Chapter 3

PARENTS AND FAMILIES' INFLUENCE ON ADOLESCENT HEALTH

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Introduction

The family has long been considered the bedrock of American society. Pictured as a place of refuge from the trials and tribulations of everyday life, the family has been praised from podium and pulpit. Poets remind us that the family ''is where, when you go there, they have to take you in. It is a safe harbor, a supportive environment for personal growth and expression. And, indeed, for most people, the family is a place of succor and nourishment-if not always, then at least most of the time.

But there is a darker side to some families that belies these virtues. Life in such families can be terrifying, as violence replaces tranquility, hatred preempts love, hope becomes despair, and a corrosion of character directs the development of family members. These are the families in which nightmares are real and children and adolescents are transformed into victims of oppression.

Adolescent growth and development are deeply affected by the family environment in manifold and enduring ways—for good or for ill. This chapter explores the positive and negative influences of families on the health and maturation of adolescents. Since parents are central authority figures in most families (even during their children's adolescence, when peers' influence increases), the discussion that follows emphasizes the role of parents vis-a-vis adolescent family members. The interactions of siblings, grandparents, and other significant individuals in a variety of family structures are clearly important for adolescent health, but the body of research on their significance to adolescent health is sparse,

This chapter provides a brief overview of the changing nature of the American family, and discusses positive, then negative, influences of parents on adolescents, including maltreatment of adolescents. The chapter is intended to provide an overview of the importance of parents in the lives of adolescents. For some specific adolescent health problems, there has been considerable research on the negative impact of specific features of parent-adolescent relationships; this research is discussed in more detail in the relevant chapters in this volume.[1] It is important to keep in mind, however, that some widely held views that parents are not an important positive influence in the lives of their children during adolescence are now seen as inappropriate inferences drawn from a small body of influential writings earlier in this century. The relationship between parents and their children during adolescence is complicated and clearly differs from that between parents and their younger children. This chapter concludes that more research is needed to investigate the positive and negative features of the parent-child relationship during adolescence, and more guidance is needed for parents during this important period.

The Changing Nature of the American Family

The traditional American nuclear family is often depicted in popular culture as a father, a mother, and several children. Grandparents are depicted either as living with the family or residing somewhere nearby. The father works and the mother cares for the children and home. Today the picture of the traditional family is evolving rapidly into a pluralistic collage of alternative structures (79).

Economic and social forces have brought about significant demographic changes that are reflected in family life throughout the Nation. Divorce, for example, has made the one-parent family commonplace, and remarriage has introduced a stepparent into many homes. Over one-third of the marriages performed in 1988 were second marriages (47,93). With about half of all marriages now ending in divorce and about 23 percent of children born today born outside of marriage, 15.5 million children under age 18—including 6.7 million 10- to 17-year-olds (92a)—live with one parent. In the vast majority of cases (90 percent), children in single parent

[1] See also ch. 10, "Pregnancy and Parenting: Prevention and Services," ch. 12, "Alcohol, Tobacco, and Drug Abuse: Prevention and Services," and ch. 13, "Delinquency: Prevention and Services," in this volume.

households live with their mother (47,92a).[2]3 According to the U.S. Department of Commerce, Bureau of the Census, in 1990, only 28 percent of households consisted of married couples living with their own children[4] underage 18; in 1970,64 percent of households consisted of married couples living with their own children under age 18 (92a).[5] Data from the Bureau of the Census's Current Population Survey indicate that 6,789,000 U.S. children under 18 (approximately 11 percent of the resident population) lived in stepfamilies in 1985 (92d). In 1986, Garbarino and his colleagues estimated that about 11 percent of all adolescents lived in stepfamilies (67).

New social values and fiscal imperatives (e.g., self-actualization, professional opportunities, desire for a higher standard of living) have enabled or compelled many women to work outside the home. Two-thirds of adolescents (17.5 million of those ages 10 to 17) live in households where both parents (or a single parent) work full time (92c). Group housing or similar extended family configurations are sometimes encountered. And all of these and other forms of nontraditional family structures are now part of the domestic landscape of America (3).

In addition, changes in employment are now routine, and families may move from one geographic area to another several times during the course of a decade, removing a child or adolescent from close contact with grandparents and altering the stability of peer relationships. Changes in longevity, later/delayed childbearing, and improvements in health care and nutrition have increased the number of older parents of adolescent children. The automobile and easy access to mass transit in urban areas have also provided adolescents a broader degree of mobility, and with it certain independence from parental influence. Although the specific influences of television and other electronic media on adolescents are not known with certainty, it is widely believed that adolescents are exposed to a more diverse set of messages through the media than they would be through their parents alone (92).

For parents with responsibility for their minor children, these changes can be confusing. Families modeled along traditional lines may feel embattled as they witness the changes occurring around them. Furthermore, many of the new family models have no established or tested guidelines for raising children. Instead, they place parents in the position of having to improvise without the benefit of the historical experience of others to assist them.

Neither research nor custom yields much counsel outside of the traditional nuclear setting. In fact, society tends to question (and sometimes condemn) nontraditional families, so that support is virtually nonexistent. At the same time, those in nontraditional families sometimes criticize traditional family arrangements, further adding to the confusion surrounding families in contemporary society.

Science, too, has added to the problem. New discoveries offering genetic linkages to a variety of health problems raise unanswered ethical questions about parental responsibilities for preventing hereditary conditions. There is increasing evidence, for example, that genetic factors play a role in schizophrenia, major affective disorders, and alcoholism (16,37,38,39,81,106). Genetic factors may also play

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[2]According to the U.S. Department of Commerce, Bureau of the Census, the increase in the number of family households maintained by women alone has accounted for a considerable amount of the change in family composition, especially during the 1970s (92b). About 17 percent of family households were maintained by women alone in 1990, compared with 15 percent in 1980, and 11 percent in 1970 (92 b). However, it is important to note that families maintained by women do not necessarily include any dependent children. For example, these families could include a woman sharing her home with an elderly parent or any other adult relative. In about 61 percent of these families in 1990, one or more of the woman's children underage 18 was present (92b).

[3]The proportion of families with dependent children maintained by mothers alone is much higher for blacks (56 percent in 1990) than for whites (18.8 percent in 1990) (92b). About 30 percent of Hispanic family groups with children under age 18 were maintained by mothers alone (92b).

[4]"*Own children*" in a family are sons and daughters, including stepchildren and adopted children, of the householder (92b).

[5]It may be somewhat important t. note that the absolute number of U.S. households increased between 1970 and 1990, from 63 million to 93 million, largely because of large increases in nonfamily households (e.g., men or women living alone)(92b). Even so, there was a greater absolute number of *family households* consisting of married couples living with their own children under age 18 in 1970 (40.3 million, or 50 percent of family households) than in 1990 (26.3 households, or 27 percent of family households)(92b). (The U.S. Department of Commerce, Bureau of the Census definesa *family as* a group of two persons or more, one of whom is the householder, related bybirth, marriage, or adoption and residing together (92b). A *household* consists of all the persons who occupy a housing unit (a house, an apartment or other group of rooms, or a single room occupied or intended for occupancy as separate living quarters, that is, when the occupants do not live and eat with any other persons in the structure and there is direct access from the outside or through a common hall) (92 b).A *family household is* a household maintained by a family; in addition, any unrelated persons who may be residing there are included in the count of household members(92b).)

[6]See ch. 7, "Nutrition and Fitness Problems," and ch. 13, "Delinquency: Preventions and Service," in this volume for further discussion.

a role in some cases of obesity and violent delinquent behavior.[6]

As if these points of departure from past experience were not enough, parents of adolescents also must face an additional transition in their parenting roles. Adolescents bring challenges that may demand revision of parenting skills; as a result, parents may confront personal uncertainty about appropriate responses to adolescence. Furthermore, some parents may be experiencing significant life changes themselves. And, indeed, studies have found that the parents of adolescents feel less adequate and more anxious about their roles than do parents of younger children (2,48,101).

