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Community Support Programs: Review of the Literature

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The Army Family Research Program (AFRP) is a five-year integrated research program which supports the Chief of Staff of the Army (CSA) White Paper 1983: The Army Family and The Army Family Action Plans (1984 - 1990) through the development of databases, models, program evaluation technologies, and policy options that assist the Army to retain quality soldiers, improve soldier and unit readiness, and increase family adaptation to Army life. This report provides a review of the literature on the impacts of various community and organizational support programs on personnel, family, and organizational outcomes to the extent that evaluation research is available. A

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COMMUNITY SUPPORT PROGRAMS: REVIEW OF THE LITERATURE

EXECUTIVE SUMMARY

Requirement:

To support The Army Family Action Plans (1984-1990) by preparing a review of the available literature on community support programs.

Procedure:

Literature on the impacts of various community and organizational support programs on personnel, family, and organizational outcomes to the extent that evaluation research was available. The impacts of two basic types of program were reviewed. First, normative programs are considered, especially those designed to enhance well-being and prevent distress and dysfunction. These programs include marital and family wellness programs, parent education programs, child development services, respite care, financial counseling, and relocation assistance. Second, treatment-type programs are reviewed since they are designed to help people recover from crises in their lives. These programs include crisis hotlines, abuse shelters, marital and family therapy, alcohol and drug treatment, individual and group therapy, and child and adolescent treatment.

Findings:

Community support programs are increasingly being used by military and civilian organizations to improve the morale and commitment of their employees, and families. Research has demonstrated that organizations benefit substantially from personnel that are experiencing higher levels of personal, occupational and family well-being.

This review of literature reveals that: (1) the number of personal, family and community support services has grown dramatically over the years; (2) public awareness of support programs is very uneven, most often non-existent; (3) unless reinforcements are built into the program, support services tend to have short-term outcomes; (4) programs focusing on individuals tend to be more effective than those focusing on groups or relationships; and (5) research on program effectiveness is still in its infancy.

Utilization of Findings:

The Army sponsor of this research effort, the U.S. Army Community and Family Support Center (CFSC), reviewed and approved an earlier draft of this report. Their comments indicate that the contents of this report will be useful in revising Army programs and policies.

COMMUNITY SUPPORT PROGRAMS: REVIEW OF THE LITERATURE

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COMMUNITY SUPPORT PROGRAMS: A REVIEW OF THE LITERATURE

Introduction

There has been a growing commitment among Army leadership toward making the Army community a better place for military members and their families to live and to work (Headquarters, Department of the Army, 1990). It is believed that community related variables have a significant impact on the Army mission of personnel retention and unit readiness (Martin, 1985; Orthner, 1980). Because of this, increased attention has been directed toward understanding various facets of community life.

Much attention has been given to the elements of a community that lead residents to report high levels of satisfaction with their community. Two important parts of a "good" community are the quality and quantity of formal and informal supports. Informal support networks are generally made up of family members, extended family, friends, neighbors, co-workers, and voluntary associations such as civic clubs or churches. Weakened or almost nonexistent informal social support has been found to be related to problems such as wife abuse, child abuse, delinquency, drug abuse, alcoholism, poor physical health, and mental illness (Antonucci, 1985; Cohen & Wills, 1985; Whittaker & Garbarino, 1983). Formal support refers to concrete community support programs and services which are specifically designed to address unmet needs of residents or to serve as formal substitutes for missing or weak informal support systems.

Community support programs or human service organizations function as formal supports by enabling individuals and families to improve, maintain, and restore well-being and personal welfare (Hasenfeld & English, 1974). Each type of organization or program addresses a target population which requires a specific array of intervention strategies. At one end of the continuum are those organizations whose primary mandate is to maintain and enhance the well-being of people perceived to be adequately functioning in the community. At the other end are organizations mandated to ameliorate and remedy the ill or deviant state of people perceived to be malfunctioning in the community.

There are many different types of services and programs that have been developed and implemented to serve community members. The following review of community programs includes two classifications: (1) prevention and wellness programs, and (2) treatment programs. The review provides descriptive and evaluative analyses of various programs and services that are often available to individuals and families in both civilian and military communities. While our focus is on military programs, we are not examining Army Community Services or any other support services per se but we are assessing what is known about the family support programs that are frequently offered within organizations that serve Army personnel and families.

The military has expanded the range of support services and programs offered to families and is currently reassessing the benefits and costs of human service support programs. Use of evaluative research to improve human service programs in the military community has been initiated within the context of the military's unique opportunity to develop a "coherent and

cost-effective set of policies, practices, and programs on behalf of its members and their families" (Bowen & Scheirer, 1986, p. 195).

