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ABSTRACT

This Article summarizes a presentation to child mental health scientists, child development experts, neuroscientists, and child health practitioners at a 2017 conference entitled "The Developing Brain: New Directions in Science, Policy, and Law."[1] We presented an evidence-based approach to strengthening families, referred to as the "4Rs and 2Ss Family Strengthening Program," as an option for protecting children and enhancing their overall development. We presented data that found child and family outcomes, including child behavior regulation and functioning, and parent depression and stress, improved among families who participated in the intervention. We also found several intervention innovations that were developed as a result of intensive collaboration with adult caregivers, child mental health providers and services researchers. These innovations include: 1) a multiple family group format composed of up to eight families, and in which at least two generations of each family attend the group; 2) family advocates (trained caregivers that have cared for a child with mental health problems) as group co-facilitators; 3) an intervention protocol that is shared with providers and families; and 4) content that increases transparency of the evidence-based principles including establishing family rules, fostering healthy parent/child relationships, enhancing caregiver social support and decreasing stress.[2]

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1. The conference was held at the Eric P. Newman Education Center on the Medical Campus of Washington University in St. Louis. Dr. Mary McKay, who is the Neidorff Family and Centene Corporation Dean of the Brown School at Washington University in St Louis, presented on the 4Rs and 2Ss Family Strengthening Program.

2. Geetha Gopalan et al., *Multiple Family Groups for Children with Disruptive Behavior Disorders: Child Outcomes at 6-Month Follow-Up*, 24 J. CHILD & FAM. STUD. 2721, 2731 (2015); *See generally* Anil Chacko et al., *Multiple Family Group Service Model for Children with Disruptive*

Evidence-based interventions that support parenting and family processes offer opportunities to meet challenges threatening positive development.[3] Such challenges may include emerging mental health issues and struggles with behavioral regulation. These interventions may be particularly critical during childhood when conduct-related challenges commonly emerge with associated impairments in key areas of functioning at school, home and in the community.

BUILDING RESILIENCE AND PROTECTING CHILDREN: AN EVIDENCE-BASED FAMILY STRENGTHENING APPROACH

The purpose of this Article is to recount exchanges between child mental health scientists, child development experts, neuroscientists, and child health practitioners during a 2017 conference. At this conference, we presented an evidence-based approach to strengthen families, known as the "4Rs and 2Ss Family Strengthening Program" as an option for protecting children and enhancing their overall development. Briefly, the 4Rs and 2Ss intervention draws from group therapy techniques, systemic family therapy and behavioral parent training. It was developed using a common elements approach, which entails identifying techniques and procedures that are common to already existing evidence-based protocols for specific problem areas. As such, the 4Rs and 2Ss multi-family group (MFG) integrates family processes and parenting skills linked to conduct problems from the empirical literature. The targeted skills and family processes are referred to in the curriculum as the 4Rs (Rules, Responsibility, Relationships, and Respectful Communication) and 2Ss (Stress and Social support).[4]

Evidence-based interventions that support parenting and protective family processes offer opportunities to overcome challenges that threaten

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Behavior Disorders: Child Outcomes at Post-Treatment, 23 J. EMOTIONAL & BEHAV. DISORDERS 67 (2015).

3. Mary C. Acri, Geetha Gopalan, Anil Chacko, & Mary M. McKay, *Engaging Families into Treatment for Child Behavior Disorders: A Synthesis of the Literature*. *in* WILEY HANDBOOK OF DISRUPTIVE AND IMPULSE-CONTROL DISORDERS (J. Lochman & W. Mathys eds.) (forthcoming).

