Chapter 4
Impact of Family Structure, Functioning, Culture, and Family-Based Interventions on Children's Health

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4.1 Introduction

There are many different types of family structures worldwide that can have differing impacts on children's health and well-being. In Western and Eastern cultures, children have been raised primarily by two biological parents with large extended families and communities.

In other cultures, parents might not be the primary caretakers or advisors, and that role is assumed by a grandparent, aunt, or uncle. The head of the household or who has the most power also varies greatly—the mother, the grandmother, the father, the grandfather, or another family member.

4.1.1 History of the Breakdown in Family Support Structures

During the Industrial Revolution, many families moved from small farming and fishing villages to work in urban factories (De Vries, 2008). This trend continues today, with one or both parents moving to cities, leaving their children to be raised by grandparents or relatives in small rural towns. In rapidly developing countries such as China, India, and Brazil, there has been a massive migration of rural parents

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M.R. Korin (ed.), *Health Promotion for Children and Adolescents*,
DOI 10.1007/978-1-4899-7711-3_4

to cities. These parents hope to pay for their children's education, welfare, and a better life (Child Trends, 2013) but are leaving their children at higher risk for academic and developmental problems because of loss of parental supervision, protection, and support (Bowlby, 2008).

In developed countries, immigrant or refugee families from developing or war-torn countries often arrive first to cities and then bring over as many relatives as possible. They live in one household or closely, so children have many "parents" and lots of siblings and cousins to play with. These families slowly become more isolated as they move up to better jobs and their own homes in the suburbs. As both parents work to pay for a house and birth control reduces family size, children are eventually left with almost no one to support and nurture them (Zhou, 2009). Because school ends long before parents return from work, children come home to an empty house (Reno & Riley, 2000). This breakdown of the family is happening worldwide.

4.1.2 Stresses on the Traditional Institutions of Marriage and Family

For most of the twentieth century, the two-parent family was the norm in the USA. Between 1880 and 1970, about 85 % of all children lived in two-parent households (Kreider & Renee, 2009; Lang & Zagorsky, 2001). With the advent of the Second Demographic Transition (SDT), starting in the 1970s, the numbers of divorces and single-parent families increased rapidly, leveling off in 1995 at 67 % and continuing to today (Child Trends, 2013). These dramatic changes in family structure have resulted in ever-widening health disparities including educational, economic, and social hardships for the children born in fragile homes of the less educated parents (McLanahan, 2004; McLanahan & Jacobsen, 2015; Putmam, 2015). Increases in divorce, separation, cohabitation, out-of-wedlock births, single-parent families, and changes in gender roles and sexuality since the 1970s have reduced the percentage of traditional mother/father families (Popenoe, 2009). Single-parent American households increased from 11 % in 1970 to 29 % by 2007. About a third of the US children under 18 live in biological father-absent homes, and about a third of these children are under 9 years of age (Mather, 2010). The collapse of the traditional family structure hit the African American families even sooner in the 1960s (Moynihan, 1965). Contributing to increased poverty and health disparities, more African American children (52 %) than white children live with single mothers (Mather, 2010). Most children who live with a divorced parent live with their mothers and only 20 % with their fathers (United States Census Bureau, 2011a, 2011b) leaving 10 % of children who live with a grandparent, with other relatives, or with nonrelatives. Of the children who live in nonrelatives' homes, about a third live with foster parents (United States Census Bureau, 2012).

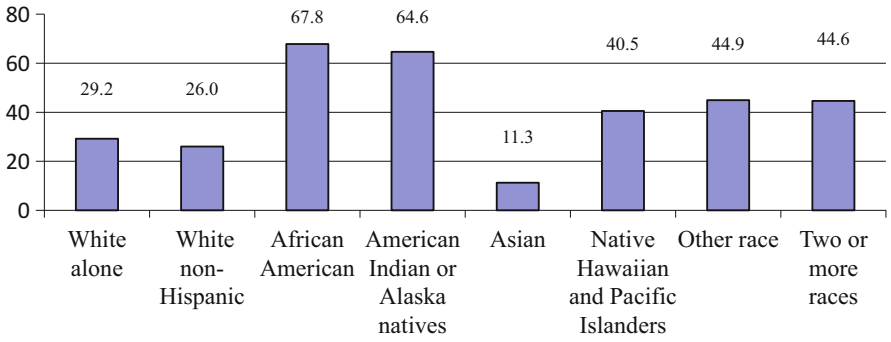

Fig. 4.1 Percentage of nonmarital births to unmarried women aged 15–50, by race and ethnicity (US Census Statistics, 2011a, 2011b)

Single mother households have increased primarily because of a sharp rise in births to unmarried women that has more than doubled in the last 30 years to 41 % by 2011. According to Putmam (2015), "the class divide is growing even as the racial gap is shrinking" as manifested in a fourfold increase in part of this decrease was due to a recent 8 % decline in the birth rate for teenagers. In 2011, the National Vital Statistics System reported that nonmarital birth rates were highest among African American women (68 %), followed by American Indians and Alaska natives (64 %) and Hispanic women (43 %) as compared to non-Hispanic whites (29 %) and Asian or Pacific Islanders (11.3 %) (Shattuck & Kreider, 2013) (Fig. 4.1).

