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From Parent Training to Community Building

ABSTRACT

For low-income families, particularly, parent-training programs need to be broadened and offered in communities in order to reduce isolation and strengthen support networks of families. Such an approach will lead not only to better parenting and fewer child-behavior problems, but also to greater collaboration with schools and more community building on the part of parents and teachers. The author describes a parent-training program's evolution from an initial goal of improving parenting skills in order to reduce children's conduct problems and promote their social competence to the broader goals of strengthening parents' social support and increasing their school and community involvement. Community-building strategies and processes embedded in the program designed to promote group cohesiveness and support networks are highlighted.

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Research indicates that aggressive behavior among children is escalating and occurring among younger and younger children (Campbell, 1990; Webster-Stratton, 1991). This trend has disturbing implications. Early-onset conduct problems in young children (in the form of high rates of oppositional defiant aggression and noncompliance) are predictive of subsequent drug abuse, depression, juvenile delinquency, and antisocial behavior and violence in adolescence and adulthood (Kazdin, 1985; Kupersmidt & Coie, 1990; Loeber, 1990; Moffitt, 1993). Acts of murder, rape, robbery, arson, drunk driving, and abuse are perpetrated to a greater extent by persons who have a history of chronic aggression stemming from childhood than by other persons (Kazdin, 1995). Thus the problem of escalating aggression among young children is a concern for

society as a whole, regardless of ethnicity, economic status, or community. Conduct disorder is one of the most costly mental disorders to society (Robins, 1981). A large proportion of antisocial children remain involved with mental health agencies throughout their lives or become involved with criminal-justice systems. In other words, everyone pays in the long run when these children are left uncared for and their behavior problems untreated.

During the past 20 years various treatment approaches based on parent-management training (PMT) have been developed to address child conduct problems (Estrada & Pinsof, 1995). The rationale for interventions targeted specifically at parenting skills arose from the considerable body of research showing that ineffective parenting is a key risk factor in the development and maintenance of

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conduct problems (Patterson, 1982; Patterson, Reid, & Dishion, 1992). Studies evaluating these interventions have shown that they fairly consistently have improved parenting skills, reduced child conduct problems, strengthened children's social competence, and generally brought child functioning back into the normal range for at least two thirds of the families treated (Webster-Stratton, 1993a). Research also suggests that if intervention in parenting occurs early, when the child is still in preschool, it is more effective and more likely to prevent a chronic pattern from developing. In fact, evidence shows that the younger the child at the time of intervention, the more positive the child's behavioral adjustment at home and at school (Strain, Steele, Ellis, & Timm, 1982). However, research studies have found that one third of families fail to respond to PMT (Webster-Stratton, 1993a). Factors related to treatment failure are lack of support, poverty, single parenthood, maternal depression, and family isolation (Dumas & Albin, 1986; Webster-Stratton, 1985; Webster-Stratton, 1995). Families marked by these risk factors are more likely to drop out of treatment prematurely, fail to show changes after treatment, or fail to maintain changes at follow-up assessments.

These risk factors are increasing. Contemporary American society is characterized by increasing poverty and econom-

ic stratification, family isolation and alienation, fewer supports for families, and a declining sense of community (Sviridoff & Ryan, 1996). Since the early 1970s when the poverty rate for children was reduced to 14%, children's poverty has become

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more widespread. In the 1990s, it has remained stubbornly at 22%–25% (Huston, McLoyd, & Coll, 1994). Coupled with this trend is the increasing number of single parents, most of whom are mothers (Hashima & Amato, 1994), which is relevant here because socioeconomically disadvantaged mothers are more likely to report depression, isolation from family members and neighbors, and less support available from informal or formal networks (Garbarino & Kostelny, 1992). As many observers of contemporary American society have noted (including the authors of Family Service America's 1995–1997 strategic plan), regardless of in-

come, families have tended to become increasingly isolated from one another and are less likely to assume a broad-based responsibility for helping and supporting one another (Putman, 1995; Wilson, 1987). Membership and participation in community organizations (e.g., PTAs, sports leagues, and various volunteer associations) have declined sharply in recent years (Putman, 1995). We postulate that increasing violence and accompanying fears for one's safety and that of one's children lead many people to isolate themselves and become less involved in their communities, which in turn results in deteriorating social networks, lack of social support for individuals and families, and greater isolation. As American families become more isolated, they focus more exclusively on protecting their own interests and lose sight of the need to advocate as a community for the needs of all children.

Increasing rates of conduct problems may be at least partially accounted for by these alarming trends, given the fact that poverty, life stress, lack of social support, maternal depression, and family isolation are related to the onset of conduct disorders (Hawkins, Catalano, & Miller, 1992). Indeed, studies have shown that economic deprivation combined with a lack of social support creates an especially dangerous situation for children in terms of potential child abuse (Garbarino & Kostelny, 1992). But because

these are the very risk factors associated with families who fail to respond to PMT, we can expect to see an increasing number of children with conduct problems who will not be helped by our traditional PMT approach.