Positive Parental Influences on Adolescent Health

Many nontechnical books on parenting laud the role of parents in shaping the character of their children,[7] but the predominance of this theme in the popular press is not paralleled in research literature on adolescent health. Instead, most research concentrates on adolescent behaviors, attitudes, and problems and systemic or institutional approaches to problem solving. As Irwin observes, much of the existing research on adolescent health has serious limitations:

> Past research has been guided by the ''storm and stress" perspective of adolescence and has focused on what goes wrong, went wrong, or is going wrong during adolescence. Less is known about what contributes to positive growth and health-enhancing behaviors (51).

To be sure, demonstrations and "projects" that marshal schools and community agencies in efforts to promote improved adolescent health abound—and some of these include family components. But the concept of the family as a front line of defense against adolescent health problems has not permeated the research or services consciousness to any significant extent. As pointed out elsewhere in this OTA Report, for example, there are few carefully evaluated primary prevention efforts that target families for the prevention of human immunodeficiency virus (HIV) infection in adolescents and virtually none that target families to prevent sexually transmitted diseases in adolescents.[8] Furthermore, in those research studies where the family is considered at length, it is usually considered in one of two contexts-either the family's economic or caregiving burden for adolescent health problems or the family's role in causing or exacerbating adolescent health problems (73a).[9,10]

A balanced approach would seem to demand some recognition of the positive parental influence, in the majority of families, on the health and well-being of adolescents. Yet there is a clear need for additional research in this arena-for all family structures, but particularly for separated, minority, and nontraditional families (6,42,43,45,85). In 1987, Campbell noted that fewer than 5 percent of the articles in the literature on families and health were empirical studies (96). If, in fact, parents serve as role models for their children, then the behaviors of parents and the strength of adolescent behavior modeled after parents would seem appropriate areas of investigation. Unfortunately, the old adage "Like father, like son' has not been evaluated extensively from a serious scientific perspective.

The opportunities for significant research on the positive influence of parents and families on adolescent health are manifold. Examples are cited below.

Parents Who Serve as Positive Behavioral Role Models and Transmitters of Values and Information

To what extent are the values and behaviors of parents regarding health practices, personal hygiene, and safety transmitted to adolescents? Do parent models influence adolescent attitudes and behavior to any significant extent? Under what conditions are parental values and behaviors imitated by adoles-

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[7]Very few nonclinical books are written to guide the parents of adolescents, however.

[8]This Petit is made in ch. 9, "AIDS and Other Sexually Transmitted Diseases: Prevention and Services, 'in this volume.

[9]This observation, of course, is not intended to denigrate the importance of a family's financial contribution to adolescent health, nor is it intended to diminish the significance of caregiving within the family setting.

[10]In contrast, Sal's review of preventive programs intended to support parents of adolescents found that most programs addressed the parental role in enforcing rules and limits and in communicating with their children; no programs addressed the basic resource provision function of parents, and very few addressed the role of parents as advocates for their children (i.e., by attempting to help parents become more knowledgeable about the availability and use of community resources) (83a). Very few of the programs had been evaluated for their effectiveness (83a).

cents? How do a parent's positive health- and safety-related values and behaviors relate to adolescent health outcomes? If a parent always uses a seat belt, is an adolescent driver any more likely to do so? If parents have strong objections to alcohol, marijuana, or other psychoactive substance use, will the adolescent be less likely to engage in the use or abuse of such a substance? To what extent do family attitudes about sexuality affect risk of pregnancy, sexually transmitted diseases, and HIV-infection? Do sound family exercise and nutrition practices reduce adolescent problems of obesity or dietary deficiencies?[11] Are parental dental practices correlated with the presence or absence of caries in their adolescent children?

Several studies have found that adolescents agree with their parents on most basic values (7,21,53,56, 72). It has been established that parents are viewed by most adolescents as credible sources of information (17,46,74,88,105). To what extent is this credibility merited? Do parents generally transmit accurate and current information on health, mental health, and safety issues to adolescent family members, or is their information incomplete, outdated, or incorrect?

There is some evidence to suggest that parents exert a great influence on particular health behaviors of adolescents (particularly daughters) within a family (4). When one examines risk factors for adolescent pregnancy, for example, there emerges a strong relationship between the mothers' experiences and those of their daughters (70). Girls in female-headed households are more likely to have intercourse at earlier ages, as are those who have large numbers of siblings (49,109). Although the evidence is not strong, some studies suggest that open communications between parents and adolescents about sexual issues result in less sexual activity, better use of contraceptives, and parental support in seeking family planning services (27,50, 59). And Rosen has shown that parents play a major role in the decision to terminate an unintended pregnancy-particularly among young adolescents (81).[12]

What is not known is how generalizable the limited existing data on the parental influences are to subjects that have not received the close scrutiny given to the parental role in adolescent pregnancy, nutrition and fitness, or substance use and abuse. Do parental influences shape the type and quantity of foods consumed by adolescents? Are cautious parents more or less likely to raise adolescents who escape accidental injury or avoid risk taking behaviors? Are childhood handwashing and teeth-brushing drills effective in shaping the personal hygiene habits of adolescents?

Parents Who Provide Emotional/Psychological Support and Encouragement

Adolescence is a time of rapid changes.[13] Relations with peers—and particularly with members of the opposite sex—raise new and perplexing questions. Can the experiences of parents provide a useful reservoir for adolescents seeking counsel on issues surrounding dating behavior, friendships, and appropriate interactions in society? If so, under what conditions? How is such counsel best conveyed? Similarly, for those physical and emotional changes which may seem inexplicable, can parents help guide their adolescent to greater understanding and knowledge, a sense of perspective, and self-acceptance-thereby reducing unnecessary anxiety? To what extent can a parent's views about an adolescent's disability-r sexuality, or need for increased autonomy, or any of a number of other issues—enhance or impede sound psychological development in the adolescent?

Parents Who Connect Adolescents to Needed Services

To what extent do parents serve as early screeners of health care needs for adolescents, either making their own discretionary diagnoses and referrals or providing direct health care services themselves? How important are parental "home remedies" for adolescent health care? Are these parental interventions appropriate and beneficial? What role do parents play in connecting an adolescent to dental,

[11] Ch. 7, "Nutrition and Fitness Problems: Prevention and Services," in this volume, notes that exercise levels are similar among members of the same family and that children in obese families expend less energy than those in lean families, suggesting that family lifestyle can be a strong factor influencing healthy behavior in adolescents. However, findings such as these must be tempered by the recent finding that obesity may have a genetic component.

[12] The limited research on the effects of parental pressure on health care decisionmaking by adolescents is discussed in ch. 17, "Consent and Confidentiality in Adolescent Health Care Decisionmaking," in Vol. III. A 1988 study by Scherer and Reppucci examined the effects of parental pressure on hypothetical health decisions by adolescents ages 14 and 15 and found that these adolescents yielded greatly to parental pressure (82).

[13] See ch. 2, "What Is Adolescent Health?" in this volume for discussion of these changes.

health, and mental health services?[14] How important are the financial, transportation, and scheduling roles of parents in the connection of adolescents with needed services? What are the role and significance of family caregivers in the system of adolescent health care? How can parents become more effective in promoting the health maintenance of their adolescent family members?

These are just a few areas where families maybe making a major, and largely unrecognized, contribution to the overall health of their adolescent members (73a). Future research should help illuminate how the "personal' family sector interacts with the public and private systems of health care, since many health problems may be first noticed in the home setting and decisions to seek professional intervention are initiated through the threshold of family concern.

Parents Who Promote Adolescents' Autonomy and Independence

As they mature, adolescents typically demand a more nearly equal and active role in family discussions and decisionmaking (87). Thus, it is perhaps not surprising that families which allow latitude for adolescent participation in family decisions have fewer problems during adolescence than more rigid and authoritarian families. According to Laurence Steinberg, a family that combines democracy with warmth and demandingness is likely to foster an adolescent's mental health:

> Generally speaking, adolescents thrive develop mentally when their family environment is characterized by warm relationships in which individuals are permitted to express their opinions and assert their individuality and in which parents expect mature behavior and set and enforce reasonable rules and standards. This constellation of warmth, democracy, and demandingness has been labelled *'authoritative*. According to several comprehensive reviews of the literature on parenting practices and their outcomes, adolescents who grow up in authoritative homes score higher on indices of psychological development and mental health, virtually however defined (86).