4. Mary C. Acri, Emily Hamovitch, Maria Mini, Elene Garay, Claire Conolly & Mary McKay, *Testing the 4Rs and 2Ss Multiple Family Group Intervention: Study Protocol for a Randomized Controlled*, TRIALS (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5716003/pdf/13063_2017_Article_2331.pdf.

positive development, including emerging mental health issues and struggles with behavioral regulation. These interventions may be particularly critical during childhood when conduct related challenges commonly emerge with associated impairments in key areas of functioning at school, at home and in the community.[5]

More specifically, rates of disruptive behavioral disorders, particularly among poverty-impacted children, are unacceptably high.[6] Nationwide, conduct problems account for one-third to one-half of all referrals to public systems[7] and are of great concern due to high impairment and poor developmental trajectory.[8] Yet, children are not receiving adequate care.[9] Thus, the rationale for programmatic and intervention approaches, which support and strengthen families that are rearing children, is based on the need to either directly address or buffer the effects of the numerous threats that can impact child development.

Children of color and those impacted by poverty disproportionately experience adverse circumstances related to hunger, exposure to violence, housing instability and constrained material resources.[10] Researchers

5. Lydia M. Franco, Kara M. Dean-Assael & Mary M. McKay, *Multiple Family Groups to Reduce Youth Behavioral Difficulties*, *in* HANDBOOK OF EVIDENCE-BASED TREATMENT MANUALS FOR CHILDREN AND ADOLESCENTS 546, 547 (2008); *See generally* Gopalan et al., *supra* note 3.

6. Deborah Gorman-Smith, Rolf Loeber, Patrick H. Tolan., *Developmental timing of onsets of disruptive behaviors and later delinquency of inner-city youth*, 9 J. OF CHILD AND FAM. STUD., 203-20 (2000).

7. Mary M. McKay et al., A Collaboratively Designed Child Mental Health Service Model: Multiple Family Groups for Urban Children with Conduct Difficulties, 21(6) RESEARCH ON SOCIAL WORK PRACTICE 664-74.

8. Paul J. Frick & Bryan R. Loney, *Outcomes of Children and Adolescents with Oppositional Defiant Disorder and Conduct Disorder,* HANDBOOK OF DISRUPTIVE BEHAVIOR DISORDERS 507-24 (1998).

9. *See* Geetha Gopalan, Mary A. Cavaleri, William M. Bannon & Mary M. McKay, *Correlates of Externalizing Behavior Symptoms Among Youth Within Two Impoverished, Urban Communities*, 31 CHILD & YOUTH SERV. 92, 112 (2009); Kimberly E. Hoagwood et al., *Integrating Evidence Based Engagement Interventions into 'Real World' Child Mental Health Settings.* 4 J. OF BRIEF TREATMENT AND CRISIS INTERVENTION 177-86 (2004).

10. Carl C. Bell & Esther J. Jenkins, *Community Violence and Children on Chicago's Southside*, 56(1) PSYCHIATRY: INTERPERSONAL AND BIOLOGICAL PROCESSES 46-54 (1993). *See also* Gary W. Evans, *The Environment of Childhood Poverty*, 59(2) AMERICAN PSYCHOLOGIST 77-92 (2004); *and* Deborah Gorman-Smith, Patrick H. Tolan, & David Henry (1999*). The Relation of Community and Family to Risk Among Urban-Poor Adolescents*. *in* HISTORICAL AND GEOGRAPHICAL INFLUENCES ON PSYCHOPATHOLOGY 349-67 (P. Cohen, C. Slomkowski & L. N. Robins eds., 1998); *and* Hirokazu Yoshikawa, Lawrence J. Aber, & William R. Beardslee, *The Effects of Poverty on the Mental, Emotional, and Behavioral Health of Children and Youth: Implications for Prevention*, *67*(4)

frequently associate these challenges with multiple developmental challenges, specifically childhood conduct problems and behavioral impairments.[11]

A. Rationale for the Need for New Evidence-Based Family Strengthening Approaches

Although there are a growing number of approaches aimed at enhancing protective family processes (e.g., establishing rules, encouraging respectful communication),[12] few specifically target families that simultaneously face poverty, discrimination and high levels of adversity.[13] Thus, one of the core premises of the work presented at the conference was reflected in the title of the presentation, "It Takes a Village (young people, parents, family advocates, researchers, policy makers, funders): To create and test new solutions for children and their families for addressing child mental health and overall well-being." One presentation of the conference particularly emphasized the various familial and provider roles in addressing child mental health. Participatory research methods were foundational in the creation and testing of the 4Rs and 2Ss Family Strengthening Program.[14]

More specifically, collaborative research methods were necessary in order to address a set of intractable program delivery challenges, including high rates of missed appointments and premature termination of service involvement by families rearing children with conduct related challenges.[15] Thus, any new evidence-based program needs to be

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AMERICAN PSYCHOLOGIST 272-84 (2012).