In response to these findings, PMT has been broadened in recent years to include adjunct strategies such as synthesis training, whereby parents are helped to understand how environment and stress may contribute to inappropriate and inconsistent parenting (Wahler, Cartor, Fleischman, & Lambert, 1993); problem-solving, marital communication, and self-control training designed to help parents cope more successfully with negative life stressors and with marital conflict (Dadds, Schwartz, & Sanders, 1987; Webster-Stratton, 1994); and child-focused training designed to target the child directly for training in problem-solving and self-control skills (Kazdin, Esveltd-Dawson, French, & Unis, 1987; Webster-Stratton, in press). Emerging evidence suggests that these adjunct treatment components produce more enduring improvements in parent and child behavior (Estrada & Pinsof, 1995).

Those interventions that have focused on adjuncts to PMT reflect a shift in focus from individual change (i.e., parenting skills) to within-family change (i.e., marital communication and problem-solving skills). Yet no further shift to what might be called interfamilial or extrafamilial change, such

as a family's need to form stronger and more supportive connections with other families and with the community in general, has occurred. For low-income families particularly, PMT programs need to focus more broadly on building community networks and parent support. As a result of the "buffering" aspects of social support (Cohen & Willis, 1985), as the number of people whom low-income parents feel they can rely on for informal assistance increases and as they feel more satisfied with their social support, the more likely they are to be nurturing and positive in their parenting and the less likely they are to report problematic behav-

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ior (Hashima & Amato, 1994) compared with low-income mothers who feel isolated and dissatisfied with their social support (Jennings, Stagg, & Connors, 1991). Few studies have investigated the effects of social support. Treatment approaches based on the individual counseling model foster reliance on the therapist, not on the group, and

programs that have used a group approach (Webster-Stratton, 1994) have not indicated whether fostering supportive social networks was a primary goal. In the research literature, little reference is made to therapeutic strategies used to decrease families' isolation or promote their involvement or to build a sense of community, either within the group or the larger community. Indeed compared with our well-developed research methods of measuring changes in parenting behavior, few studies report outcome measures having to do with social networks, parents' sense of support, or their involvement in their children's education or school. Yet if we are going to develop more effective interventions targeting such factors as sense of community, social support, and involvement, we will need suitable outcome measures.

The purpose of this article is to describe briefly the evolution of the parent-training program at the University of Washington from the initial goal of improving parenting skills in order to reduce children's conduct problems and promote social competence to the broader goals of strengthening parents' social support and increasing their school and community involvement. An established clinic-based treatment program—one that was effective with clinically referred young children with identified conduct problems—was evaluated to determine its effectiveness as a community-based, early-prevention program

in a sample of low-income Head Start families. The content of the parent training is not discussed here (see Webster-Stratton, 1992a; Webster-Stratton & Hancock, in press); rather, the community-building strategies and processes embedded in the program to promote group cohesiveness and support networks are highlighted.

The Parenting Program

Emphasis on Parenting Skills

In developing the University of Washington parenting program, we were guided by Patterson's (1982, 1986) seminal work and theoretical formulations concerning the etiology of conduct disorders and problem behaviors. The pioneering research of Patterson and others found that parents of children with conduct problems exhibit fewer positive behaviors; use more violent disciplinary techniques; are more critical, more permissive, less likely to monitor their children's behaviors; and are more likely to reinforce inappropriate behaviors while ignoring or even punishing prosocial behavior (Patterson, Chamberlain, & Reid, 1982; Wahler, 1976). We felt that if we could improve the parenting skills of at-risk parents while their children were still very young and the families' negative interaction styles were still malleable, we could improve the long-term prognosis for these children and their families.

Accordingly, in 1981, we developed the Parents and Children Videotape Series, a 10–12 week parent-training curriculum based on four programs that presented the following topics:

- *Program one:* How to play with your child and help your child learn
- *Program two:* Using praise and encouragement to bring out the best in your child
- *Program three:* Effective limit-setting
- *Program four:* Handling misbehavior

This content was presented via videotape in conjunction with parent-group discussions; groups of 8 to 16 parents met weekly for two hours. Heavily guided by the modeling literature, programs one through four attempted to enhance modeling effects by including parents and children of both sexes and a range of ages, ethnicities, socioeconomic backgrounds, and temperaments so that parents would identify with at least some of the families shown on the tapes and would therefore perceive the tapes as relevant. The decision to use videotape modeling was based on two factors: Videotape seemed to hold enormous potential as a practical and cost-effective means of reaching more parents in a group format (as opposed to individual therapy), and research suggested that verbal training methods (i.e., didactic lectures and group discussion) are inefficient methods for inducing behavioral changes in parents, particularly for less formally

educated parents (Chilman, 1973). Videotape modeling, on the other hand, offered promise as an effective means of influencing behavior and a flexible training method that could illustrate a variety of situations, thereby promoting better generalization of the training content and better long-term maintenance. A more complete description of the videotape parent-training program and training manual is available (Webster-Stratton, 1992a; Webster-Stratton & Herbert, 1994).