Thus, basic questions on parent-child relationships during adolescence include: How can parents best facilitate movement toward adolescent autonomy and interdependence? What external controls should be relaxed and when should relaxation occur? Most parents continue to exercise some restrictive authority throughout adolescence. Where behavioral restrictions are imposed for health or safety reasons, to what extent are these effective? What kinds of restrictions are appropriate and under what circumstances? How can parents more effectively transfer external controls to internalized self-controls in adolescents?

Photo credit: Office of Technology Assessment

Views on the nature of adolescent and family development have undergone radical transformation. Rather than becoming detached and independent of their parents, adolescents need to learn to assume increasing responsibility y and decision making within the context of their close relationships, not away from them. A burgeoning body of research suggests that parents can help their adolescent children become socially and cognitively competent by adopting a style of interacting that is simultaneously stimulating, demanding, loving, supportive, and committed to the adolescent.

As *Summarized* recently by Ooms and Owen for the Family Impact Seminar:

> Views on the nature of adolescent and family development have undergone radical transformation. Earlier research and writing about adolescence described the central [developmental] task of adolescence as . . becoming detached and independent of, in effect 'emancipated' from, parents. Recent research has led to a reconceptualization of the developmental tasks of the adolescent stage of the family life cycle.

[14] We do know that most childhood cancers, for example, are detected at early stages, as parents are likely to seek medical care soon after observing a health problem (100).

> Adolescents need to learn to assume increasing responsibility and decision making but within the context of their close relationships, not away from them. They must renegotiate their relationship with their parents so that they can assume greater autonomy, but they also need to remain connected with their parents in a new relationship of mutuality and friendship rather than dominance and control. Parents need to gradually 'let go,' but stay interested in their children, and provide them with continued advice and support. . .(73a).

Baumrind describes two parent types that have positive outcomes for adolescents: authoritative and democratic parents (3,6). She states:

> ***Authoritative parents,*** by definition, are not punitive or authoritarian. They may, however, embrace traditional values. Authoritative parents, in comparison to lenient parents, are more demanding and, in comparison to authoritarian-restrictive parents, are more responsive. Authoritative parents are demanding in that they guide their children's activities firmly and consistently and require them to contribute to family functioning by helping with household tasks. They willingly confront their children in order to obtain conformity, state their values clearly, and expect their children to respect their norms. Authoritative parents are responsive affectively in the sense of being loving, supportive, and committed: they are responsive cognitively in the sense of providing a stimulating and challenging environment. Authoritative parents characteristically maintain an appropriate ratio of children's autonomy to parental control at all ages. However, an appropriate ratio is weighted in the direction of control with young children and in the direction of autonomy in adolescence. Authoritative parents of adolescents focus on issues rather than personalities and roles, [and] they encourage their adolescents to voice their dissent and actively seek to share power as their children mature (3).
>
> ***Democratic*** parents are highly responsive, moderately demanding, and not restrictive. They are less conventional, directive, and assertive in their control than authoritative parents, but like authoritative parents are supportive, caring, personally agentic, and manifest no problem behavior or family disorganization (6).

The extent to which American families follow these models is not known. Research has shown, however, that adolescents in authoritative and democratic families on the average are better adjusted in terms of mental health, self-image, social integration, and ability to make independent decisions (self-directed) than their peers from *authoritarian* homes (i.e., homes in which parents exert rigid controls) or *permissive* homes (i.e., homes in which parents are either uninvolved or are lax in controlling behavior of their children) (3,5,6,15,20,44,45,63, 78,86).

In the Family Socialization and Developmental Competence Project, Baumrind evaluated the consequences for children of four parental styles in terms of the children's social and cognitive competence:

- authoritative,
- authoritarian,
- permissive, and
- rejecting-neglecting (or indifferent) (6).

Preadolescent children from *authoritative/democratic* families, Baumrind found, had developed the greatest social and cognitive competence (6). Preadolescent girls from *permissive* families were less self--assertive than preadolescent girls from authoritative families, and boys and girls from permissive families were less cognitively competent than those from authoritative families. Preadolescent children from *rejecting-neglecting* families, were the least socially competent of all. Baumrind found that the effects of family structure among preadolescents varied with the socioeconomic and demographic characteristics of the family. An *authoritarian* family upbringing, for example, was more harmful, as measured in terms of a variety of social competency scales, to middle-class boys than to girls; more harmful to preschool white girls than to black girls, and more harmful to white boys than Hispanic boys (6).[15]

When children in the Family Socialization and Developmental Competence Project were adolescents, Baumrind measured the consequences of different parental styles again (using a different categorization), and the findings were similar to those for preadolescents (6). Adolescent children from *democratic/authoritative* homes were the most socially competent, and adolescents *from permissive* and *rejecting-neglecting* families continued to have the most interpersonal problems.

Researchers other than Baumrind have identified yet another type of family that frequently produces

[15]The problems faced by many poor adolescents and adolescents in specific racial and ethnic minority groups are discussed in ch.18, "Issues in the Delivery of Services to Selected Groups of Adolescents," in Vol. III.

psychological dysfunction and involvement in various problem behaviors in adolescents—the *indifferent* family ***(63). An*** indifferent family is one in which the parents are uninvolved, making few, if any, demands on their adolescent family member. In this model, decisionmaking is laissez-faire and there is a low level of warmth and affection among family members.

Negative Parental Influences on Adolescent Health

Whereas positive family influences on adolescent health have received only scant attention from researchers, negative parental influences are more widely documented. Dysfunctional families,[16] for example, have been shown to be associated with poor diabetic control in adolescents (96). Furthermore, there is some evidence to suggest that stresses within families can ''trigger' streptococcal infections or increase the severity of respiratory illnesses (12,66). And, while the 'schizophrenogenic mother' concept has been largely discredited as a causal factor in major mental illnesses and replaced by genetic/biological or other theories of etiology, there is evidence that environmental factors (including family interactions, support, and stress) contribute to both the course and treatment of such illnesses (96). High levels of family conflict and lack of intimacy have been correlated with heroin abuse in adolescents (40). Some other adverse ways in which families can affect the health and well-being of their adolescent members are described below.

Parents Who Serve as Negative Behavioral Role Models and Transmitters of Values and Information

Just as parents can presumably contribute in a positive way toward adolescent development through their behaviors and values, so too can they provide negative role models. Furthermore, well-intentioned but uninformed parents may, through ignorance, provide adolescents with information that is incorrect.

Substance-Abusing Parents

Alcoholism and illicit drug use by an adolescent's parents or siblings have been shown to significantly increase an adolescent's vulnerability to becoming an alcohol or drug abuser (18,38,84,91).17 Some research suggests that sons of alcoholic fathers may have up to nine times greater probability of becoming alcoholics than sons of nonalcoholic fathers (11,16).

Whether these increased risks are due to an inherited genetic vulnerability, adolescent identification and mimicking of parental or sibling substance use, easy accessibility to substances, or lack of family prohibitions and punishments has not been established. According to Kandel, however, parents who use alcohol can become role models for an adolescent's use of alcohol, while families characterized by lack of closeness, lack of maternal involvement in the activities of children, lack of or inconsistent parental discipline, and low parental educational aspirations for the children tend to experience greater adolescent illicit drug use (55). Kandel identifies three parental factors that help to predict initiation into drug use during adolescence: parental drug-using behaviors, parental attitudes about drugs, and parent-child interactions.

Violent Parents

The risk of a child's being physically abused increases proportionately to the degree and severity of assault between that child's parents (89). This relationship appears to carry over into the child's adolescence, although the greater physical power of abused adolescents may lead to reciprocal assault (and even parricide) in some instances (13,76). In fact, adolescents who kill their parents (and wives who kill their husbands) often do so in retaliation for abuse, usually as the culmination of a long period of mutual assault (31).