11. Patrick H. Tolan, Deborah Gorman-Smith & Rolf Loeber, *Developmental Timing of Onsets of Disruptive Behaviors and Later Delinquency of Inner-City Youth*, 9 J. CHILD & FAM. STUD. 203, 206 (2000); Mary M. McKay et al., *Multiple Family Therapy Groups: A Responsive Intervention Model for Inner City Families*, 18 SOC. WORK WITH GROUPS 41, 42 (1995); Gopalan et al., *supra* note 3, at 2721; *See generally* Chacko et al., *supra* note 3.

12. *See* Acri et al., *supra* note 3.

13. *See* Gopalan et al., *supra* note 2; *and* Chacko et al., *supra* note 2.

14. *See* Gopalan et al., *supra* note 2 (containing a description of the collaborative development of the intervention with providers and caregivers of children with mental health problems).

15. Myla E. Harrison, Mary M. McKay & William M. Bannon, Jr., *Inner-City Child Mental Health Service Use: The Real Question is Why Youth and Families Do Not Use Services*, 40 COMMUNITY MENTAL HEALTH J. 119, 127 (2004); Gopalan et al., *supra* note 9, at 190; *see generally* KIMBERLY E. HOAGWOOD ET AL., CHILDREN'S MENTAL HEALTH RESEARCH: THE POWER OF

maximally aligned with adult caregivers' priorities, their need for relevant information and practical strategies, as well as a delivery model which can be integrated and sustained within resource constrained service systems.[16] In sum, in order to address child mental health and bolster protective family processes to foster positive development for low-income children of color, the presentation stressed the importance of programs that meet the demands of both families and the systems attempting to serve them.

B. Example of a Family Level Strengthening Approach that Improves Young People's Outcomes

The literature around children with emerging or more serious conduct problems, commonly referred to as disruptive behavior disorders, suggests that enhancing parenting and family processes is key to enhancing behavioral regulation and success.[17] More specifically, family factors have been consistently implicated in the onset and maintenance of child disruptive behavioral disorders.[18] Alan Kazdin and Moira Whitley describe how specific family factors tied to poverty (e.g. stress, social isolation) may undermine parenting and contribute to serious childhood behavior problems.[19] In collaboration with parents of color impacted by poverty, living in a large city and service providers, this body of research was summarized to encourage transparency of the evidence base for families and to provide an "easy to remember" means of organizing existing science for busy providers. Specifically, four broad conceptual categories were created and became the family-level targets for MFG: Rules, Responsibility, Relationships and Respectful communication. Stress and Social support were added as these impact service engagement and outcome.[20] Further, researchers decided on a group modality, with multiple family groups being identified as the preferable delivery method

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PARTNERSHIPS (2010) (an overview of family and systems-level barriers that impede families impacted by poverty from accessing and remaining in child mental health services).

16. *See* Gopalan et al., *supra* note 2.

17. *See* Acri et al., *supra* note 3.

18. *See* Acri et al., *supra* note 3.

19. Alan E. Kazdin & Moira K. Whitley, *Treatment of Parental Stress to Enhance Therapeutic Change Among Children Referred for Aggressive and Antisocial Behavior*, 71(3) J. CONSULTING AND CLINICAL PSYCHOLOGY 504 (2003).

20. *See* Acri et al., *supra* note 4.

given key elements of social support that aligned with cultural values of families of color.[21]

Thus, in a first randomized test of the 4Rs and 2Ss Family Strengthening Program, we examined a MFG approach of service delivery.[22] A MFG consists of children and their caregivers coming together with other families in order to learn about and practice a set of family processes that have been empirically linked to children's behavioral success.[23] We chose to employ a group delivered model given the constrained resources and long waiting lists that frequently exist within public safety net service systems.