In a new book, *Our Kids: The American Dream in Crisis*, Robert Putnam (2015) argues that class, and not race, is related most to health disparities and unwed births, leading to a bifurcation into two different family structures. The college-educated upper third of society tend to have stable "neo-traditional" two-parent marriages, in which both parents work and share household duties. Divorce rates have gone down from their peak in the 1970s and mother's age of first birth has increased. With two incomes and higher education, these parents provide more opportunities for their children. In contrast, in the only high-school educated, a much more diverse pattern of family structure emerged with sexual partnership being less durable. Sara McLanahan (2004) labeled these "fragile families" where the parents may have never been married or divorced later, resulting in more single-parent families and poverty. Age of first birth has also decreased to 10 years earlier than in the better-educated mothers.

Putnam (2015) highlights that these very different family structures are resulting in an ever-widening gap or inequality of opportunity for children in the USA. He suggests that class (education level and income), rather than race, is the major predictor of how well children do in life because of more opportunities and effective parenting in better-educated parents. The incidence of unwed mothers and single-mother households is more related to lower education levels today than race. By 2012, the percent of children aged 0–7 living in a single-parent household was lower

than 10 % in parents with a bachelor's degree but over 65 % in 2012 for parents with only a high-school degree (Putnam, 2015). Fewer than 10 % of births were nonmarital for college-educated females regardless of race, whereas it was 65 % for women with just a high-school education.

Race does make a small difference as only 2 % of births were out of wedlock for white college graduates. According to Putnam (2015), "the class divide is growing even as the racial gap is shrinking" as manifest in a fourfold increase in nonmarital births to high-school-educated whites to 50 % but a decrease by a third to 25 % in college-educated African American women.

As will be discussed in detail later in this chapter, upper- and middle-class parents are richer, are more nurturing, spend more time with their children, and provide educational opportunities. Births to underage, unmarried, and low-education-level women not only restrict children's access to social and economic resources but increase their risk of poor outcomes (e.g., low birth weight, preterm birth, infant mortality, and poorer developmental outcomes) (Chandra, Martinez, Mosher, Abma, & Jones, 2005).

4.2 Impact of Different Family Structures on Children

The social and sexual revolution in the 1970s or the SDT brought new and more fluid family structures such as cohabitation, divorce, and step-, adoptive-, foster-, and single-parent families. These changing family structures increase children's stress, reduce attachment to significant others, and decrease time with pro-social fathers or male role models, which can negatively affect children's psychosocial development as well as physical and mental health (McLanahan, 2004; Lamb & Lewis, 2011).

The Impact on Children of Single-Parent Families: Most children who grow up with a single parent can have positive health and psychosocial developmental outcomes if the family has adequate resources, time for parents or other caring adults to spend with their children, and effective parenting skills. Unfortunately, children in father-absent homes are almost four times more likely to be poor (44 % compared to 12 % in married-couple families) (United States Census Bureau, 2011a, 2011b). Unless child support is paid, children in single-parent families with little extended family support typically are negatively impacted. As discussed earlier, parents' low levels of education can also negatively affect children's well-being. Single mothers are generally poorer, more highly stressed, and less well educated (McLanahan & Jacobsen, 2015).

Most research focuses on the impact of fathers' absence, but mothers' absence also puts children at risk. The differences in single-parent and two-parent families are insufficient to support the claim that parental absence is the *primary* cause of children with worse behavioral and physical health. There is evidence, however, that above the mediating factor of poverty, the absence of fathers is responsible for at least some negative child outcomes (McLanahan & Sandefur, 1994).

The Effect of Divorce on Children: Unfortunately about 50 % of US marriages end in divorce (CDC, 2011). Family conflict, separation, and litigation are stressful

for the couple and the children too. Children who experienced divorce have strained family relationships, poorer academic achievement, more school dropout, delayed psychosocial development, higher levels of anxiety and depression, anger management and trust issues, and early sexual behavior. As adults, they have higher chances of divorcing, choosing cohabitation over marriage, and negative religious feelings (Carrier & Utz, 2012).

The Effects of Cohabitation on Children: Compared to only 5 % of unmarried pregnant women who choose a "shotgun" wedding, 18 % opted to move in with their boyfriends before the child was born (CDC, 2014). Of all births in the 2000s, 60 % were to married mothers, 24 % to cohabiting mothers, and 16 % to single mothers. This increase is attributed to reduced social stigma for out-of-wedlock births and cohabitation (Bramlett & Mosher, 2002). Cohabitation is more likely to lead to stable relationships and marriage as well as lower pregnancy rates in the more highly educated cohabitating couples. But in contrast for high-school-educated Americans, cohabitation is a considered way station to finding the right person and to permanent partnership (Putnam, 2015). McLanahan and associates (2005) found that 5 years after the birth of a child, about 50 % of cohabitating women, but more than 66 % of unmarried women, were no longer in any romantic relationship with the father. Some couples cohabitate to save money, learn if they are really compatible, or wait for more stable jobs and better finances. Forty percent of children are expected to spend some time in a cohabiting parent family because of being born to already cohabiting parents or one of their biological parents opting for cohabitation (Bumpass & Lu, 2000; Fields & Casper, 2000). Children of cohabiting partners or cohabitating grandparents tend to follow the same lifestyle of cohabitation (Sassler, Cunningham, & Lichter, 2009).