Evaluation of Programs One Through Four

A series of five randomized studies with more than 500 families of children (three to seven years of age) with early-onset conduct problems has shown this series of programs to be effective in significantly improving parental attitudes and parent-child interactions as well as in significantly reducing parents' reliance on violent and critical disciplinary approaches and reducing child conduct problems, when compared with control groups, individual one-to-one parent training, discussion groups without videotape modeling, and videotape modeling without discussion (Webster-Stratton, 1981, 1982, 1984, 1990b, 1992b; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989). One-year follow-up assessments indicated that most of the significant improvements reported immediately posttreatment were maintained. Moreover, two thirds of the entire

sample showed clinically significant improvements (Webster-Stratton et al., 1989). We also found that children who were still maladjusted (according to teacher and parent reports) at our three-year follow-up assessment shared the common features of a family characterized by marital distress or single-parent status, maternal depression, lower social class, high levels of negative life stressors, and low levels of social support (Webster-Stratton, 1990a, 1990b; Webster-Stratton & Hammond, 1990).

Broadening the Programs— Social Support

When we looked at predictors of relapse and the failure of improvements in child behaviors to extend beyond the home to school and peer relationships, we concluded that our treatment model was incomplete. Consequently, we developed our family videotape programs in 1989 (programs five through seven) to supplement the original programs and to promote increased maintenance and generalizability of treatment effects by addressing the effects of marital distress, stress, depression, poverty, and lack of social support as predictors of treatment relapse. We theorized that this broader-based training, which included problem-solving and coping skills, interpersonal-communication skills, self-control skills, and understanding ways to build support, could help buffer the negative influences of poverty and other life stressors on

parenting skills. Moreover, we moved from the narrower model of training in parenting skills to the broader model of training in interpersonal skills, which included not only building within-family support but also strengthening social support, which included support within the parent group. We theorized that training in interpersonal support, communication, and problem solving would decrease feelings of isolation for parents.

Evaluation of Family-Focused Programs

In a randomized study comparing the broader, more family-focused programs with the original four-program intervention that focused on parenting skills, we found significant improvements in communication, problem-solving, and collaboration skills among parents who participated in the broader programs compared with parents who received only the basic parent-skills training. Moreover, children of parents who attended the broader programs showed significant increases in the total number of solutions generated during problem solving, most notably in prosocial solutions (as compared with aggressive solutions), in comparison with their counterparts, suggesting that promoting parents' coping skills had secondary benefits for children. Parents in the broader-focused programs also reported significantly greater consumer satisfaction than did parents who did not receive the added components (Webster-

Stratton, 1994). Only one family dropped out of the family-focused programs, which attests to its acceptance by families.

However, some limitations of the basic parenting-skills training were not addressed by the broader programs, namely, school-related problems. In the one- and three-year follow-up assessments, we found that of the entire group of treated families, 25% to 46% of parents and 26% of teachers still reported concerns about school-related problems such as peer relationships, aggression, noncompliance, and academic underachievement (Webster-Stratton, 1990b). Data from parents pointed to a need to help parents become more effective in supporting their child's education and working with teachers on their child's social and academic problems. Data from teachers revealed a need to help teachers become more effective in managing classroom behavior problems and in collaborating with parents (Webster-Stratton, 1990b; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988).

Extending the Programs— School Involvement

A second limitation of the broader family programs is that they did not build support networks for these parents and children within their natural communities. The family programs fostered strong friendships and support among the parents who participated; however, when formal training ended, groups had difficulty

continuing to meet because of the distances and logistics involved in getting together. We theorized that optimal intervention should be delivered in the context of families' own communities and within existing networks such as schools, housing developments, and churches so that groups could continue to meet for ongoing support after formal training ended. When programs are offered in the communities where families live or within their children's schools, mutual-support networks are more likely to emerge and become a sustaining force, thereby increasing parents' involvement with schools and building a sense of community for these parents. We perceived a distinct advantage in offering these programs in a more accessible, nonstigmatizing context—that is, outside a clinic and in families' communities. Moreover, a nonclinical program would have the potential to prevent behavior problems before they escalated into severe symptoms that might lead to an oppositional defiant disorder or conduct disorder (ODD/CD) diagnosis that would require extensive clinical treatment.

Evaluation of Prevention Program

To pilot our prevention program, we chose to work with families enrolled in Head Start because children in this population are at high risk for developing conduct problems because of the increased risk factors in socioeconomically deprived fami-

lies (e.g., McLoyd, 1990; Trickett, Aber, Carlson, & Cicchetti, 1991). In our study of 426 families comprising a multiethnic group, 42% of the mothers were experiencing moderate to severe depression, scoring 17 or higher on the Depression Questionnaire (Radloff, 1977); 45% had been physically or sexually abused as a child; 29% had a partner who had a history of criminal activity; and 65% were single parents. Approximately 49% of the population had 4 or more (of 14) risk factors for conduct problems (e.g., low education, lived in shelter, psychiatric illness, substance abuse, criminal history, abused as child, moderate depression, pregnant as teenager, etc.).