In our presentation, we organized the MFG content around four areas of family life that we summarized with words beginning with the letter, "R," and two addition aspects of family experiences that affect protective family functioning, which we referred to with words beginning with the letter, "S." More specifically, the sixteen-week intervention protocol helped children and adults work together with other families to strengthen processes related to: Rules, Responsibilities, Respectful communication, Relationships, Stress and Social Support.[24] Importantly, content is duplicated so that each "R" and "S" is presented twice, which allows for families to receive all of the content, even if they miss a session. The studies demonstrated that each one of these intervention targets is linked to the emergence of early conduct related difficulties in children, as well as were associated with childhood behavioral success.

21. Patrick H. Tolan & Mary M. McKay, *Preventing Serious Antisocial Behavior in Inner-City Children: An Empirically Based Family Intervention Program*, 45 FAMILY RELATIONS 1 (1996).
22. *See* Franco et al., *supra* note 5.
23. *See* Gopalan et al., *supra* note 2.
24. *See* Acri et al., *supra* note 4.

Table 1

MFG target	Family-level influences on ODD and CD
Rules	Family organization; consistent discipline
Responsibility	Family connectedness; positive expectancies
Relationships	Family warmth; within family support
Respectful communication	Family communication; conflict; time together
Stress	Parenting hassles and stress; life events
Social support	Social isolation

Researchers examined the impact of the program within an experimental effectiveness study set in resource-constrained child mental health clinics in urban areas.[25] During the course of the program, we followed a sample of hundreds of low-income families of African and Latino descent over ten months; we noted significant improvement in child behavioral functioning, as well as family protective processes.[26]

An important aspect of the intervention protocol hypothesizing a link to these positive outcomes relates to the transparency of the evidence base (e.g., empirical studies that support the relationship between an intervention and outcomes) to both adult caregivers and clinicians operating within urban service delivery settings. More specifically, it was a collaborative working group of adult caregivers raising children with emerging behavioral challenges, as well as providers and child mental health researchers, that developed the 4Rs and the 2Ss.[27] This collaborative process, as well as numerous participatory pilot studies, was believed to enhance the relevance and practicality of the content for MFGs, as well as the format of the intervention. As noted previously, the intervention was developed collaboratively with providers and caregivers of children with mental health problems. In fact, during the conference presentation, our interaction with participants centered on the need to use accessible, non-technical language so that families could relate the information to their day-to-day lives. Further, the information and the

25. Gopalan et al., *supra* note 2, at 2723; Chacko et al., *supra* note 2.
26. Gopalan et al., *supra* note 2, at 2728; Chacko et al., *supra* note 2
27. *See* Frick & Loney, *supra* note 8.

practice activities are purposefully described in ways that support the challenges that interfere with parents' child rearing responsibilities and the degree of difficulty that is associated with making any changes within a family system where there are multiple demands.

Additional core features of the intervention worthy of mentioning include: 1) the intervention manual is shared with both adult caregivers, as well as providers; 2) providers are guided by the protocol, but can modify activities or discussion questions to fit their own preferences and skills and; 3) when possible, a family advocate is tapped to co-facilitate the MFG with a clinician.[28]

In sum, our hypothesis was that, if we drew upon existing evidence-based components coupled with family collaboration with participating families, we could develop and test a highly engaging, impactful service that could potentially protect children and help them correct course to address any behavioral challenges. There was an underlying, straightforward idea that the evidence-base needed to be more aligned with the needs and perspectives of families.