Cohabiting parents have slightly more negative parenting practices because they are more highly stressed by family instability and lack of financial resources (Brown, 2002; Hofferth & Anderson, 2003; Morrison, 2000). Children residing in cohabiting stepfather families experience higher rates of school suspension or expulsion, delinquency, lower grades, lack of college expectations, and increased emotional and behavioral problems than teenagers living with two married biological parents (Manning & Lamb, 2003). However, children in cohabitating families have better outcomes than those living with single parents because they have better financial security and more positive parent support and nurturing.

The Impact of Stepfamilies on Children: The number of stepfamilies in the USA has risen because of high rates of divorce and remarriage. About 40 % of US families are stepfamilies or "blended" families. Almost half of US adults have at least one step relationship (e.g., being a stepchild, a stepsibling, or a stepparent), including 15 % of men being stepfathers and about 12 % of women who are stepmothers (Deal, 2013; Parker, 2011).

Joining a stepfamily can be especially stressful for adolescents as it often also involves ending any lingering hopes of the biological parents reuniting. Research shows that younger children adjust more easily than teens (Amato, 2005). Adolescents living with a single parent tend to have more autonomy and lack of interference by parents. Parental monitoring by a stepparent can be viewed by

teens as interference, and sometimes they react with aggression. Children may suffer from loyalty conflicts between their stepparent and the biological parent because of a belief that accepting their new stepparent would mean betraying their biological parent. They can also experience insecurity, abandonment, resentment, and jealousy when having to share parental time and attention with a stepparent or siblings (Hetherington & Kelly, 2002). These children often have less mother-child interaction, more mother-child disagreement, and more problem behaviors than children in two-biological-parent families (Amato, 2005; Demo & Acock, 1996; Hoffmann, 2006). Hence, remarriage of a single parent does not necessarily ensure better psychological well-being for the children. Factors that can impact children's health and well-being in new stepfamilies include ages of the children and *adults*, length of time since the divorce and remarriage, and, most importantly, the stepfamily's functioning—the type of relationship between stepparents and children and between the biological parents and children (Hoffmann, 2006).

Impact on Children of Adoption and Foster Care: Research on the impact on children of foster care is complicated because children may have been exposed to maltreatment before placement, leading to negative outcomes, feelings of being unloved, and lack of attachment and bonding (Erickson & Egeland, 2002). Children are removed from their homes primarily because of maltreatment, including neglect and abuse (physical, emotional, sexual), and also because of poverty, caretaker death, and incapacity. The impact on the children's health and psychosocial development depends primarily on the quality of the child/foster parent relationship, the length of time in foster care, and number of placements. Multiple failures or rejections by foster parents are related to increased behavioral health problems such as substance abuse and delinquency. Children from unstable foster homes are more likely than children in the general population to suffer poorer developmental outcomes (e.g., poor physical and mental health, lower academic performance and increased school dropout, teen pregnancies, attachment problems, low self-esteem, failed marriages, social isolation) (Rubin, O'Reilly, Luan, & Localio, 2007; Simms, Dubowitz, & Szilagyi, 2000). Outcomes are improved, however, if the child gets a stable long-term foster home and nurturing parents or is adopted.

Lawrence, Carlson, and Egeland (2006) suggested that adoption could better serve these children because of economic advantage, stability, and positive parenting. Adoption to long-term loving families has positive impact on children, but foster care can negatively impact children if they are moved from home to home.

One hopeful statistic is that the number of children in foster care has dropped by about a quarter since 2002 and the average number of months in foster care has declined from 31 to 22 months. More judges are requiring parents reported for child maltreatment to participate in parenting education courses in an effort to reduce the very high costs of foster care from about $25,000 to $75,000 per year and keep children with their parents. Effective parenting programs have cut days in foster care in half (Brook, McDonald, & Yan, 2012). However, this is still a long time for children to be in out-of-the-home placement and without their parents.

4.3 Impact of Family Functioning on Children

This section will highlight research on family or parental functioning that are mediating or more direct causal factors in negative health outcomes for children. In other words, the major risk factor for children is not the family structure directly but the impact of family structures on the parent–child relationship, parenting effectiveness or style, and functional relations within the family. For instance, research on the impact of having only one parent is confounded by moderating and mediating factors such as socioeconomic status, class, poverty, educational opportunities, amount of time spent with the child, and parental emotional or mental dysfunction. Many nontraditional family structures provide less security, protection, and care for children because overstressed or dysfunctional parents often lack the money or time to provide adequate parenting opportunities. Research on critical functional risks is discussed below.

4.3.1 Impact of Dysfunctional Parents

Clearly, mentally ill, depressed, highly stressed, and substance-abusing parents face more difficulties in child raising. Parents who are substance users are often unable to provide a safe and nurturing home for their children, as studies have found their family environment to be chaotic with reduced family organization and family routines and rituals and increased conflict between parents and children (Kumpfer & DeMarsh, 1986). Drug abusers spent about half as much time with their children as normal families. Authoritarian and inconsistent parenting was also a hallmark of substance-using and depressed parents (Dette-Hagenmeyer & Reichle, 2013). Researchers also found that parental depressive symptoms were a mediator of children's poorer social-emotional development. Children of parents with substance use disorders (SUDs) experience two to nine times greater risk of becoming substance abusers as adolescents or adults (Chassin, Carle, Nissim-Sabat, & Kumpfer, 2004). They are also at higher risk for child maltreatment and foster care placement.