Evaluation of community programs is one method of measuring successful community functioning by determining whether the resources available to address identified needs are being administered efficiently and effectively. Evaluations of community programs are undertaken for a variety of reasons, including: monitoring the direction of program development; program assessment to determine how well goals and objectives are met; measuring program effectiveness; comparison of different program methods to determine relative impact; justifying past or projected expenditures; gaining support for program expansion; and identifying factors both internal and external to the program or service that facilitate programmatic impact (Intagliata, 1986; Knutson, 1969).

It is generally recognized, however, that human service organizations often lack reliable and valid measures of effectiveness. These difficulties result from at least two sources: lack of clear and operational definitions of desired outcomes, resulting in the problem of defining criteria for effectiveness; and inadequate knowledge of cause-effect relations, resulting in the organization's inability to evaluate and measure consequences of intervention strategies (Hasenfeld & English, 1974). For example in their review of program assessments, Wackman and Wampler (1985) cite at least six specific empirical issues that need to be addressed prior to implementation of marital and premarital enrichment programs: durability of change, generalizability of change, range of potential participants, timing of programs in the developmental life cycle of the couple, demonstration of change through non-participant rating sources, and identification of change-inducing components. These suggestions highlight the need for expanding evaluation methodologies for all types of formal supports that will insure quality of life for families and family members living, in military and civilian communities.

The first section of this report, "Prevention and Wellness Programs," contains information on the effectiveness of programs designed to enhance health and well-being and prevent distress and dysfunction of families and family members. In this context, wellness is defined as "the active process of being aware of and altering behavior toward a more successful physical, intellectual, emotional, social, occupational and spiritual existence" (Jenkins, 1986, p. 3). Taking responsibility for one's health and well-being enhances quality of life and reduces the need for medical and other intervention programs. Prevention and wellness programs are available to Army families through a variety of post and off-post family service providers.

Prevention and Wellness Programs

Marital Enrichment

Marital enrichment is an educational and preventative approach to relationship enhancement. The primary purpose of marital enrichment programs is to assist couples in achieving an increase in individual self-awareness as well as an awareness of the strengths and growth potential of the partner and the marriage. The programs promote an increase in exploration and self-disclosure of the partner's thoughts and feelings, facilitation of mutual empathy and intimacy, and development and encouragement of effective communication skills for problem-solving and conflict resolution (Hof & Miller, 1981). While there is some variation in structure, marital enrichment programs usually focus on improving the quality of dyadic communication and increasing conflict resolution and negotiation skills (Gurman & Kniskern, 1977).

The cornerstone of marriage enrichment is growth and human potential, based on the premise that all persons and relationships have a great many untapped strengths and resources which can be developed (Mace & Mace, 1975, 1976). In light of this, marital enrichment programs are often considered to be preventative in nature (Clinebell, 1976; L'Abate, 1977). One of the purposes of marital enrichment is to prevent the "emergence, development, or recurrence of interpersonal dysfunction." It is believed that marital enrichment may prevent deterioration in the marital relationship by developing potential and existing strengths and promoting growth and satisfaction (Hof & Miller, 1981). While the majority of marital enrichment programs tend to fall in the prevention category, there are therapists who have utilized marital enrichment programs as an adjunct to intensive marital and family therapy.

Marriage enrichment programs vary from very unstructured, voluntary associations to highly structured, skills based, training programs. For example, the Association of Couples for Marriage Enrichment (ACME) was created to encourage and assist couples in pursuing growth and enrichment in their marriages; to organize activities through which couples can assist each other in pursuing marital growth and enrichment; and to promote and support effective community services designed to foster successful marriages (Hopkins, Hopkins, Mace, & Mace, 1978).

In contrast, the Couple Communication Program (CCP) is a structured learning experience. The program is the result of research on marital communication conducted by Sherod Miller and associates in the late 1960s. CCP is one type of marital enrichment program that uses social skills training to help couples learn new ways to communicate (Wackman & Wampler, 1985). The unit of treatment is the marital dyad, with family developmental theory, systems theory, and modern communication theory contributing to the intervention strategy. CCP generally appeals most to couples in the 25-40 age range, with middle and upper-middle class backgrounds.

Research on marital enrichment programs is still in its infancy (Hof & Miller, 1981). This is partially the result of the difficulty in establishing

outcome criteria that can be efficiently monitored over time. Selection of appropriate measures of change is especially difficult. The outcomes most commonly sought and assessed in marital and premarital enrichment programs are overall program satisfaction; overall marital satisfaction and adjustment; relationship skills, and individual personality variables.