C. Next Steps for Testing and Scaling Family-Strengthening Approaches

Although the outcomes from the first randomized test of the 4Rs and 2Ss was encouraging, we knew from conducting the study that there were numerous issues we needed to address for the program to be embedded in existing child-serving systems.[29] More specifically, given the rates of emerging child conduct problems in children raised in low-income communities, opportunities to participate in these groups had to be made available across communities and distinct service sites.[30] This required us to consider reducing any barriers to implementation and integration of the program into resource-constrained settings. We addressed the most salient obstacles to delivery that we identified in the first trial: 1) some providers' preferred working with families individually as opposed to in groups; 2) the model for being reimbursed by insurance for group delivered services was complex and; 3) providers wished to tailor the intervention material to

28. *See* Gopalan et al., *supra* note 2.
29. *See* Acri et al., *supra* note 4.
30. *See* Acri et al., *supra* note 4.

specific family needs that was not easy within the existing intervention protocol. In order to allow more flexibility in intervention delivery, but also test the impact of any modification, we are currently conducting a large-scale hybrid effectiveness-implementation study of the family strengthening program.[31]

With funding from the National Institute of Mental Health, our team offers child-serving mental health clinics the opportunity to participate in a randomized study. Briefly, all 134 licensed child behavioral health clinics in a large urban city have been randomized to one of three study conditions: 1) standard of care; 2) the 4Rs and 2Ss delivered as it was in the first study and; 3) the 4Rs and 2Ss modified by a local clinic implementation team.[32]

D. Clinic Implementation Teams

A clinic implementation team is an on-the-ground group at the clinical site, which includes a director, providers, adult caregivers and staff. This team works on the evidence-base practice to make it align with what the site can actually deliver, what the providers prefer, and what the families recommend.

In addition, findings from a study regarding implementation strengths and challenges associated with the 4Rs and 2Ss were systematically shared with the members of the clinic implementation teams in order to guide future efforts at reducing barriers to integrating the intervention across settings.[33] Briefly, we found clear benefits associated with MFGs; families who were normally difficulty to engage received treatment that they may not have gotten, families received support from other families, and providers learned about parenting and the group process. However, significant challenges were noted: namely, frustration at a perceived lack of motivation on the part of caregivers, and maintaining consistent attendance and the energy of the early groups over the course of sixteen weeks. Further, providers expressed fatigue as a result of high levels of

31. *See* Acri et al., *supra* note 4.
32. *See* Acri et al., *supra* note 4.
33. Mary C. Acri et al., Standardizing an Evidence-Based Treatment Adaptation Process (manuscript under review) (on file with author).

consistent attendance by families, providing service to more than one high need child/family at a time, providers' weekly involvement with parents. Providers expressed that these areas exposed a serious weakness in skill and preparation. Directors expressed frustration that estimating revenue generated by MFGs in comparison to individual sessions was complex. Given that no-shows are considerably higher and efficiency lower for individualized care, directors endorsed MFGs.[34]

E. Next Steps and Questions to Be Answered

The presentation focused primarily on addressing parent- and family-level outcomes to impact child development and mental health. However, ending remarks focused on protecting children and the adults who rear them from threats that exist at the community level. Abundant research evidence indicates that the exposure to multiple and persistent stressors often found in high poverty neighborhoods can undermine the efforts of parents and families [35] Stressors can (1) disrupt effective parenting practices[36]; (2) undercut protective aspects of family life, such as consistent family interaction and communication opportunities[37]; and (3) create a sense of danger and uncertainty that can heighten family conflict and undermine social ties.[38] These disruptions are often compounded by the adult caregivers' attempts to cope with their own high levels of stress.[39] The parent-child relationship may lead to increased parental stress, directly affecting the teen's development and, in turn, the strength

34. *See* Gopalan et al., *supra* note 2.

35. *See* Gopalan et al., *supra* note 2.

36. *See* Kazdin et al., *supra* note 19.