Families were randomly assigned to either an experimental condition in which parents, teachers, and family service workers in Head Start participated in the prevention intervention (called *Partners*) or to a control condition in which parents, teachers, and family service workers participated in the regular center-based Head Start program. Baseline assessments consisted of school observations, home observations, parent interviews, and teacher and parent questionnaires. Teachers from the experimental centers underwent a two-day training workshop designed to familiarize them with the content of the parenting program and to learn ways they could promote collaborative relationships with parents. Head Start family service workers completed a four-day

parent-group-leader training. After the parenting program was completed, 91% of the families from the experimental centers (125 of 137) and all of the families from the control centers were reassessed.

Measures for the study were chosen with the goal of measuring not only parenting and child-behavior changes but also parents' involvement with schools, satisfaction with group support, and commitment to give back to their communities. We used a revised version of the Parent-Teacher Involvement Questionnaire (INVOLVE; Webster-Stratton, 1993b), a 32-item scale derived from the Oregon Social Learning Center (1993), with parents of preschool children. This questionnaire, conducted as an interview, enabled us to evaluate the amount and quality of parents' involvement with their children's education at home and at school. Both parents and teachers completed this measure separately. In addition, parents completed the Parent Satisfaction and Involvement with Community questionnaire (Webster-Stratton, 1993b). This measure asked trained parents to rate the program methods and processes (e.g., use of book, videotapes, group support, therapist skills, etc.) as well as to indicate whether the parents would be interested in supporting the program in future years either by going to orientation meetings to recruit new families, running day care for families, participating in groups, or being trained as a group coleader.

The results of the short-term outcome measures were promising. Independent observations in the home revealed that intervention mothers had significantly ($p < .01$) higher rates of positive affect, praise, and warm, caring physical touching behaviors, whereas they had sig-

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nificantly lower amounts of criticisms, commands, and negative affect in their interactions with their children when compared with control mothers postintervention (baseline data used as covariates). In addition, intervention mothers were rated significantly higher than control mothers in supportive behaviors and discipline competence and significantly lower in harsh and critical discipline approaches. Parent reports also indicated that intervention mothers perceived their discipline as being more consistent and that they used fewer inappropriate strategies. In regard to child-behavior changes, ANCOVA analysis in-

dicated that intervention children had significantly ($p < .01$) lower rates of negative behaviors, noncompliance, and negative affect (valence), as well as higher positive affect, when compared with control children postintervention. According to the coder-impressions inventory, they also had significantly ($p < .001$) higher levels of prosocial behaviors and lower levels of misbehavior than did control children.

According to parent reports of school involvement, the percentage of parents attending parent meetings at school was significantly higher for the intervention parents (80%) than for the control parents (62.5%). Moreover, intervention parents reported calling or meeting with their teachers significantly more often than did parents in the control condition. ANCOVA analysis indicated that intervention parents were significantly more satisfied with their relationships with their family service workers than were control parents. Individual item analyses revealed that intervention mothers reported more satisfaction talking with family service workers, felt that the family service workers were more personally interested in them, and felt more comfortable asking questions and making suggestions to them, compared with control mothers. No significant difference in overall parent satisfaction with teachers was found between the two conditions. In summary, these findings suggest that parents who received train-

ing were more involved in their children’s education, were more involved in school activities, and had formed stronger positive relationships with the family service workers who conducted the parent groups than parents in the regular Head Start centers where the weekly parenting groups were not offered.

Teachers corroborated the parent-report findings. Summary scores on teachers’ reports of parents’ involvement in their child’s education were significantly higher for the intervention mothers than for control mothers. Specifically, teachers rated intervention mothers higher in terms of mutual goals for their child, positive attitude regarding education, involvement in their child’s education, and perceiving education as important, compared with teacher ratings of control mothers on these variables. In addition, teachers rated intervention mothers as having significantly higher total involvement with teachers and the school than did the control mothers: talking more with teachers, attending more parent-teacher conferences, attending more school meetings, asking more questions and making more suggestions regarding their child, and volunteering more in the classroom. Teachers in the intervention centers also reported making significantly more calls to intervention parents and sending home more notes to parents than did teachers from the control centers. In sum, teachers in the intervention centers who

had received the training in the parent program were more active in forming relationships with parents than were teachers in control centers. It appeared that this comprehensive parenting program not only served the purpose of teaching parents more supportive skills with their children, but empowered parents to be more involved with their children's education, to participate in school activities, and to meet with their teachers more often. This had a reciprocal effect on teachers, who in turn contacted, communicated with, and supported parents more often:

Not only did intervention parents form stronger connections with their schools, teachers, and family service workers, they also experienced the support of other parents in their communities. They wanted the parent groups to continue for themselves and wanted to make them available to other parents. Eighty-eight percent of the parents rated the group support as "very useful" and requested that their groups continue as a support group to assist them during the kindergarten year. When asked if they would like to participate in the Head Start parenting program in some kind of support role during the following year, 81% said they would. Approximately 38% wanted to help by recruiting new families, 35% by being trained to conduct home interviews with new families, 34% by providing day care for children so parents could attend parent groups, and

26% by being trained to co-lead parent groups. This high percentage of parents committed enough to volunteer to give back to their communities in various ways suggests that their sense of isolation from their communities may have been diminished and at least partially replaced with a new sense of responsibility, commitment, and caring for their communities.

Building Support and Community

Our program has evolved over the past 15 years from a parent-training program whose goals were to reduce conduct problems by improving parenting skills to one that aims to strengthen parents' social support networks and increase parents' involvement in their children's schools and communities. The following describes some of the therapeutic processes embedded in the parenting program that are directed toward those goals.

Support Begins With the Therapist

We operate from the assumption that if parents are going to learn how to be supportive in their relationships with one another, they need a supportive therapist. The group therapists not only teach parenting skills, they model a style of interaction. This modeling requires that the therapists promote intimacy and assume the

role of a friend to parents in the group—that is, the kind of friend who listens, is reflective and nonjudgmental, empathizes, asks for clarification to ensure that he or she understands what the parent is saying, helps to solve problems, and does not command, instruct, or criticize. Developing this kind of supportive relationship is important in that the literature suggests that low-income families are likely to report professionals as unsupportive, critical, and judgmental toward their lifestyle (Dumas & Wahler, 1983; Wahler, 1980).

Therapists can also assume the supportive role of advocate, particularly in situations in which communication with other professionals may have been difficult. As advocate, the therapist connects the family with relevant persons, programs, and resources. For example, the therapist can arrange and attend meetings between parents and teachers to help the parents clarify their child's problems, agree upon goals, and set up behavior-management programs that are consistent from home to school. It must be emphasized that the ultimate goal of this advocacy role is to strengthen the parents' ability to advocate for themselves and for their children. The danger of advocacy is that it can become a "rescue" role, resulting in the parents feeling dependent or being uncommitted. An example of this might be the therapist who makes recommendations to a child's teacher without involving the parents. Our approach

to advocacy in this situation would be to offer to accompany parents to a school meeting but to say to them, "We want you to share with the teacher the strategies that you are trying to use at home in order to see whether the teachers might consider setting up a similar program at school." By involving parents, giving parents responsibility for their own solutions, and acting *with* (rather than *for*) parents, we both support them and teach them how to engage in a collaborative process with teachers.

A supportive relationship between therapist and parents is a collaborative relationship in which the therapist does not set him- or herself up as an expert who dispenses advice to parents about how they should parent more effectively. Rather, collaboration implies a reciprocal relationship based on equal use of the therapist's and the parents' knowledge, strengths, and perspectives. A collaborative model of parent training is nonblaming and nonhierarchical. The collaborative training model acknowledges that expertise is not the property solely of the therapist; the parents are the experts concerning their child, their family, their cultural background, and their community. The therapist functions as an expert on child development, family dynamics in general, behavior management principles, and so forth.

Collaboration implies that parents participate actively in setting therapy goals and the intervention agenda. It implies

that parents evaluate each session and that the therapist is responsible for adapting the intervention to meet the family's needs. *Webster's New Collegiate Dictionary* defines collaboration as simply "to labor together"; the collaborative therapist labors with parents by actively solicit-

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ing their ideas and feelings, understanding their cultural context, and involving them in the therapeutic process by inviting them to share their experiences, discuss their ideas, and engage in problem solving. The collaborative therapist works with parents to adapt concepts and skills to the circumstances of those parents and the temperament of their child. By building a relationship based on mutual understanding, the therapist creates a climate of trust, making the group a safe and supportive place for parents to reveal their problems and to risk new approaches.

A noncollaborative approach is hierarchical, didactic, and nonparticipative—the therapist lectures, the parents listen.

The noncollaborative therapist analyzes, interprets, and makes decisions for parents without incorporating their input. Principles and skills are presented to parents in terms of prescriptions for successful ways to deal with their children. Homework assignments are rigid and given without regard for the family's circumstances. We reject this approach because research suggests it is likely to lead to a low level of commitment, increased dependency, low self-efficacy, increased resistance, higher attrition rates, and poor long-term maintenance (Janis & Mann, 1977; Patterson & Forgatch, 1985) as well as resentment of professionals. In fact, if parents are not given opportunities to participate they may see no alternative other than to drop out or resist the intervention as a means of asserting their control over the therapeutic process. They may prefer isolation over treatment, which perpetuates a sense of inadequacy and creates dependence on the therapist.