Program satisfaction levels associated with marriage enrichment tend to be quite high. In samples of military personnel and spouses, Orthner and his colleagues have typically found very high levels of satisfaction among clients of these programs (Orthner, 1980; Orthner & Bowen, 1982; Orthner et al., 1985).

Orthner and Bowen (1982) conducted an investigation to determine utilization rates and satisfaction with family enrichment programs, including marriage encounter, couple communication training, and family clusters by Air Force families. It was hypothesized that enrichment programs may be especially meaningful to military families, due to the independence and isolation of most of these families (Orthner, 1980). The fairly widespread introduction of marriage and family enrichment programs in the military services is a result of the recognition of their value and parallels their development in civilian communities (Hof & Miller, 1981).

In their investigation of Air Force families, Orthner and Bowen (1982) found minimal awareness of Couple Communication Training and low levels of program participation but interest in attending was high for both married men and women (50%) after the program objectives were explained. The majority of Air Force spouses had knowledge of marital enrichment or marital encounter programs with 4% having attended a program of this kind, and about half of the respondents reporting that they would be likely to attend some type of marital enrichment program in the future.

Investigations with Army samples have found similar results. In the Families in Green research (Orthner et al., 1985), two out of three couples were aware of marriage enrichment programs but only 3 percent had experience with the program. Nearly all of these couples reported the experience to be valuable to them.

In research with civilian samples with criterion based measures, positive personal or family change is consistently demonstrated on approximately 60% of criterion tests following program completion (Gurman & Kniskern, 1977). While these results initially appear impressive, closer examination reveals that 84% of criterion measures used were based on participants' self-reports, with the majority (58%) of the investigations using self-reports as the sole criteria for change. Considering the small number of investigations that have been conducted, those that have compared different marital enrichment formats suggest that communication training and behavioral exchange programs are superior to insight-oriented group experiences (Hof & Miller, 1981).

The Couples Communication Program has been the most heavily researched enrichment program and, with only one exception, measures were obtained at pre-test and post-test on the twenty-two investigations that have been published. All of the investigations were field experiments, with a

no-treatment control group included, although random assignment occurred in only a few of the investigations (Wackman & Wampler, 1985).

The consequences of participation in CCP programs appear to be quite positive for couples, at least in the short term. Of the twelve investigations using behavioral measures, ten found significant positive changes in behavior and none reported negative changes. The findings regarding subjective ratings of communication were more mixed; of the ten investigations examined, only two had significant positive results. Many researchers have wanted to establish whether CCP has an effect on relationship satisfaction. Of the fifteen investigations addressing, this issue, five had a positive effect, eight had no effect, and two had a mixture. Using effect size, CCP has a moderately positive effect on relationship satisfaction ($ES = .41$; $N = 24$).

The evidence for durability of effects is weak, due to the small number of investigations including behavioral measures at follow-up (Wackman & Wampler, 1985). Wampler and Sprenkle (1980) found that positive changes in perceived quality of couples' relationships persisted for 4-6 months after completion of CCP, but behavioral measures failed to indicate long-term positive change. The program appears to have an immediate positive effect on communication behavior and relationship satisfaction, but does not appear to affect self-disclosure or self-esteem after several months, unless further training or reinforcement is provided.

These investigations indicate that knowledge of Marital Enrichment programs is moderate in military communities, satisfaction among participants is high and participation is low. It seems reasonable to suggest that simply increasing awareness of programs could significantly increase participation rates.

Family Clusters

The process of educating families in groups, including persons other than their own kin, is sometimes known as "Family Clusters", "Family Growth Groups" or "Family Enrichment Groups." These types of programs were developed by several persons in the 1970s. A family cluster is defined as "a group of four or five complete family units, including twenty to twenty-five persons, who meet together weekly for an educational experience to strengthen their family units" (Sawin, 1977). Family units can be composed of singles, one-parent families, older couples with children out of the home, nuclear families, or groups of persons living together under one roof. A cluster is oriented toward improving relationships of between individual and families, enlarging social networks, and improving connections to other support systems, such as the church and community.

The goals of the family cluster model are to provide a structure for several families to experience family relationships in an intergenerational context, so that perspectives of older and younger adults, adolescents and children can be utilized in various aspects of family life, including decision-making and problem-solving, discipline, and other relationship issues. Sessions are usually held on a weekly basis for a scheduled number of

weeks. Families are expected to contract for a minimum of ten weeks and most attend for the full twenty-five weeks (Sawin, 1977).