37. Laurel J. Kiser & Mauren M. Black, *Family Processes in the Midst of Urban Poverty: What Does the Trauma Literature Tell Us?*, 10 AGGRESSION AND VIOLENT BEHAVIOR 715, 719-20 (2005); Gayla Margolin & Elana B. Gordis, *The Effects of Family and Community Violence on Children*, 51 ANN. REV. PSYCHOL. 445, 459 (2000); Cynthia G. Baum & Rex Forehand, *Long Term Follow-Up Assessment of Parent Training by Use of Multiple Outcome Measures*, 12 BEHAVIOR THERAPY 643 (1981)

38. Taken together various studies and others identify stress and how it undercuts the protective functions of family life. *See e.g.,* James Garbarino & Kathleen Kostelny, *Child Maltreatment as a Community Problem*, 16 CHILD ABUSE AND NEGLECT 455, 456 (1992); Nicholas Zill, *Parental Schooling & Children's Health*, 111 PUB. HEALTH REP. 34 (1996); *see generally* Martha R. Burt & Rarbara E. Cohen, *Differences Among Homeless Single Women, Women with Children and Single Men*, 36 SOC. PROBS. 508 (1989)

39. *See generally* ALBERT BANDURA, SOCIAL LEARNING THEORY (1975)

of the adult protective shield,[40] which is the parent's ability to protect their child from adverse outcomes. Existing evidence suggests that families can maintain protective family structures, as well as supportive processes and routines, even in the most adverse circumstances.[41] Focusing on context moves the inquiry from "what is wrong with families and communities?" to "what has happened to them?"[42] This shift promotes a search for conditions that we can address with community-level, structural interventions.

At the conference, we presented a structural intervention, referred to as MAPS, which stands for Mobilizing the Adult Protective Shield. MAPS aims to mobilize families, system leaders and government officials make significant investments in their communities and to address some of the toxic influences that are impacting children. The MAPS intervention is guided by a set of principles: (1) community-level data is transparent to all adults involved in the MAPS study condition (e.g. rates of graduation, unemployment, health indicators); (2) adult caregivers are supported to collaborate with their neighbors to mobilize, plan, and implement strategies that can directly buffer, address or change the adverse effects of underlying neighborhood conditions on their teens.[43]

The Triadic Theory of Influence (TTI),[44] which supports the need to bolster the adult protective shield as well as to address community-level structural conditions, informs MAPS.[45] TTI is a comprehensive ecological

40. Carl C. Bell et al., *Strategies for Health Behavior Change*, *in* THE HEALTH BEHAVIORAL CHANGE IMPERATIVE: THEORY, EDUCATION AND PRACTICE IN DIVERSE POPULATIONS*, 17-39* (2002).

41. Patrick H. Tolan, Deborah Gorman-Smith & Rolf Loeber, *Developmental Timing of Onsets of Disruptive Behaviors and Later Delinquency of Inner-City Youth*, 9 J. CHILD & FAM. STUD. 203, 206 (2000); Mary M. McKay et al., *Multiple Family Therapy Groups: A Responsive Intervention Model for Inner City Families*, 18 SOC. WORK WITH GROUPS 41, 42 (1995); Gopalan et al., *supra* note 3, at 2721; *See generally* Chacko et al., *supra* note 3.

42. Robert Abramovitz & Sandra L. Bloom, *Creating Sanctuary in Residential Treatment for Youth: From the "Well-Ordered Asylum" To A "Living-Learning Environment"*, 74 PSYCHIATRIC Q. 119, 126 (2003).

43. Mary M. McKay & G. Parker, *Mobilizing the Adult Protective Shield (MAPS) Intervention Manual*, New York University (2014).

44. Carl C. Bell, Arvin Bhana, Mary M. McKay & Inge Petersen, *A Commentary on the Triadic Theory of Influence as a Guide for Adapting HIV Prevention Programs for New Contexts and Populations*, 5 SOC. WORK IN MENTAL HEALTH 243 (2007). *See generally* Brain R. Flay & John Petraitis, *The Theory of Triadic Influence: A New Theory of Health Behavior with Implication for Preventive interventions*, 4 ADVANCES IN MED. SOC. 19 (1994).