Because of their higher risk, children of substance abusers need evidence-based family services and also extra community support services to prevent child maltreatment, poorer health and behavioral health outcomes, and placement into foster care (Kumpfer & Johnson, 2011). A 5-year multi-site federally funded study (Brook et al., 2012) found days in foster care reduced by half and improved parenting skills and children's behavioral and depression outcomes in families graduating from the *Strengthening Families Program*, an evidence-based 14-week family skills training program designed to improve the behavioral health of children of drug abusers.

4.3.2 Decreased Parent Time with Children

Worldwide, parents are spending less time parenting and supporting their children. The increased absence of parents and extended family is related to child health and educational risks. A study conducted by the Annenberg Center (2009) found that in just 3 years the amount of time parents in the USA spent caring, teaching, or socializing with their children decreased by a third to only 4.5 h per week by 2008. Education level and two-parent households are related to the amount of time spent with children. In the 1970s, there was almost no difference by socioeconomic level in time that parents spent talking, reading, and playing with their children. However, for children 0–4 years, more educated parents increased their time in "developmental care" from 30 min per day in 1975 to a high of 132 min per day for more educated parents but only to 89 min per day for less educated parents. Today, the children of college-educated parents receive 50 % more of what Putnam (2015) calls "Goodnight Moon" time.

Few US parents still eat with their children every day, although two-thirds of children in other countries still have their main meal with their parents. Once again, parent's education is related to eating dinner together, which decreased in both lower- and higher-education-level parents to 70 % and 74 %, respectively, until 1990 for "usually eat dinner together." However, for the more highly educated parents, usually eating together increased slightly to 75 % by 2005, but decreased to 63 % in parents with only a high-school degree (Putnam, 2015). Even fewer children talk with their parents on a regular basis (UNICEF, 2007). Educated parents engage in constant dialogue with their children to teach values, skills, and expectations for their behavior. This takes time, and it helps to have a reliable and supportive spouse to share the job of child raising, not to mention cleaners, drivers, babysitters, and cash for educational and recreational opportunities. Overworked and less educated parents tend to demand from their children to just obey them or else be spanked. While this saves time, Putnam (2015) suggests that these poor parenting practices are a barrier to upward social mobility because the children do not learn to think for themselves.

This trend toward reduced parent–child involvement is particularly evident in immigrant or refugee families whose parents must often work more than one low-paid job. The loss of parent–child time together is even more apparent in developing countries, such as China and India, where more parents are moving away from their rural children to cities to work in factories. Even in developed countries Europe and Australia/New Zealand, parents are spending less time in child rearing (IREFREA, 2010).

Behavioral health problems such as alcohol and drug use and delinquency in European youth are increasing particularly in girls as they did in the USA in the mid-1990s with the breakdown of the traditional family structure (Kumpfer, Smith, & Franklin Summerhays, 2008; Kumpfer, 2014). This increase in substance abuse in teen girls was related to increased divorce rates and separation of fathers in US families as well as more single-mother families living in poverty. High levels of parental absence are also related to substance abuse (Kumpfer & DeMarsh, 1986),

divorce, separation, imprisonment, military deployment, foster care placement, and parental employment in another location.

Although generally parents are spending less time with their children, the good news is that fathers who do live with their children are much more involved and provide more child care than in previous generations (Livingston & Parker, 2011). The large fivefold increase from 1975 to 2013 in time spent by educated parents in child care of children under 4 years is likely due to fathers caring more for children. Even less educated parents increased their time with young children from 27 to 88 min per day (Putnam, 2015). This trend appears to be happening worldwide. Unfortunately, because of increases in nonmarital childbearing, fewer fathers now live with their children (Martin et al., 2013; CDC, 2014). The impact of nonmarital childbearing on the presence of fathers is moderated by more children being born into cohabiting unions (Martinez, Daniels, & Chandra, 2012).

4.3.3 Impact of Father Absence on Children's Developmental and Health Outcomes

Because more children today are raised without consistent father involvement, research on the impact of fathers' absence or presence on a child's development has increased (Booth & Crouter, 1998; Lamb, 1997; Lamb & Lewis, 2011). Lamb (2004) proposed that fathers influence children's outcomes, as do mothers, by their degree of emotional support, security, and encouragement. Conversely, father absence or disengagement is associated with negative effects on children (i.e., child abuse, depression, school failure, substance abuse, delinquency, early sexual activity, and teen pregnancy) (Jafee, Moffitt, Caspi, & Taylor, 2003). A child living with his/her divorced mother, compared to a child living with both parents, is 375 % more likely to suffer from anxiety or depression and hyperactivity and needs treatment (Ventura, Abma, Mostter, & Henslaw, 2008). Living with an involved father also decreases the risk of first substance use (Bronte-Tinkew, Kristin, Randolph, & Jonathan, 2006) and child maltreatment (Bendheim-Thomas Center, 2010). Even living in a neighborhood with fewer fathers increases the risk of teen violence (Resnick et al., 1997). Positive interaction by any father figure predicts better child health (Carr & Springer, 2010), including reduced obesity if the father is physically active (Trost, Kerr, Ward, & Pate, 2009). Paternal involvement in childhood is related to reduced police contact and crimes in teens (Flouri, 2005), and parent/teen closeness is correlated with greater adult marital satisfaction and happiness (Flouri & Buchanan, 2002).

