peer relationships. Cohen and Rice (1995) evaluated an intervention that attempted to facilitate this adjustment. The intervention failed to produce changes in adolescent initiation of tobacco or alcohol use. Parent participation was poor, and even among those who participated, attempting to influence their child's choice of peer group was not considered a practical target. Interventions for families with adolescents must be carefully designed, as there are many tensions between issues such as youth requirements for autonomy and increasing family cohesion.

Integrating parent education within schools.

Several research teams are currently active in developing multi-level family support programs for delivery within early secondary school. Dishion and Kavanagh (2000) reported a program in the United States that involves the integration of three levels of support within school (early in US middle school, when children are around 11 years old). At the universal level, all parents are invited to an in-school meeting, and written information and videos covering key parenting skills (cooperation in the home, supervision, problem solving and communication) are distributed. At the next level, a four-hour "family check-up" offers a family assessment and motivational interviewing to encourage accurate appraisal of child risk behaviour and the use of appropriate parenting.
resources. For families where problems are evident, more extended parent training is offered.

Work is underway in Queensland schools to evaluate an adolescent version of the Triple-P Positive Parenting Program. Toumbourou et al. (2001b) are currently investigating the impact of an integrated multi-level secondary school intervention, Resilient Families, which incorporates communication training for students, an information night for parents, sequenced parent education groups, and brief family therapy. The project aims to further explore the assumption that community-based interventions can generate benefits beyond the minority of participants directly exposed to the intervention.

**Conclusions**

A range of work, much of it published in the past six years, suggests the practical potential of involving families in adolescent health promotion. A common thread among family interventions is that of improving communication and reducing conflict. Although there is a dearth of evaluated interventions in Australia, experience overseas and promising local approaches testify to the potential, both at targeted and universal levels, of interventions to support parents and families through the adolescent phase.

Although Australian governments have identified the reduction of adolescent health-compromising behaviours as a priority, significant investment in family-based adolescent health promotion has emerged only recently. There appear to be considerable opportunities to integrate family work in juvenile justice and drug abuse treatment settings. For example, Aos et al. (1998) reported the net economic benefit at around four dollars for each dollar invested in juvenile justice programs such as Functional Family Therapy. Further development of both targeted and whole-population family programs in late primary and early secondary school are promising prevention strategies, but further research will be required to quantify the benefits.

There are many examples of innovative family work in Australia. However, a low level of investment in evaluation creates the risk of this promising work being ignored.

**References**


A common thread among family interventions is that of improving communication and reducing conflict.


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