On the other hand, the collaborative relationship between parents and group therapist has the effect of giving back dignity, respect, and self-control to parents, whose problems, including poverty, instill low self-confidence and feelings of guilt and self-blame and may make them vulnerable (Spitzer, Webster-Stratton, & Hollinsworth, 1991). A collaborative approach is more likely to increase parents' confidence and self-efficacy. The essential goal of collaborative intervention is

to empower parents so that they feel confident about their parenting skills and ability to respond to new situations that may arise when the therapist is not there to help them. Bandura (1977) calls this strategy strengthening the client's "efficacy expectations"—that is, the parents' conviction that they can successfully change their own and their child's behaviors—and suggests that self-efficacy is the mediating variable between knowledge and behavior. Parents with high self-efficacy will tend to persist at tasks until they succeed. Moreover, this model is likely to increase parents' engagement in the intervention. Research (Backeland & Lundwall, 1975; Janis & Mann, 1977; Meichenbaum & Turk, 1987) suggests that the collaborative process has the multiple advantages of reducing attrition rates; increasing motivation, commitment, and a sense of support; reducing resistance; increasing temporal and situational generalization; and giving parents and the therapist a joint stake in the outcome of the intervention. This model has another purpose: Because we want parents to adopt a supportive, collaborative, empowering approach with their own children and in their interactions with teachers and their school community, it is important to use this approach with them in the parent program, that is, to model the relationship style we wish parents to use in their relationships with their children and others. (The

collaborative model is more extensively described by Webster-Stratton and Herbert, 1994.)

Group Work—a Basis for Community Building

The collaborative approach requires that parents take responsibility for their own therapy goals and for the intervention agenda. Parents' work begins in the first session when the therapist asks parents to define their personal goals for the training program. The goals for each parent are posted on the wall so they can be referred to throughout the program. Sometimes parents change or add to their goals during the program. For example, a parent may start by defining his or her goal as "to make my child obey more" and later add "to control my anger." Parents are asked to write down (as an at-home assignment) the child behaviors they want to increase or decrease; these targeted behaviors (e.g., go to bed at 8 P.M., not interrupt when parent is on the telephone, etc.) then become the focus of parents' discussion during group sessions as well as the weekly home assignments. This emphasis on parents' individual goals is based on the literature suggesting that people who have determined their own priorities and goals are more likely to persist in the face of difficulties and less likely to show debilitating effects of stress (Dweck, 1975; Seligman 1975). Furthermore, it is unethical to impose goals on parents that may not be congruent with their own goals, values,

or lifestyles and with their child's temperament. This principle is particularly important in instances of cultural or class differences between the therapist and the group when assumptions arising from the therapist's own background or training may simply not apply.

The parents' work within the group is individualized through weekly assignments. These homework assignments include reading a chapter each week (or listening to it on audiotape), tracking specific behaviors in themselves or their child, practicing a particular parenting skill, or setting up a chart with their children. Sometimes these home assignments may be perceived by parents as an unnecessary burden. Nevertheless, parents need to feel ongoing ownership of the therapy beyond merely attending sessions. The therapist approaches this resistance by discussing with parents the rationale for the assignments and exploring with them any difficulties they may perceive in doing the assignments. If a parent perceives an assignment as too difficult or too time consuming, the therapist will contract with that parent for what is feasible (in the parent's view) for him or her to accomplish that particular week. If a parent feels an assignment is pointless, then the therapist may negotiate an alternative assignment based on the parent's personal goals. Because the assignments are designed to provide practice and review of what is covered in the group session,

discussion of the assignments provides critical feedback to the therapist. Each week, when parents arrive at group, the therapist returns to them the prior week's assignment together with comments on it and the parents put in their personal folder the current week's assignment and check off whether they were able to do the assignment or meet their personal goal. The

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personal folders, in addition to being a method of self-monitoring, are a private place for personal communication between the therapist and parent. The parents can make comments or ask questions they do not want to share with the entire group, and the therapist can respond personally and frankly.

Parents' work within the group includes concern about self-care and self-nurturance, which the supportive relationship with the therapist facili-

tates. We have found the notion of parental self-care to be a foreign concept among low-income families, who are typically so overwhelmed with daily tasks or so limited by their life circumstances that they feel unable to think about providing for their personal needs. For instance, when we talked with them about taking personal time for no-cost or inexpensive pleasures, we met resistance: “I can't take care of myself—I can't afford a sitter and I can't leave my children alone to take a walk.” Or “I can't go to a movie—I don't have a car or any money.” Or “You've got to be kidding—I've got enough to do!” When this happens, we brainstorm with the group to come up with a list of things they can do to give themselves some relief from parenting responsibilities.