4.3.4 Gender Differences in Children-Rearing Styles

Research suggests that fathers' and mothers' child rearing and discipline styles differ significantly (Lamb, 2010). The direct effects of fathering are especially salient when fathers' and mothers' interactions differ. Rowe, Coker, and Pan (2004)

have suggested that, because fathers use more imperatives and attention-getting utterances and utter more complex sentences than mothers do, they contribute in unique, though still poorly understood, ways to linguistic development. Fathers also tend to stress justice, fairness, and duty (based on rules), while mothers stress sympathy, care, and help (based on relationships). Fathers tend to observe and enforce rules systematically and sternly, which teaches children the objectivity and consequences of right and wrong. Fathers tend to use more behavioral controls ("If you do that again, this is what will happen to you") as compared to mothers who tend to use more psychological controls ("If you loved me, you wouldn't disobey me"). Fathers tend to have a greater impact on their sons even if they do not refer to them as a role model (Fuhrmans & Fuhrer, 2013). Children with fathers tend to work harder to succeed in school and avoid getting into trouble. But if fathers control their children primarily through excessive physical punishment versus clear expectations, positive relationships, and time together, their children are more likely to experience emotional problems, psychosomatic disorders, and school difficulties and have lower levels of moral development (Lamb & Lewis, 2011).

4.4 Impact of Culture and Differential Cultural Acculturation on Health

Minorities now comprise 37 % of the US population (US Census Bureau, 2012). Because of higher birth rates and immigration rates of minority families, particularly Latin and Asian families, they are predicted to become the majority (57 %) by the year 2060 (CDC, 2013; US Census Bureau, 2012). Because of this demographic transition, racial and ethnic minorities will need increased attention from health educators, policy makers, and the government to identify and prevent health problems that afflict them. There is currently insufficient research on their cultures, traditions, health disparities, and culturally appropriate and effective health promotion programs and services.

4.4.1 Acculturation Among Minority Groups

Acculturation is defined as "the extent to which individuals have maintained their culture of origin or adapted to the larger society" (Phinney, 1996, p. 921). Acculturation is a complex multidimensional process, and the level of acculturation among minority populations depends on numerous factors such as age at immigration, circumstances during immigration, purpose of immigration, socioeconomic status, length of stay and location of residence in the host culture, exposure to host culture in work or community activities, and other cultural factors (Farver, Bhadha, & Narang, 2002).

Immigration imposes substantial pressures and increases stress in families. Immigrants are torn between retaining their original cultural identities while simultaneously accepting and assimilating into the host culture (Inman, Howard, Beaumont, & Walker, 2007). Previous research studies among Hispanic immigrants suggested that acculturation stress and deviation from the original cultural norms such as daily contact and social interaction with family and friends, language barriers, lower self-esteem, social isolation, boredom, and loneliness result in increased alcohol and substance abuse among immigrants (Gonzalez-Guarda, Ortega, Vasquez, & De Santis, 2010). Increased substance abuse is linked with negative health-related consequences such as cancer, cardiovascular disease, hepatitis, complications in pregnancy, mental illness, HIV infection, and intimate partner violence.

Differential Acculturation and Family Conflict: Children often assimilate more quickly to a new culture, creating increased family conflict because of differential generational acculturation (Chung, Flook, & Fuligni, 2009) leading to children's developmental problems such as delinquency, substance abuse, anxiety, depression, suicidal tendencies, violence, and prostitution (Dow, 2011; Farver et al., 2002; Feldman & Rosenthal, 1993). Role reversal can also happen in immigrant and refugee families when children learn the new language much faster and take on the parent role, creating a familial schism. Increased family conflict leads to a reduction in the family protective factors of family bonding, supervision, and communication of positive family values and influence (Rodnium, 2007).

Cultural Pride and Family Traditions: One of the protective factors against differential generational acculturation is the maintenance of ethnic pride and family traditions by individual family members leading to positive academic and psychological adjustment especially among adolescents and healthy familial environment (Berkel et al., 2010; Guilamo-Ramos, 2009; Smokowski, David-Ferdon, & Bacallao, 2009). Cuellar and Paniagua (2000) found that families and adolescents who strike a balance between maintaining their original family values and cultural traditions and acculturating to the new host culture have better emotional and behavioral health. Previous research suggests that parent–child communication and attachment and parental warmth promote ethnic pride among the children resulting in decreased risk of drug use and increased self-esteem (Umana-Taylor, Diversi, & Fine, 2002).

Multicultural Competencies: Research suggests that youth living in two or more cultures, while initially stressed, can acquire multicultural competencies that increase their resilience to behavioral health problems (Beauvais & Trimble, 2006). When facing additional stressors or in a new environment, they have a broader range of skills and appropriate responses. This increases the youth's confidence and self-esteem.