In 1980, one research group found that 18 percent of the children and adolescents they studied engaged in physical attacks on their parents (90). Since the research team interviewed mothers in half of the families and fathers in the other half, the team estimated that as many as one out of every three

[16] *Dysfunctional families* are families which lack cohesion and mutual support within a framework of affection that respects individual differences and the need for personal expression of autonomy. Such families may either stifle individuality or use inappropriate means of expressing such individuality (conflict and confrontation).

[17] For a general discussion of substance use and abuse by adolescents, see ch.12, "Alcohol, Tobacco, and Drug Abuse: Prevention and Services," in this volume.

children in their sample hit their parents at least once during the year in which the interviews occurred. They attributed this violence to retaliation for physical abuse and mimicking of parental behavior which was itself violent. Within families where parents were categorized as "nonabusive," the rate of assault by a child upon a parent was only 1 in 400.

Parents Who Are Unable To Resolve Conflicts

Observational research shows that abusive families are behaviorally differentiated from nonabusive families mainly in their handling of the 5 to 10 percent of parent-child interactions that are negative (80). Nonabusive families are able to conclude (or at least terminate) these negative interactions quickly. Abusive families are ineffective and become enmeshed in escalating conflict.

Parents Who Do Not Have Accurate Information

Parents, in assuming a conscious teaching role or as unintentional conveyors of knowledge and attitudes, may not always possess accurate or current information. Thus, parents may sometimes inadvertently transmit erroneous "facts" or myths and superstitions, causing potential problems for the adolescent who acts on the basis of the information. The low rates for which adolescent girls seek care for dysmenorrhea,[18] for example, may be due in part to their mothers' beliefs that nothing can be done about menstrual cramps (61).

In addition, although parents are often seen as credible sources of information, they do not often discuss sensitive topics like sexuality, homosexuality, or prostitution with their adolescent family members (46,88,99). Sixty percent of U.S. parents receiving the brochure "Understanding AIDS" from the Centers for Disease Control in the U.S. Department of Health and Human Services (DHHS) did not discuss it with their 10- to 17-year-olds according to a 1988 National Health Interview Survey (97,98).

Parents Who Maltreat Adolescents

As noted earlier, some parents abuse or neglect their adolescent children, either emotionally or physically .19

Emotional abuse and neglect are difficult to define (31,34). Emotional abuse can involve the deliberate or unintentional assault on the emotional well-being of a dependent. Emotional neglect is the withholding of warmth, affection, and psychological support necessary to maintain sound mental health. Mild emotional abuse or neglect is difficult to differentiate from normal and occasional ''ribbing' or expressions of disapproval. But in extreme cases, parents can destroy an adolescent's self-esteem or ability to cope by belittling the person and making repetitive attacks on personality traits or ego needs.

Some, emotional abuse results from well-meaning ignorance, as when a parent taunts an adolescent about acne, ascribing the condition to a failure to attend to personal hygiene. Sometimes, however, emotional abuse is pathologic in origin and may reflect a parent's need to maintain dominance and control in the face of increasing resistance by an adolescent. Like emotional abuse, emotional neglect can be innocent and unknowing. The parents of an adolescent with a disability, for example, may deny the adolescent's growing sexuality or limit his or her socialization with able-bodied peers out of protective instincts and ignorance, but the adolescent must pay the price in stunted sexual development, a more confining self-image, and restricted opportunities for emotional expression (64).

Whether resulting from benign motives or not, emotional abuse and neglect can have long-lasting adverse consequences for an adolescent.[20] In her studies of parenting styles, Baumrind has demonstrated that adolescents from families characterized by a lack of warmth and affection-families whose members are disengaged from any emotional involvement with one another--consistently rank

[18] *Dysmenorrhea* is painful menstruation and may be caused by any of several factors. See ch. 6, "Chronic Physical Illnesses: Prevention and Services, " in this volume, for information on the rate at which adolescents seek care for dysmenorrhea.

[19] *Maltreatment* includes both abuse and neglect. *Abuse*, which refers to the active assault upon a dependent victim (as distinguished from violence against an individual over whom the perpetrator has no dependency relationship), may be physical, sexual, or psychological. *Neglect*, which refers to acts of omission that include failure to meet basic needs (as defined by prevailing community standards), may be either physical neglect (i.e., grievous failure to provide physical necessities such as food or clothing) or psychological neglect (i.e., failure to provide appropriate supervision or basic emotional responsiveness and stimulation necessary for development).

[20] At least one authority believes that emotional *neglect* generally has more serious consequences than emotional *abuse* for personality development (30).

lowest on social competency scales and highest on substance use and other problem behaviors (6).

Physical abuse and neglect are less elusive than their emotional/psychological counterparts and have been studied in greater depth. Wauchope and Straus have analyzed parental self-reports of "minor violence" (i.e., corporal punishment such as spanking, pushing, or slapping generally accepted as nonabusive in American communities) and found that prevalence varies with the age of recipient (104). Minor violence by parents against children increases from a prevalence of 20 percent in the first year of life, to a high of 90 percent at age 3, and then declines to approximately 15 percent by age 17, The prevalence of 'severe violence"[21] exhibits a similar pattern, moving from 5 percent during the first year to a high of 16 percent at age 6, and then declining to 6.5 percent by age 17. When ''hitting or trying to hit" was removed from the data, however, age differences disappeared, yielding a uniform 2 to 4 percent prevalence of physical abuse throughout childhood and adolescence.

There is some evidence that physical maltreatment is related to an adolescent's behaviors considered unacceptable to the abuser (e.g., disobeying or arguing), Libby and Bybee report that in more than 90 percent of the cases they studied, specific abusive incidents were *preceded* by negative adolescent behavior (60). One cannot tell from the existing data, however, precisely what is cause and what is effect. The precipitating behavior may itself be the result of earlier maltreatment.

As defined by the U.S. Department of Health and Human Services' National Center on Child Abuse and Neglect, *sexual abuse* of a child can take three forms: actual penile penetration; molestation with genital contact; and other unspecified acts not known to have involved actual genital contact (e.g., fondling of breasts or buttocks, exposure), or inadequate or inappropriate supervision of a child's voluntary sexual activities.

Incidence and Prevalence of Adolescent Maltreatment

Table 3-1 outlines the small body of research on adolescent victims of maltreatment. As noted in box 3-A, studies of adolescent maltreatment have several limitations related to the availability of data. Furthermore, such studies use different definitions of maltreatment.

Table 3-1 includes both surveys and small-scale studies. The surveys are as follows:

- two studies of the national incidence and severity of child abuse and neglect conducted by the National Center on Child Abuse and Neglect in DHHS----one in 1979-80 (published in 1981) (94) and the other in 1986 (published in 1988) (95);
- the annual tabulation (through 1986) of reported cases of maltreatment compiled by the American Humane Association (l), and
- two national probability samples assessed for domestic violence conducted by Straus and colleagues in 1975 and 1985 (89).

The small-scale studies include clinical and questionnaire studies of identified or suspected cases of adolescent maltreatment (34).

The National Center on Child Abuse and Neglect's study of the national incidence and severity of child abuse and neglect conducted in the late-1970s defined maltreatment as "demonstrable harm due to maltreatment" (94). Using a sample of 26 U.S. counties, this study estimated that there were approximately 650,000 cases of maltreatment (including ''educational neglect"[22]) of children and adolescents in the United States. The national incidence study by the National Center on Child Abuse and Neglect conducted in 1985 defined maltreatment as instances where ''a child's health or safety is seriously endangered. ' This study estimated that there were 1,025,900 cases of maltreatment of children and adolescents in the United States (95).

The 1979-80 national incidence study by the National Center on Child Abuse and Neglect found that 47 percent of the known cases of all forms of child maltreatment were against adolescents, who made up just 38 percent of the population under age 18 (94), A 1985 American Humane Association survey, on the other hand, found that adolescents were victims in 24 percent of all reported cases of child maltreatment (1). The discrepancy between the

[21] Severe violence includes kicking, biting, hitting with one's fist, beating, burning or scalding, and threatening to or using a weapon.

[22] *Educational neglect* refers to the failure to provide appropriate education (e.g., through failure to enroll a dependent in school or permitting/encouraging truancy).