Another group exercise directed at self-care is to list typical daily stressors and positive strategies for handling them. Discussion on this topic includes an exercise in which parents list all possible obstacles to following through with their self-care plan and to think about ways to counteract some of these obstacles. As participants hear themselves express feelings of being trapped by life's circumstances or dismiss their own personal needs, they begin to identify patterns of devaluing themselves and discounting the need for self-care. After they identify this tendency, they are more likely to understand its destructive results and begin to brainstorm ways they can accomplish this goal.

When parents value themselves and regularly act upon that self-respect, they are able to be more nurturing with their children and to build relationships with others in the group and their community. Self-care is an important link between parents' individual work and their ability to become involved in their community.

Developing a Sense of Community

Our research with clinic families shows that group training utilizing videotape modeling is far more cost effective than is one-on-one intervention and is at least as effective therapeutically (Webster-Stratton, 1984, 1989). Increased peer support is another benefit of the group format and it in turn fosters greater parental engagement and satisfaction with the program. Parent groups that are supportive are an empowering environment that decreases parents' sense of isolation. The group itself becomes a new source of support.

The therapist builds within-group support by encouraging debate and alternative views and by treating all viewpoints with respect. The therapist keeps the focus of the group on the parents' insights (versus therapists' answers) and reinforces the parents for sharing their reactions and ideas so that every member gradually feels comfortable participating in discussions. The therapist tries to ensure that parents' insights and experiences have relevance for everyone. He or she may do this by translat-

ing their stories into common themes, such as breaking the family curse of violence or having the confidence to parent differently from one's parents. In addition, the therapist utilizes the videotapes to stimulate parents' discussion and sharing of ideas. For example, videotape scenes show parents interacting with their children in natural situations, such as during mealtimes, getting children dressed, toilet training, handling disobedience, and playing together. Scenes depict parents responding in ways that may result in a child continuing to misbehave as well as in ways that successfully end the conflict. The intent of showing negative as well as positive examples is to reduce parents' sense of stigmatization and guilt about their parenting problems and to illustrate how parents can learn from their mistakes and those of other parents. The videotapes are used to stimulate group discussion and problem solving, with parents sharing their own experiences and contributing solutions and ideas based on their own experiences with their children and on their family's cultural, class, and individual background.

Within-group support is facilitated by group exercises. Several times during the program the therapist draws up a composite list of child behaviors that parents are working on so that group members can see the similarities in their issues as well as appreciate their differences. Another exercise is to ask the group to discuss barriers and

advantages to parenting strategies such as time out. The exercises promote group cohesion as well as attention to individual goals, thereby increasing parents' commitment to and ownership of the program.

A more direct way of building support systems is by assigning everyone a parent "buddy" in the second session. Buddies are asked to call each other during the week to talk about how the homework assignment (e.g., praising, limit setting) is going. Many parents are initially hesitant about making these calls, but as they experience the support they receive from these conversations, they want to continue making these contacts. Many fathers state that this is the first time they had ever talked to another father about parenting. This assignment is carried out every few weeks throughout the program with different "buddies" assigned each time. If a parent misses a session, the buddy will call right away to let the person know he or she was missed and to inform the parent about the coming week's material. When parents share solutions with one another that they view as appropriate, the therapist reinforces and expands on these ideas. This approach highlights parents' capabilities, not their deficiencies, and builds the group's sense of community.

In the parent group, parents learn how to collaborate in problem solving, how to express their appreciation for one another, and how to cheer one an-

other's successes in tackling difficult problems. They also learn to share their feelings of guilt, anger, and depression as well as their mistakes or their children's misbehaviors. These discussions are a powerful source of support. By sharing feelings and experiences the parents discover their commonality. Feelings of isolation decrease, and parents become empowered by the knowledge that their problems are normal. This sense of group support and kinship increases parents' feeling of commitment to the group, as is indicated by the following comments:

Mother: This group is all sharing. It's people who aren't judging me, who are also taking risks and saying, "Have you tried this?" or "Have you considered you might be off track?"

Father: You know when this program is finished, I will always think about this group in spirit.

Promoting Within-Family Support

Parents often report conflicts with partners and grandparents about how to handle the child's problems, conflicts that result in stress in relationships and among individuals. Therefore, in addition to building support within the parent group, the program also emphasizes building support within the family and home. We encourage every parent in the training program to bring a spouse, partner, close friend, or family member (such as grandparent) with him or her to provide mutual support. Our follow-up studies (Webster-Stratton, 1985) as well as those of others have indicated

that the greatest likelihood of relapse occurs in families in which only one person was involved in the intervention.