4.4.2 Professional Multicultural Competence

The American Association for Health Education defines cultural competence as "the ability of an individual to understand and respect values, attitudes, beliefs, and mores that differ across cultures, and to consider and respond appropriately to these

differences in planning, implementing, and evaluating health education and promotion programs and interventions." One of the potential solutions to eliminate racial/ethnic disparities in health care is by developing a culturally competent health-care system (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). However, chief barriers in achieving cultural competency include, but are not limited to, lack of cultural diversity among the health-care professionals, limited awareness regarding cultural differences in health-care professionals, and a dearth of culturally competent health programs leading to reduced enrollment of the ethnic population in health promotion and prevention programs (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004).

Cultural competency can be achieved by recruiting ethnically diverse health-care professionals or training them to practice multicultural competencies, developing cultural appropriate and tailored health programs, increasing the participation of minority groups in national health surveillance and data systems, and increasing efforts toward research among ethnic minorities (Betancourt, Green, Carrilo, & Ananeh-Firempong, 2003). The greatest challenge that lies before the health-care system is developing culturally competent, evidence-based health programs that could address the health disparities among the ethnic minorities in the USA.

4.4.3 Lack of Culturally Tailored Programs for Ethnic Families

Previous research studies suggested that when family-based intervention programs are offered in schools and communities, it is difficult to recruit and retain ethnic families because most programs are not culturally appropriate nor taught in their primary language (Biglan & Metzler, 1999; McLean & Campbell, 2003; Watson, 2005). Participation of ethnic families can be as low as 10 % in these programs (Kumpfer, Alvarado, Smith, & Bellamy, 2002). Moreover, the majority of the health promotion and universal prevention programs are developed for the general American culture focusing mostly on white, middle-class values which might not be culturally appropriate or tailored to the specific needs of ethnic families.

Traditional ethnic families favor family systems change approach as compared to individual change approach for prevention, because of their cultural values that stress interconnection, reciprocity, and filial responsibility as contrasted with the Western value of individual achievement (Boyd-Franklin, 2001; Kumpfer, Alvarado, Smith, & Bellamy, 2002). Previous meta-analyses found that family-based interventions have effect sizes 2–9 times larger than youth-only interventions in decreasing youth behavioral health disorders in both traditional and acculturated minority families (Kumpfer et al., 2002; Tobler & Kumpfer, 2000). Hence, family interventions should be more effective for minority families.

4.5 Solutions to Strengthen Families

Because of the breakdown of the traditional family and the decrease in parental involvement in child rearing, parents have to be more effective and efficient with the little time they have with their children. Behavioral parenting programs and family therapy help to improve parents' child rearing skills. Evidence-based family interventions have proven to be the most cost-effective way to reduce negative health and social outcomes in youth.

4.5.1 Importance of the Family in Health Promotion and Prevention

While there are a number of different approaches to improved youth's health outcomes and delayed onset of alcohol and drug use among young people, evidence-based family skills training interventions appear to be the most effective (UNODC, 2009; Kumpfer & Hansen, 2014). Whereas youth-only programs work mostly for boys and not for girls, family interventions work for both girls and boys (Kumpfer, 2014). Meta-analyses have found that health promotion or prevention programs that improve ongoing family dynamics are the most effective (Foxcroft, Ireland, Lister-Sharp, Lowe, & Breen, 2003; Foxcroft & Tsertsvadze, 2012) because they promote healthy parent–child relationships including those causal factors found most important such as improved communication, bonding, parental monitoring, supervision, discipline, and family organization and rule setting (Petrie, Bunn, & Byrne, 2007).

4.5.2 Intervention Theories: Family Systems Theories

The family interventions found to be most effective are based on family systems theories proposed by Bowen (1991) and perfected in structural family therapy (Minuchin, 1974). The most effective parenting and family skills training programs are based on cognitive behavioral change theories including social learning/efficacy theory (Bandura, 2001). This theory emphasizes that learning occurs primarily in the social context of the family and friends and that behavior change occurs through role modeling, positive reinforcement, and even vicarious learning. These behavior change theories are targeted in effective parenting and family interventions to improve the most critical risk/resilience factors such as family attachment, supervision, and communication of positive expectations that are particularly important for preventing health problems for girls (Kumpfer, 2014). Our tested social ecology model (Kumpfer, Alvarado, & Whiteside, 2003) found that girls are slightly more impacted by these three family protective factors than are boys; hence, Evidence based (EB) family interventions are very useful in the prevention of behavioral health problems in girls as well as boys.

4.5.3 Types of Family Interventions and Effectiveness

A review of effective Evidence Based Program (EBP) approaches or types of family interventions determined that four family-based approaches demonstrated the highest level of evidence of effectiveness in reducing behavioral and emotional problems in children 5 years old and up. These evidence-based family intervention approaches include (1) behavioral parent training (primarily cognitive/behavioral parent training), (2) family skills training (including parent training, children's skills training, and family practice time together), (3) family therapy (structural, functional, or behavioral family therapy), and (4) in-home family support (Kumpfer & Alvarado, 2003).

Although these effective family interventions target different stages of a child's early development, they share certain critical core content. They all include interactive experiential teaching methods rather than didactic teaching methods and stressing knowledge change to achieve faster behavior changes. Additionally, they include methods for engaging and retaining hard-to-reach families and removing barriers to attendance (e.g., transportation, meals, child care, personal invitations, incentives for homework completions or attendance, a warm and welcoming staff and location).