Table 3-I-Studies of Adolescent Maltreatment

Study[a]	Sample	Age	Types of rnaltreatrnent	Measures
surveys				
U.S. DHHS, Office of Human Development Services, National Center on Child Abuse and Neglect, Survey of 1979, 1980	26 counties-all maltreatment cases known to professionals surveyed	0-17	Alltypes, including educational neglect	Case records
U.S. DHHS, Office of Human Development Services, National Center on Child Abuse and Neglect, Survey of 1986, 1988	29 counties-all maltreatment cases known to professionals surveyed	0-17	All types, including educational negiect	Case records
American Humane Association, Survey of 1985,1987	40 States' case reports of maltreatment	0-17	All types	Demographic and case records
Straus, Geiles, and Steinmetz, 1980	2,143 famiiies	3-17	Physical abuse and "normal violence" (corporal punishment)	Conflict Tactics Scale (parents' seif reports)
Gelies and Straus, 1987	3,229 famiiies	0-17	Physical abuse	Conflict Tactics Scaie
Powers and Eckenrode, 1988	1,874 reported cases (NY State)	0-17	All types (31% neglect, 42% sexual abuse, 19% physicai abuse)	Protective services[b] case reports
Small-scale studies				
Farber et ai., 1984	199 runaways 47 abused protective services cases	12-18	Physical abuse	Conflict Tactics Scale
Farber and Joseph, 1985	77 youth (diverse sampie)	12-18	Physical abuse	a) Conflict Tactics Scale b) Structured Ciinicai Assessments Checklist c) Demographic background
McCormack, Janus, and Burgess, 1986	89 maie runaways 55 femaie runaways	15-20	Sexuai abuse	interview on dealing with sexual abuse, delinquency, and demographic background
Garbarino, Sebes, and Schellenbach, 1984	27 females 35 maies	10-16	All forms of maltreatment	a) Adolescent Abuse Inventory b) Child Behavior Checklist c) FACES-(famiiy cohesion and flexibility) d) Demographics e) Adolescent Famiiy inventory of Life Events and Changes
Berdie and Waxier, 1984	163 families	12-17	Ali forms of maltreatment	Ciinicai assessment
Libby and Bybee, 1979	25 reported cases	12-17	Sexuai abuse *excluded*	Case history based Protective Service
Lourie, 1977	70 reported cases	12-17	Physical abuse	Clinical assessment case records
Pelcovitz et al., 1984	33 cases to protective services	12-17	Physical abuse	Clinical assessment
Garbarino and Kosteiny, 1989	2 neighborhoods, inner citv Chicago	10-19	Physical abuse, negiect, sexual abuse	_____

[a] Full Citations are listed at the end of this chapter.
[b] *Protective services* are an aspect of social services designed t. prevent neglect, abuse, and exploitation of children by reaching out with social services to stabilize family life (e.g., by strengthening parental capacity and ability to provide good child care). The provision of protective services follows a complaint or referral, frequently from a source outside the family, although it may be initiated by an adolescent him or herself.

SOURCE: Office of Technology Assessment, 1991.

national incidence study by the National Center for Child Abuse and Neglect and the American Humane Association survey may be accounted for by the fact that the former study included data from not only children's protective services[23] but from other agencies as well.

[23] *Children's protective services* are services provided by a State or local child welfare agency to children and adolescents who have been identified as being abused or neglected. They may include assessment, family support services, removal from the home and placement in foster care, or similar interventions and assistance by a caseworker.

Box 3-A—Limitations of Research on Adolescent Maltreatment

Available studies of adolescent maltreatment, which includes abuse and neglect, have several limitations. Perhaps the most important is that they rely on data from official reports and self-reports. Both these data sources have serious limitations and are likely to underrepresent the extent of adolescent maltreatment. Parents who maltreat their children are unlikely to give self-reports that accurately reflect the true incidence and prevalence of maltreatment because abuse and neglect are criminal offenses. Official reports may significantly undercount the incidence of abuse and neglect because public agencies are unlikely to learn about instances of abuse and neglect that do not result in major physical injury. Furthermore, adolescent victims of maltreatment tend to be served by agencies other than children's protective services and hospitals, which makes adolescents less likely to be identified and included in the hospital and children's protective services samples. Finally, local jurisdictions may have varying degrees of competence in and fidelity to reporting abuse and neglect cases or have administrative practices that confound the data.

Yet another problem with available studies of maltreatment is that researchers have used various definitions of maltreatment, with some including and others excluding spanking, verbal abuse, and emotional abuse. The variation in definitions has made it difficult to compare data across studies and has led to contentious challenges to survey findings. Compounding the problem, communities (and laws) vary in their tolerance and acceptance of physical expressions of parental discipline; some actions deemed abuse in one area of the country maybe considered appropriate--even commendable--in another.

An additional problem is that the bulk of family studies involving maltreated adolescents have been conducted on samples of white, middle-class, two-parent families. Family influences within minority populations have not been as intensively examined. As a result, ethnic, cultural, economic, and nontraditional family differences from these samples await further research.

A limitation of available studies of adolescent maltreatment for the purpose of this OTA Report is that most of these studies cite data on age groups other than the 10-to 18-year-old age group. Thus, the figures quoted from these studies typically reflect a smaller number than the actual incidence of abuse and neglect among the population focused on in this study.

SOURCE: Office of Technology Assessment, 1991.

Table 3-2 shows the overall rate of maltreatment cases known to professionals (children's protective services and other agencies) from the 1975 national incidence study by the National Center for Child Abuse and Neglect. Also shown are rates of maltreatment cases from the 1985 survey. In both surveys, known maltreatment rates were higher among older children than among younger ones.

The 1986 national incidence study by the National Center for Child Abuse and Neglect found that psychological abuse was more common among adolescents ages 12 and over than among children ages O to 11 (32 percent of reported adolescent cases v. 25 percent of cases reported among children) (95). Conversely, it found that physical abuse was more common among children ages O to 11 than among adolescents (52 percent of reported children's cases and 42 percent of adolescent cases). In a smaller clinical study, Berdie and Wexler reported that 68 percent of their sample of abused adolescents suffered emotional maltreatment, 54 percent experienced physical abuse, 35 percent were neglected, and 24 percent had been sexually abused (9).

Gender Differences in Adolescent Maltreatment

Some gender differences are evident in the data on adolescent maltreatment. Females appear to be more likely to be abused as they pass through adolescence than in childhood, while risk for males peaks early and generally declines through adolescence. The study of the national incidence and severity of child abuse and neglect conducted by the National Center on Child Abuse and Neglect in 1975 identified two female adolescent maltreatment victims for every one male (73).

Small studies tend to confirm the finding that female adolescents are at greater risk for maltreatment than males, with the reported figures for females in their samples of maltreatment adolescents ranging from 55 percent (34) to 77 percent (62). Powers and Eckenrode's analysis of New York State data found that among 12- to 17-year-olds, females accounted for 65 percent of the physical

Table 3-2-Cases of Maltreatment per 1,000 Children/ Adolescents, 1979 and 1986[a]

Age	National Center on Child Abuse and Neglect, Survey, 1979	National Center on Child Abuse and Neglect, Survey, 1986
0-2	6	6
3-5	6	10
6-8	11	15
9-11	11	15
12-14	12	23
15-17	14	28

[a]Definitions for maltreatment were different in the two surveys. In the survey conducted in 1979 -80 the definition of maltreatment was "demonstrable harm due to maltreatment." In 1986 the definition of maltreatment included instances where "a child's health or safety is seriously endangered."

SOURCE: J. Garbarino, "Adolescent Victims of Maltreatment," contract paper prepared for the Office of Technology Assessment, U.S. Congress, Washington, DC, April 1990.

abuse cases reported, 88 percent of the sexual abuse cases, and 54 percent of the neglect cases. A 1984 study by Pelcovitz and others, however, found that only 45 percent of the abused and neglected adolescent population studied were females (75).[24]

Perpetrators of Adolescent Maltreatment

Families at high risk for maltreatment of adolescents can be characterized in terms of family structure or family dynamics. These factors may not be independent, but there has been little research on family dynamics (e.g., authoritative v. other styles) in nontraditional families.