During parent groups, partners are helped to define ways they can support each other when one is feeling discouraged, tired, or unable to cope. We help parents generalize the principles learned in the parenting program to relationships in general: the importance of having fun together; the value of praise in all relationships; the feeling of support that comes from communication that is nonjudgmental, empathic, and collaborative; the value of sharing feelings; the necessity of setting limits and complying with others' requests and limits; and the need to give and receive support. Single parents discuss ways they can use the newly acquired skills to strengthen other interpersonal relationships, such as communication with bosses, boy-friends, or grandparents. Finally, we believe parents' self-care and ability to take some time to meet personal needs strengthen their ability to nurture and support others in their family. Frequently, the energy used to care for children, coupled with financial constraints, leaves parents feeling too exhausted to make plans to spend time with each other or with adult friends. Yet time away from the child with a partner or a friend can make parents feel supported and energized, helping them gain perspective so they are better able to cope with parenting.

Parents' Involvement In Schools and Communities

Parents often report having had stressful childhood experiences with teachers or a school. In addition to making parents reluctant to become involved with their child's school, such experiences make it difficult for them to know how to work with teachers in support of their child's education. If English is their second language, they often feel uncomfortable approaching teachers or even entering the classroom. They frequently talk about not knowing what to ask teachers, how to act in the classroom, and how to develop a positive relationship with teachers. Several home assignments address this problem by giving parents examples of questions they might ask and ways they might share their knowledge of their child with teachers. For example, one assignment, completed in a group session, is a letter to the teacher telling him or her what they like about their child's classroom. Other assignments include visiting the classroom, going on a field trip with the children, and taking their child to the library. To support a parent who is reluctant to approach a school or a teacher, another parent will offer to visit the same school on the same day so they can help each other. Parents are encouraged to have individual meetings with their

child's teacher and brainstorm in their group about the kinds of questions they can ask teachers to promote collaboration.

Parents are included in all opportunities for community building. For example, we approach agencies in the community for resources, including funds for food for parent meetings, toys for the day-care program, space to house the parent groups, and so forth. Parents accompany the therapist to the schools, churches, Rotary clubs, or businesses to create a sense of ownership in the program and support between the therapist and parents as well as to encourage parents to advocate for their needs and give them a stronger sense of involvement with their community.

In addition to promoting parents' involvement in the school and community, we also facilitate teachers' involvement with families. At the beginning of the year we encourage teachers to develop and send home interest surveys (parents' perceptions of their child's interests and temperament and ways parents would like to be contacted) as a way to get to know the child and his or her family. Not only do we present the parenting program to teachers in briefer form so they understand what the parents are learning and will support it, but we also train them in positive classroom management strategies. Our teacher workshops cover such topics as how to set up a home-school behavior-incentive program for behavior problems,

how to develop positive relationships with difficult students and their parents, how to improve the quality of parent-teacher conferences, and the value of home visits, weekly letters, and positive telephone calls to families. Some teachers are reluctant to make home visits or telephone calls: Some are unsure of what to do or say; others fear they will be perceived as intrusive if they call or request a home visit; and others feel that the demands on their time are prohibitive. We try to counteract such reasoning by discussing the advantages and disadvantages of trying these strategies. We try to help teachers understand parents' fears. At the end of the year, parents and teachers collaborate to develop transition plans that outline their continuing goals for the child, specific strategies that have been effective with the child, and how the parents wish to be involved in their child's education.

Conclusion

A healthy society is built on strong families and communities and not on families alone, as Family Service America's 1995-1997 strategic plan declared. Parenting interventions must be broad focused and delivered within the communities where the families live. They must be designed not only to help parents adopt parenting strategies that promote their children's social competence and reduce be-

havior problems but also to give them the support they need to become engaged citizens collaborating with teachers, involved in their schools and communities, and supporting one another as parents. If we are successful in promoting social support and community involvement we will reduce the risk of parents maltreating children and strengthen communities for all our children in the long run. As a Head Start mother and father state,

Head Start mother: That's real important for me, you know, to have the support group. I mean I have my friends, but they don't really understand. Here, everybody that has taken the class has something in common, you know, you can talk to them. We are real supportive of each other. You find out you're not alone, you know, we could understand what each other was going through. I mean everyone brought into the group something that they used in parenting that really worked, you know, that's another thing about the class, it's not a set class, you kind of take from other people. You build your bridges—just the support of being there I think is a majority of what helped me.

Head Start father: The first night I went because I felt an obligation, I couldn't wait for it to be over. I looked at my wife and said, "This is going to be ridiculous. I'm going to come here for 12 weeks and listen to two women I don't know tell me how to raise my kids!" By the time it was over, I'm thinking, "God, can we get these people's phone numbers and keep in contact?" I did a complete 180-degree turnabout. The longer I was there the more I got to like the other parents. I wanted to go early each week to talk with the other parents before the class started. I like myself a lot better now than I did then, and my wife and I can talk more without yelling. My kids aren't going to be in Head Start next year, but, you know, if there's anything I can do to help I

am more than willing, because it's helped me out so much that I'd like to help someone else. You know what else? I'm actually looking forward to becoming more involved in school next year, which is something I never even thought about before.

It is noteworthy that the Head Start parents quoted above went on to be trained as co-leaders for future parent groups offered in their Head Start centers.

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