4.5.4 Effective Evidence-Based Family Interventions

Periodic expert reviews conducted over the past 20 years have helped identify individual evidence-based family interventions. Criteria for evidence of effectiveness included large positive changes, randomized control trial studies of high quality, and independent replication. These reviews have found eight exemplary family interventions which include the following: Helping the Noncompliant Child (the basis of the FAST Track Project), the Incredible Years, the Strengthening Families Program, functional family therapy, multisystemic family therapy, Preparing for the Drug-Free Years (now called Guiding Good Choices), treatment foster care, and Triple P (UNODC, 2010). These family interventions are effective because they have sufficient dosage or length to meet the needs of the parents, involve the whole family in the behavior change, and target the most important family protective and risk factors (family bonding, supervision, and communication of positive values and norms). Other factors that impact attendance include attractive materials, adequate schedules, provision of meal and transportation, inclusion of child care, a warm and respectful staff, and good relationship skills.

Almost all evidence-based family programs tend to share common characteristics and focus on critical core elements that improve positive results. A CDC meta-analysis suggested that family skills trainings that include interactive training such as role playing, group discussion, and homework assignments and particularly parent–child practice time are more effective in preventing child maltreatment than training that uses reading and lecturing (Kaminski, Valle, Filene, & Boyle, 2008).

The most significant components predicting better outcomes were practicing with their child with a family coach, practicing consistent and positive communication, and home practice assignments to change behaviors at home. These components are important as they improve the parent–child relationship, which subsequently improves child behavior. Additionally, boosting children's social skills and emotion regulation skills has been shown to be the most important in preventing delinquency (Kumpfer et al., 2003). These skills create self-reinforcing pro-social behaviors that allow the child/adolescent to bond with positive adults, authority figures, and peers, and through these positive relationships, they can avoid delinquency and have more positive life outcomes. Other factors that increase program success are having a strength- and resilience-based focus, involving fathers, adapting the program to target the needs and cultural sensitivities of the families, having the appropriate intervention dose, and providing incentives and transportation to improve retention (Kumpfer & Alvarado, 2003).

The results from a meta-analysis suggested that family programs are on average nine times as effective in reducing conduct disorders, delinquency, substance abuse, and child abuse as youth-only focused programs (Tobler & Kumpfer, 2000, Tobler & Stratton, 1997). Another particular benefit of family programs is their cost benefit at $9–33 saved per dollar spent (Miller & Hendrie, 2008). Early elementary school parent training or family skills training programs have been found to be very effective in reducing aggression, conduct disorders, attention deficit/hyperactivity, and oppositional defiant disorders and preventing child abuse, drug abuse, and delinquency (Kumpfer & Alvarado, 2003; Kumpfer, 2014). Family skills training programs (e.g., SFP, Guiding Good Choices, Adolescent Transitions, Parents Who Care, Positive Parenting Program, or Triple P) appear to have particular promise. This category of program includes parent training, children's skills training, and a family practice session in family groups. The key to the success of these family skills training programs appears to be having the parents and children directly practice the new skills together and to have home practice assignments to bring their new modes of interaction into the home.

4.6 Use of Information Technology for Program Delivery and Dissemination of EBPs

Information technology has been increasingly used to obtain health-related information, manage and prevent diseases, and deliver behavioral change interventions (Budman, 2000; Moore, Fazzino, Garnet, Cutter, & Barry, 2011). In spite of promising results, information technology-based interventions (ITBI) have yet to attain their full potential. Though evidence-based family prevention programs have proven to be highly effective in preventing even inherited diseases in adolescents (Brody et al., 2012, 2014; Kumpfer, 2014; Loveland-Cherry, 2000), the cost of staff and staff training, multiple intervention sites, follow-up, and numerous implementation

costs hinder their wide-scale dissemination and increase costs (Gordon, 2000; Miller & Hendrie, 2008). In addition, attendance barriers such as transportation and trouble with accessibility, busy family schedules and time constraints, inability to commit to multiple sessions, stigma associated with family therapy, or even parent education can reduce the program retention and engagement. Finally, using digital delivery technology could be beneficial for ethnic families because of the convenience of participation, lack of stigma, unwillingness to participate in group interventions, and the ability to review and practice the sessions for a longer period of time (Gordon, 2000; Ito, Kalyanaraman, Ford, Brown, & Miller, 2008; Haggerty, MacKenzie, Skinner, Harachi, & Catalano, 2006; 2007, Haggerty, Skinner, MacKenzie, & Catalano, 2007; Kumpfer & Brown, 2012; Kumpfer, 2014; Wingood et al., 2011). Haggerty et al., (2006, 2007) found that ethnic mothers benefited more from a CD of the program than attending family skills training group because they could review the video multiple times and could self-pace and were less likely to attend groups in person.