Family Structure--Considerable research demonstrated that families at high risk for maltreatment in adolescence often contain stepparents. A variety of analyses point to the stepparent-adolescent relationship as a very risky one (19,54) and studies of maltreatment discussed below tend to confirm this.

Libby and Bybee reported that 28 percent of the families in their study of adolescent maltreatment were stepfamilies, even though only 11 percent of all adolescents live in stepfamilies (60). Berdie and colleagues reported similar findings; 25 percent of their families were stepfamilies (8). Olson and Holmes analyzed the data from the National Center on Child Abuse and Neglect's 1979-80 study of the national incidence and severity of child abuse and neglect and concluded that 40 percent of the adolescent maltreatment cases occurred in families with a stepparent (73). Garbarino and his associates found that, among a sample of 10- to 16-year-old adolescents (from families containing two adults—not always married) whom professionals identified as ''having problems, ' families at "high risk" for adolescent maltreatment were more likely to have a stepparent (35). Farber and Joseph reported that only 30 percent of their maltreated adolescents were living with both biological parents (25).

Obviously, these findings do not imply that the majority of stepfamilies are abusive or that intact birth families are nonabusive, but they do suggest the stepfamily as a possible risk factor in adolescent maltreatment.

Family Dynamics--Families characterized as being high risk for adolescent maltreatment reveal a general pattern of difficulty in relating as an interpersonal system (6). Such families are at high risk on the dimensions of adaptability, cohesion, support, discipline, and interparental conflict.

Pelcovitz and colleagues conducted a clinical analysis of 22 families in which adolescents were physically abused, classifying them either as families in which the onset of abuse was during childhood (8 families) or as families in which the onset of abuse was during adolescence (14 families) (75). The eight families with adolescents who were first physically abused in childhood (involving 14 adolescents) manifested intergenerational abuse, spousal abuse, and developmentally inappropriate demands (75)—all elements of what has been termed ''the world of abnormal rearing" (41).

Pelcovitz and colleagues classified the 14 families with adolescents where physical abuse first occurred during adolescence (involving 19 adolescents) in one of two categories on the basis of multiple, independent clinical assessments—' 'authoritarian families' (7 families) and 'overindulgent families' (7 families). The *authoritarian* families (as distinguished from the ''authoritative" families discussed earlier) were characterized by paternalistic, harsh, rigid, domineering styles of childrearing (75). They were also characterized by denial by the parents of their feelings toward each other and about the family

[24]However, this study only involved 33 adolescents from 22 families, with ages ranging from 13 to 18. In 80 percent of the cases where girls were the victims of maltreatment, the abuse was attributed to dating or sexual exploration% while in all cases of maltreatment of boys, the abuse was associated with truancy or delinquent behavior. The investigators used the definition of "abuse' found in the New York State Family Court Act of 1976, which includes physical injury, risk of death or disfigurement, impairment of physical or emotional health, and impairment of a bodily organ. The record does not indicate if any of the maltreatment cases involved sexual abuse--the exclusion of which could be a source of sample bias.

system. Incidents of abuse typically arose from a challenge by the adolescent (acting out or testing behavior) that was met with overwhelming force. The high priority placed upon control provided the foundation for high levels of force.

In contrast, the *overindulgent* families were characterized by parental efforts to compensate for the emotional deprivation that they had experienced in their own childhood (12 of the 14 parents had lost one or both of their parents during childhood) (75). These families made few demands upon their children, set few limits, and desired a high level of emotional gratification from their children. But when the children reached adolescence and sought to form primary attachments outside the home or began to act impulsively in important social settings, the overindulgent parents also reacted with excessive force.

Garbarino and his colleagues have contrasted the family system of families judged to be abusive with that of families judged to be nonabusive (34). These researchers used FACES, a measure of family adaptability and cohesion, to assess overall family interactions. Abusive families were more likely to be scored as ''chaotic' or ''enmeshed. Nonabusive families tended to fall into the more normal ' 'flexible" and "connected" ranges.[25] On a measure of interparental conflict, adolescents in the abusive families tended to rate their parents as evidencing more conflict. It is important to note, however, that the average difference masks the fact that some abusive families evidenced extremely high conflict while, consistent with the finding that abusive families were more likely to be ''enmeshed,' others evidenced extremely low conflict. In a 2-year followup, it appeared that some abusive families dealt with conflict by expelling the adolescent, while others simply suppressed all manifestations of conflict through a conspiracy of silence.

Poverty and Adolescent Maltreatment—Families at high-risk for destructive parent-adolescent relations are less heavily concentrated among families living in poverty than families at high risk for child maltreatment (34). The National Center on Child Abuse and Neglect's study of the national incidence and severity of child abuse and neglect conducted in the mid- 1970s suggests that the big social class differences that characterize *child* maltreatment cases are attenuated in the case of adolescent maltreatment (94), Families in which adolescents were abused were half as likely to be poor (i.e., earning less than $7,000 per year in 1979 dollars) as families in which children were abused, Presumably, some of the observed attenuation of social class differences in adolescent maltreatment is attributable to the fact that parents of adolescent tend to be older, and thus earning higher wages (on average) than the parents of young children. The attenuation may also be due to the greater difficulties that some families have in dealing with adolescence than with early childhood.

Blum and Runyan reported, for example, that 42 percent of all confirmed cases of maltreatment in Minnesota involved adolescent victims (10). Minnesota is a State with relatively little of the extreme poverty that tends to be associated with maltreatment (particularly neglect) in early childhood, and has been a leader in promoting professional awareness of adolescent maltreatment. In contrast to the Minnesota study, Garbarino and Kostelny report an intensive study of maltreatment rates in inner city Chicago neighborhoods where poverty is a major problem and there is little leadership in dealing with adolescent maltreatment (32). This study revealed a different picture, but still supported previous findings of a relatively poor predictive association between poverty and adolescent maltreatment, at least relative to child maltreatment (see table 3-3). Garbarino and Gilliam also reported findings consistent with the National Center on Child Abuse and Neglect's study of the national incidence and severity of child abuse and neglect (31). In their work, they found that families with adolescent-onset cases of maltreatment were about half as likely to be poor as families with the child onset (and child maltreatment) cases.

Despite the finding that family income alone is not a powerful predictor of risk for adolescent maltreatment, some research does suggest that a *feeling* of deprivation and strained resources, often associated with larger family size, may play a role (102). In addition, other measures of social status not based on income yield contradictory results. Farber and Joseph report that their families were predomi-

[25] A *chaotic* family is a family characterized by lack of structure. An *enmeshed* family is a family in which individuals are excessively dependent upon each other. A *flexible* family is one that is able to combine structure with responsiveness to situational conditions. A connected family is one that is able to have close relationships without finding them stifling.

Table 3-3-incidence of Maltreatment Among Children/Adolescents in Two Poor Inner-City Areas of Chicago

	Cases per 100 children/adolescents					
	Physical abuse		Neglect		Sexual abuse	
Age	Area I[a]	Area II[b]	Area I[a]	Area II[b]	Area I[a]	Area II[b]
0-4	5.1	3.8	40.0	32.8	1.6	1.7
5-9	5.2	4.6	22.3	22.5	0.7	1.8
10-14	2.4	1.8	10.8	13.5	0.5	1.9
15-19	1.5	1.8	3.9	4.6	1.0	0.1

[a]Area I poverty rate = 51 percent.
[b]Area II poverty rate -40 percent.

SOURCE: J. Garbarino and K. Kostelny, "Patterns and Trendsin Reported Cases of Maltreatment and Infant Mortality in Chicago Community Areas," Erikson Institute, Chicago, IL, 1989.

nantly lower class, while Pelcovitz and his colleagues report that 59 percent of their families were classified in the top two socioeconomic groups on a five-point measurement known as the Hollingshead Index (25,75). Only 12 percent of Libby and Bybee's families were categorized among the lowest socioeconomic groups, while Garbarino's research team found differences on the Hollingshead Index of socioeconomic status among abusive and nonabusive families (35,60). Berdie and colleagues reported that about 51 percent of the families in her study of maltreated adolescents earned less than $15,000 at a time when approximately 20 percent of all families did so (8).