45. *See* McKay & Parker, *supra* note 43.

framework that seeks to understand youth behavior as being a product of multiple streams of influence—an intra-personal stream, a social normative stream, and a cultural attitudinal stream.[46] TTI incorporates sociological theories of social control and social bonding,[47] peer clustering,[48] cultural identity,[49] psychological theories of attitude change and behavioral prediction,[50] personality development,[51] social learning,[52] and other integrative theories.[53]

Translated into operational field principles, TTI informs the MAPS condition of the current study.[54] Field principles include: (1) re-building the village by developing and expanding community partnerships through community organization around health behavior issues (the "cultural/attitudinal stream" and "social/normative stream" of TTI); (2) improving bonding, attachment, and connectedness—within the community and between stakeholders (the social/normative stream of TTI); (3) improving self-esteem and self-respect (the intra-personal stream of TTI); and (4) reestablishing the adult protective shield (the social/normative stream of TTI). These field principles can serve as the basis of community-level structural interventions, such as MAPS.[55]

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46. *See* Bell et al., *supra* note 44; *and see* Flay & Petraitis, *supra* note 44.

47. E.R. Oetting & Fred Beauvais, *Adolescent Drug Use: Findings of National and Local Surveys*, 58 J. CONSULTING & CLINICAL PSYCHOL. 385 (1990).

48. E.R. Oetting & Fred Beauvais, *Orthogonal Cultural Identification Theory: The Cultural Identification of Minority Adolescents*, 25 SUBSTANCE USE & MISUSE 655 (1991); *see also generally* ICEK AJZEN & MARTIN FISHBEIN, UNDERSTANDING ATTITUDES AND PREDICTING SOCIAL BEHAVIOR (Prentice-Hall, Inc) (1981).

49. Icek Ajzen, *From Intentions to Actions: A Theory of Planned Behavior*, ACTION CONTROL FROM COGNITION TO BEHAVIOR 11 (1985); John M. Digman, *Personality Structure: Emergence of the Five Factor Model*, 41 ANN. REV. PSYCHOL. 417 (1990)

50. *See generally* ALBERT BANDURA, SOCIAL LEARNING THEORY (1975).

51. *See generally* BANDURA, *supra* note 39; *and* ALBERT BANDURA, SOCIAL FOUNDATIONS OF THOUGHT AND ACTION: A SOCIAL COGNITIVE THEORY (Prentice-Hall 1986); *see generally* John P Flay, Brian R. Flay & Todd Q. Miller, *Reviewing Theories of Adolescent Substance Use: Organizing Pieces in the Puzzle*, 117 PSYCHOL. BULL. 67 (1995).

52. *See* Flay et al., *supra*, note 51; *see generally Reducing Health Disparities Through a Focus on Communities*, POLICYLINK (Dec. 19, 2012), http://www.policylink.org/atf/cf/{97c6d565-bb43-406d-a6d5- eca3bbf35af0}/REDUCINGHEALTHDISPARITIES_FINAL.PDF.

53. *See generally* Carl C. Bell, Brain Flay & Roberta Paikoff, *Strategies for Health Behavior Change*, *in* THE HEALTH BEHAVIORAL CHANGE IMPERATIVE: THEORY, EDUCATION AND PRACTICE IN DIVERSE POPULATIONS 17 (2002).

54. *See* McKay & Parker, *supra* note 43.

55. *See generally* Margaret K. Keiley, *The Development and Implementation of an Affect Regulation and Attachment Intervention for Incarcerated Adolescents and Their Parents*, 10 FAM. J.

In sum, in order to protect child development and address challenges that emerge within childhood, there is a need for interventions which:

- Bolster protective parenting and family processes
- Include novel interventions and approaches that can effectively support children, parents and families within resource-constrained systems
- Have an evidence-base that is easily communicated and used by families and providers operating within challenging circumstances
- Use additional approaches that extend beyond the family to directly address aspects of communities that directly undermine the functioning of parents and families
- Include robust experimental examinations of new approaches that can identify not only the strengths of new approaches, but implementation challenges that can be addressed.

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177 (2002); Karol L. Kumpfer et al., *Cultural Sensitivity and Adaptation in Family-Based Prevention Interventions*, 3 PREVENTION SCI. 241 (2002); Robert Wahler & Jean E. Dumas, *Attentional Problems in Dysfunctional Mother-Child Interactions: An Interbehavior Model*, 105 PSYCHOL. BULL. 116 (1989).