4.7 Effective Health Promotion Programs for Ethnic Families

As discussed above, immigrant and minority families have particular challenges that need to be addressed when creating family programs. Below are listed some critical protective factors in developing health promotion programs that are likely to be effective with minority or ethnic youth:

1. *Instill Cultural Pride and Competence*. Youth whose parents move to a new cultural community adapt better if they maintain pride in their ethnicity and culture of origin. Youth who feel culturally inferior feel more depressed and reject their family culture which leads to family conflict and rejection also.
2. *Promote Maintaining Cultural and Family Traditions*. Cultural traditions often help create order and predictability for children which reduce their stress. These cultural traditions often also connect the family to a cultural and religious community and increase support systems and participation in community celebrations.
3. *Build Multicultural Competencies.* As explained earlier, ethnic youth who understand and have multicultural skills to behave appropriately in both their culture and other cultures have been found to be less likely to become substance abusers and delinquent (Beauvais & Trimble, 2006). Hence, health educators should promote youth learning skills to be competent in both their culture and other cultures by exposing them to different cultures and peoples.
4. *Increase Family Attachment and Reduce Family Acculturation Conflict*. Youth who are bonded and attached to their parents are less likely to reject their culture or language of origin and have better adjustment (Champagne & Meaney, 2007; Champagne, 2010; Jirtle, 2010).

5. *Culturally Adapt Evidence-Based Health Promotion Programs*. Rather than develop culturally tailored health promotion program from scratch, it is usually more effective to select the best evidence-based program (EBP) that addresses the community's health risk and protective factors and needs and then culturally adapt the program following steps of gradual cultural adaptations and evaluation of effectiveness as recommended by the author and associates (Kumpfer, Pinyuchon, de Melo, & Whiteside, 2005; Kumpfer, Magalhães, & Xie, 2012). Five studies of cultural adaptation with the Strengthening Families Program for each major ethnic populations (rural and urban African Americans, Hispanics, American Indians, and Pacific Islanders) found that although outcomes were similar, recruitment and retention of participants were 40 % better when the program was culturally adapted (Kumpfer et al., 2002).

Hence, cultural adaptations of health promotion EBPs work to substantially improve engagement, acceptability, recruitment, and retention. Better outcomes will occur, however, only when adaptations reflect sensitivity to cultural values without affecting program fidelity (e.g., not reducing dosage, core interactive elements, and the focus on behavioral change). Culturally informed and responsive programs can both deliver the best science and address the practical concerns of a particular community (Castro, Barrera, & Martinez, 2004). And by implication, prevention interventions that are "culturally blind" will fail to appeal to local participants and likely erode the effectiveness of the original program (Kumpfer et al., 2002).

4.8 Policy Recommendations

Citizens and policy makers understand that the economic, cultural, and social future of a country depends on the quality of their young people in the next generation. Investing in children and families then should logically be a high priority, but often in budget decisions this is not the major factor considered compared to the needs of businesses and keeping taxes low. The USA trails many countries in policies that support families to raise productive and healthy children. There is a shared value in equality of opportunity, but class realities show a growing inequality of economic and social opportunity.

Effective policies to reduce the opportunity gap have been suggested by scholars in many different fields (Kenworthy, 2012), including emphasis on ways to keep families and children of all classes strong and effective, such as the following:

1. *Evidence-Based Parenting and Family Programs*: These should be funded and implemented widely in many settings, such as workplaces, community centers, child care centers, faith communities, and schools. Parenting and family skills classes should be acceptable for all families and not just high risk or failing families. EBP parenting programs should be mandated by judges for parents with open CPS reports and parents of youth involved in juvenile court.

2. *Provide EBP Parenting Programs Digitally*: Because of their high costs especially for family skills training groups or family therapy, these parenting programs should also be provided digitally without charge on the web, DVDs, smartphone apps, and TV. Because of their low cost, many more participants could be reached with equally effective outcomes to family group or individual delivery (Fang & Schinke, 2013; Haggerty et al., 2006, 2007; Kumpfer & Brown, 2012; Schinke, Fang, & Cole, 2011).
3. *Maternity and Paternity Leave for Both Parents in the First Year of the Child's Life*: Lack of bonding can lead to reactive attachment disorder, which is a known cause of violence against others due to lack of empathy.
4. *Child Care Quality Improvements*: There should be better standards, credentialing, and pay for child care workers. Evidence-based parenting programs should be offered or even made mandatory for parents to have their children attend child care programs.
5. *Reduce the Number of Children in Foster Care using EBP Family Skills Training*: Foster care is not a good substitute for helping biological parents learn to be better parents, which they can be done by mandating EBP parenting skills training courses. Family and drug court judges need the resources to mandate evidence-based parent and family skills training courses versus short but ineffective parent education classes.

4.9 Conclusions

The relationship between lack of positive parental involvement and negative outcomes in children and adolescents is well established. This relationship is not absolute; however, evidence-based prevention and treatment interventions should be disseminated widely to reduce health-care and social costs by helping parents or caregivers improve their parenting effectiveness, reunify children in foster care with their families, or help absent parents to reconnect with their children. Parent training opportunities in effective parent and family skills training programs should be disseminated widely at low or no cost to help mothers and fathers to feel more confident and competent in their parenting ability. In the end, it is the functioning and not the structure of the family that matters most. Children can be raised in stable two-parent families but still not receive the time and loving attention they need. However, in general, single parents who have not graduated from high school spend less time and provide fewer developmental learning opportunities for their children leading to increased educational, socioeconomic, and health disparities. This growing gap in opportunity for all children should be a high national priority. Since all children want and deserve loving and caring parents, policy makers should do all that they can to improve the ability of all parents to care for their children effectively regardless of income or educational level.

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