Genesis of Adolescent Maltreatment: When Does It Begin?

Two theories dominate current thinking about the origins of adolescent maltreatment. The first holds that parents establish patterns of child abuse and simply continue such behavior through their child's adolescence. The second avers that much adolescent maltreatment occurs independently of earlier childhood abuse and may reflect the inability of a previously functional family to adapt to the new challenges of adolescence (28). The existing body of research on this question suggests that both theories account for a portion of the adolescent maltreatment population, but that there is a distinctly adolescent genesis to a significant number of cases-ranging from a high estimate of 90 percent to a low of 24 percent (8,9,25,31,60,62,75).

Sexual abuse may represent a special case, since studies suggest that sexual abuse begins in childhood, before the onset of adolescence. Kendall-Tackett and Simon interviewed 365 adults who were victims of childhood sexual abuse and found that the average age of onset was reported to be 7.5 years, with less than 10 percent having an onset after 12 years of age (57). In over half of the cases, the sexual abuse did not continue past the age of 12. This study offers an intriguing opportunity for further research to identify factors related to the ages of the victim and perpetrator which may be associated with both the onset and the cessation of sexual abuse within families.

Effects of Adolescent Maltreatment

Adolescents who are maltreated seldom die from the maltreatment. The fatality rate declines with age—from 0.09 per 1000- to 2-year-old children to less than 0.01 per 1,000 adolescents. As Garbarino notes, however, some adolescent deaths may be indirectly attributable to maltreatment:

> A full accounting of the adolescent fatalities attributable to maltreatment could reasonably include numerous suicides and other self-destructive behavior appropriately linked dynamically and developmentally to the experience of maltreatment. For example, a runaway who leaves home to escape abuse and then falls prey to AIDS, or is murdered, or becomes suicidal on the streets is, in a very real sense, an "adolescent maltreatment fatality" (29).

Berdie and her colleagues report that 49 percent of their adolescent maltreatment victims exhibited significant clinical indicators of depression (8). Between 45 and 70 percent of the adolescents showed problems such as nervous habits, isolation, poor social skills with peers, lethargy, low self--esteem, low frustration tolerance, temper outbursts, and stubbornness.

Running away from home is directly correlated with maltreatrnent.[26] Approximately 73 percent of adolescent female runaways and 38 percent of the male runaways in one recent study reported that they ran away to avoid further sexual abuse (65).

Who Investigates Adolescent Maltreatment Cases?

The study of the national incidence and severity of child abuse and neglect conducted by the National Center on Child Abuse and Neglect concluded that "the child's age may be a major determinant of whether or not a recognized maltreatment problem is reported to CPS [children's protective services] for investigation and treatment" (95). The bulk of adolescent maltreatment cases are reported to and handled by agencies other than children's protective services. Thus, intervention models designed from study findings that rely on data from children's protective services and hospital samples may not be generalizable across the full range of adolescent maltreatment cases.

One reason that adolescent maltreatment is so often investigated by agencies other than children's protective services is that it is often viewed as a consequence of ''acting-out' behavior by the adolescent or dysfunction within the family; and agencies such as community mental health centers or family services may be called upon to provide assistance.

Adolescents in the Child Welfare System

For children and adolescents who-for reasons of parental abuse and neglect, findings of delinquency, or other causes—are unable to live in an acceptable home environment with their parents, an elaborate child welfare system has been developed throughout the Nation.[27] This system includes the foster care system, a network of public and private institutions and agencies intended to provide substitute out-of-home care for dependent youth. Primarily regulated by the States, the child welfare system is backed up by juvenile and family courts.

While child welfare programs have their historic roots in orphanages and institutions, today the emphasis is largely upon community-based care, provided by surrogate families under professional supervision by public entities (23).[28] Two-thirds of all children in foster care are placed in families; the remainder are sent to institutions, including detention centers, mental hospitals, and special schools—often because no suitable family homes can be found (108). Foster care is designed as temporary placement until a child or adolescent can be returned to his or her family or pending completion of necessary treatment and rehabilitation.

Unfortunately, the reality has fallen short of the promise of foster care. The criteria for removal of children from their homes tend to be vague and subjective, and studies have confirmed significant differences in the handling of cases by caseworkers and judges (58,68). Nonwhites and Hispanics are placed out-of-home more frequently than other children (108). But worst of all, the "system" has tended to "lose" children and adolescents, in the sense that temporary out-of-home placements have resulted in permanent failures to reintegrate clients back into their homes.[29] In 1984, the average foster care stay was about 17 months (108). Tragically, children who remain in care longer than 18 months are seldom ever returned to their parents (58,68).

The 1990 Family Impact Seminar notes that a recent study of 500 adolescents/young adults who received care from the Casey Family Program indicates that the more placements they had, the more difficulties they encountered later in life (23). Between 20 and 30 percent of those evaluated had serious difficulties. In addition, a significant number of children in foster care were exposed to physical and sexual abuse from foster parents (24). A 1988

[26]For a discussion of the health and other needs of homeless and runaway adolescents, see ch. 14, "Hopelessness: Prevention and Services,' in this volume.

[27]*Child welfare services* include adoption, child protection, foster care and centers, independent living programs, drop-in centers, sexual abuse and prevention programs, victim assistance programs, adolescent pregnancy programs, and shelters for runaway children and adolescents. Frequently, programs are operated by private nonprofit entities under grants or contracts with governmental agencies.

[28]In 1982, 76 percent of children in foster care were in family or group homes, and only 16 percent were in institutions. Group homes are the fastest growing form of care, yet they accounted for only 7 percent of out-of-home placements in 1982—mostly for adolescents.

[29]There are clearly instances when an adolescent's welfare requires continued out-of-home placement. But even though the return of some adolescents to the home environment may not always be desirable, the adolescents who are considered "lost" in the child welfare system do not return for other reasons (e.g., because family reintegration efforts are nonexistent, superficially conducted, or easily abandoned in poorly monitored programs).

study by the William T. Grant Foundation's Commission on Work, Family, and Citizenship found that older adolescents average four different placements and at least one runaway episode while in foster care (108).

There has in general been increasing recognition that the child welfare and foster care systems are not functioning well. In a recent article in the journal *Child Welfare,* Woolf noted that:

> A review of foster care history reflects a perpetual march down a road of good intentions with the failure to check the quality of the road, and, indeed, whether the interim goals to be accomplished along the way coincide with those of the final destination. . .The time has come to integrate good intentions and optimism with wisdom in the development of child welfare strategies for foster care. Cooperation, teamwork, and self-discipline between professionals and organizations is imperative to the development, implementation, and monitoring of a systematic treatment approach to foster care services (108a).

A 1989 National Health Policy Forum workshop referred to the child welfare system as ''a crisis intervention system in crisis' (58a). In their issue brief for the National Health Policy Forum workshop, Koppelman and Jones noted the emerging health and social problems that burden a child welfare system; in turn, the child welfare system is fraught with case overloads and personnel shortages (58a). Personnel shortages include a shortage of foster parents (58a).

Although they are indicative of the problems faced by the child welfare system, it is important to note that recent commentaries have not focused specifically on adolescents in the child welfare and foster care systems.

Recognition of the problems associated with foster care has led to increasing emphasis on preserving families and reuniting children with their natural parents. Between 1977 and 1983, the number of out-of-home placements for children of all ages declined from 502,000 to 272,000 (108). Apparently aiding this trend was passage of the 1980 Federal Adoption Assistance and Child Welfare Act (Public Law 96-272).[30] In addition to requring child welfare agencies to make "reasonable efforts' to maintain a child or adolescent in the home prior to placing him or her in foster care, this act funded family preservation demonstration programs and research. Nonetheless, between 1984 and 1985, 31 States reported an increase in foster care placements (108). In 1985, there were 270,000 children in foster care, and about 45 percent of these (121,000 children) were between the ages of 13 and 18.[31]

In an effort to reduce out-of-home placements, State and local governments have experimented with innovative family preservation programs in which adolescents are viewed as an integral part of their family system.[32] These programs seek to assess and treat families as units (23). The family is seen as a part of the community in a broad ecological context. Services provided to families are generally oriented to specific and limited goals, which are jointly defined by the family and a program worker, in accordance with the expressed needs of the family. Such services may include parent education and skills training, referral to other services, family therapy, and individual psychological support and counseling. Family preservation programs attempt to draw on the strengths of families, with a caseworker acting as a catalyst and enabler.

Among the widely replicated models of family preservation programs are the following:

- *the Homebuilders* model, a crisis intervention model, which provides intensive services to families over 4 to 8 weeks, based on the assumption that the placement crisis presents a ''window of opportunity, " when parents are most likely to be able to learn and change;
- the *FAMILIES* model, a home-based services model, which is adapted to rural areas and widely used in Iowa, where it had its beginnings; and
- the *Oregon Intensive Family Preservation Services* model, which unlike the other two places primary emphasis on family therapy rather than on the provision of concrete services (23).

[30] In a 1989 report, the U.S. General Accounting Office made the point that in the absence of national evaluations or comprehensive information systems, they could not determine whether or to what extent the Public Law 96-272 reforms were responsible for reducing the number of unnecessary out-of-home placements.

[31] In the preceding year, about 180,000 children entered foster care and an M@ number left it (108).

[32] The Family Impact Seminar has identified programs in California, Colorado, Connecticut, Delaware, Florida, Illinois, Iowa, Kentucky, Maryland, Michigan, Minnesota, Missouri, New Jersey, New Mexico, NewYork, North Dakota, Oregon, Pennsylvania, Tennessee, Texas, and Washington (23).

According to a review for the Family Impact Seminar,[33] the Oregon Intensive Family Preservation Services model emphasizing family therapy has the highest success rate (87.3 percent, measured at termination of service) in terms of preventing out-of-home placement of children and adolescents, but the other two models have nearly as good success rates (81.4 percent for the crisis intervention model and 79.6 percent for the home-based services model) (23).[34]

Implicit in family preservation strategies is the assumption that it is better for a child or adolescent to remain with his or her family than to be taken out of the home and placed in foster care. It is important to note, however, that there may well be circumstances when preservation of the family is not in the best interests of the child or adolescent, For some, like the runaway and homeless adolescents studied by Shane, there isn't always a home to which they can return (83).[35] For others, the home environment is irretrievably hostile and destructive. Thus, reduction in out-of-home placements should not be the sole criterion for program success or public policy. **Future evaluations** of family preservation services should develop broader measurements of effectiveness and clearer definitions of outcome expectations.

Finally, Woolf notes that the family preservation policy mandated by Public Law 96-272 has meant that only the severest cases are remanded to foster care (108a). The implication has been that foster care has had to become more treatment-oriented, although, according to Woolf, it is not nearly treatment- or family-oriented enough (108a). A true treatment- and family-orientation would place foster care in a continuum of services for children and families, in which ''the entry of a family into the foster care system should be accompanied by a diagnostic component to assess specified areas such as family system dysfunction, placement requirements for the child, and recommendations for treatment of family members' (108a). Such an initial assessment would be the frost component in determining the treatment services needed to assist the family in becoming a healthier, functioning system (108a). Additional research on attitudes and skills needed by parents of adolescents (e.g., 5,6,86) may help to keep adolescents in their homes or improve the foster care system for adolescents.

Conclusions and Policy Implications

Adolescents do not grow up in a vacuum. Both their health and their development are influenced by myriad social and environmental interactions from the immediate (e.g., daily contact with peers, parents, and teachers or physical contact with poison ivy) to the global (e.g., changes in the ozone layer). The family's significance in this constellation of influences, if not preeminent, is at least major—for it touches the lives of most adolescents on a daily and deeply personal basis. Because parents usually have continuing proximity and can exercise some degree of power over the actions of adolescent family members, they are centrally important to any configuration of social factors shaping adolescent health. From time to time, peers and community may loom larger or smaller among an adolescent's external influences, but the family and parents will remain as constant elements despite fluctuations in their relative importance.

Given their ongoing role, if parents and families are to be a positive influence, they need to have accurate and useful information about adolescent development. Using parenting strategies with adolescents that were successful with children may generate conflict that could be avoided through alternative approaches to resolving differences.

Research (as documented through this Report) has suggested that the enhancement of parenting skills can improve the quality of life within families and reduce conflict, but studies of the effectiveness of

[33] The Family Impact Seminar is an activity of the American Association for Marriage and Family Therapy Research arid Education Foundation; Family Impact Seminar meetings provide information to public policy staff (23).

[34] The Family Impact Seminar notes that these Comparison are hampered by methodological concerns but suggests that the Oregon Intensive Family Preservation Services model emphasizing therapy seems best adapted to families with *adolescents* at risk of placement. At an average cost of $1,000 per family, the Intensive Family Preservation Services model also appears to be the least expensive (the average cost of Homebuilders is $2,600 per family and that of FAMILIES is $2,000). The reader is cautioned, however, that these cost figures, in the absence of experimental designs, do not provide a reliable basis for estimating cost savings over placement services.

[35] While "rumway' adolescents usually leave their homes voluntarily and without parental permission, sometimes parents or guardians encourage them to leave, abandon them, or force them out of their residence. The parents or guardians of these "pushout" or "throwaway' adolescents may resist family preservation services and deny an adolescent reintegration into the family. For a general discussion of homeless and runaway adolescents, see ch. 14, "Hopelessness: Prevention and Services, ' in this volume.

parenting programs on improving parent-adolescent relations and reducing specific problems of adolescence remain inconclusive (83a).[36] Still, the evidence suggests that authoritative parenting skills should be encouraged and information and training about this family model more widely disseminated.

A variety of public and private supports could help to relieve families in distress. Respite care to relieve family caregivers, family and parental leave, comprehensive (or at least catastrophic) insurance coverage, and increased access to family therapy and parenting education programs all merit serious consideration for development or expansion.

Policy aimed at reducing adolescent maltreatment should be a high priority. First, however, more analysis is needed concerning the definition and causes of adolescent maltreatment. Much of the research, policy, and programs on the causes, prevention, and treatment of maltreatment has not been specific as to the age of the child victim or has focused on younger children.

Additional research on a range of other issues and aspects related to families and adolescent health would be useful. Research on the effect of parenting styles on adolescent health and development in nontraditional families (e.g., stepfamilies and single-parent families) and ethnic and racial minority families, for example, is sparse (42,43,45,85). It would be useful if additional research emphasis were given to examining effective, well-functioning families and their impact on adolescent health rather than maintaining g the traditional focus of research on family dysfunction and pathology. Knowledge of family influences that work to enhance adolescent health and development is as important as an examination of negative family influences. To assist researchers, improvements in the collection and reporting of data about intrafamilial maltreatment and family caregiving are desirable.

Perhaps most importantly, though, parents need to be viewed with respect and treated with dignity in their interactions with public and private agencies. The institutions of society-religious, social, and political institutions and the media—should ***recog***-nize the diversity of America's families and the family's potentially significant role in improving the health of our Nation's children and adolescents. Rather than adhering to the outdated notion that parents are solely the obstacles to treatment for children and adolescents, many more professional health/mental health care providers should try to regard parents and other family members as partners-together with the practitioner and the patient—in the prevention, treatment, and rehabilitation of adolescent health problems (73a). While some families surely bear culpability for the health problems of their members, a' 'blame the family' or 'blame the parents' approach to understanding the problems of adolescent health obfuscates more than it illuminates. Through strengthening the many positive contributions of families and parents to adolescent health, a more balanced and constructive perspective can be maintained.

Chapter 3 References

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[36] **For further discussion, see ch.** *9, "AIDS* **and Other Sexually Transmitted Diseases: Prevention and Services," ch. 10, "pregnancy and Parenting: Prevention and Services," and ch. 13, "Delinquency: Prevention and Services, " in this volume.**

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