Data on the effectiveness of family cluster type programs is scarce at this time. In one investigation, sixteen adolescents were interviewed regarding their experiences and participation in family clusters over a two year period. The investigator reported that adult-adolescent interaction and communication was improved, from the viewpoint of the adolescents interviewed. There was also a perceived increase in the understanding of the adult's point of view, with opportunities for adolescents to discuss and question adults regarding their views and ideas. These discussions also increased tolerance of adults' ideas and values (Hof & Miller, 1981).

In their research on Air Force couples, Orthner and Bowen (1982) reported that very few husbands or wives knew about family clusters. Only one out of ten had any information about this program, even though chaplains had been trained to offer it. While only 3% had actually attended a family cluster program, the majority of those who had participated found the program to be very helpful. Perhaps most important, the greatest interest in the family cluster program was found among families living overseas. For these families, the clusters would have provided kin-like support systems that might replicate social networks that were left behind.

Parent Education Programs

In their research on military families, Orthner and Bowen (1982) found that parent education programs were considered very attractive family support programs. Two out of three Air Force parents were aware of some type of parent-education program, with women having more awareness than men. Although actual participation rates were low, with less than 10% having actually attended, those who participated often felt these programs were very helpful, especially single-parent men (67%) and wives (46.2%).

Awareness of parent education programs is equally high among Army personnel but participation rates are also low. In the 1985 DoD Survey of Military Families, about half of all parents were aware that these programs were available but few had used them. At Fort Benning, only one in fifteen parents (6%) had received any parent education (Orthner et al., 1985). In both investigations, 65% of those who had participated felt satisfied with the program.

Parent education programs are growing in popularity in both military and civilian communities. In the Army, these programs may be offered by Army Community Services, Child Development Services, Chaplains or Social Work Services. Nevertheless, the field of parent education represents considerable diversity. Some programs focus on family-community relations while others teach parents how to stimulate a child's cognitive development. Certain programs prescribe specific skills and styles in relating to young children while other programs help parents determine their own ideal style. Some programs are designed primarily to disseminate child development information to parents while others attempt to foster supportive relationships among program participants.

Programs may vary from being highly structured to allowing parents to select activities and curriculum they wish to offer. Staff in some programs serve as child development experts, while staff in other programs adhere to a self-help model, serving in non-directive facilitator roles. There are also important differences in the use of professionals, assistants, or volunteers, program length (weeks versus years) and program setting (group versus home-based) (Powell, 1986).

Dokecki et. al. (1979) have conceptualized a continuum of parent education needs and corresponding professional responses at four levels:

Level 1. Parents who provide well for their children, with no obvious parent education needs. Professional response is a 'prospective mode' in which the worker anticipates future developmental needs of the child.

Level 2. Parents who generally manage well most of the time, but who need additional support and guidance regarding specific childbearing skills and who unknowingly engage in childbearing practices that are likely to lead to difficulties in the future. Professional response is a 'resource mode' to be available to parents who request information.

Level 3. Parents whose parenting needs are obvious, based in part on their children's lack of appropriate social skills. Professional response is 'collaborative mode' that involves the parent and professional working together to identify possible solutions to problems causing difficulty for the child.

Level 4. Parents who have limited social, emotional, and material resources that are not sufficient to provide for the growth and developmental needs of their child. Professional response will likely be to act in "protective mode" to protect the child and parent.

Two of the most popular parent education programs are Parent Effectiveness Training (PET) and Systematic Training for Effective Parenting (STEP). These programs are widely offered in both military and civilian community settings and are examples of parent education programs primarily designed to address two objectives: to meet the demands of parents of 'normal' children for effective child management techniques, and to incorporate communication and problem solving skills with childbearing practices. PET was developed by Gordon (1970) and was based on the concepts of Carl Rogers. It emphasizes the use of several skills to enhance parent-child relationships: active listening, 'I' messages, and a 'no-lose' method of conflict resolution.

STEP was developed by Don Linkmeyer and Gary McKay and was based on child management principles of Alfred Adler and Rudolf Dreikurs. One of its similarities to PET is that communication training is an integral part of STEP. STEP teaches understanding the purpose of children's misbehavior, encouragement of responsible behavior, use of natural and logical consequences, and usefulness of family meetings for planning and decision-making (White, 1981). The original STEP program has been enlarged to include STEP-Teen, developed to address the adolescent population's particular needs and issues.

While there are several kinds of research that have been used to justify parent education, each type is quite limited as a basis for parent education. Children whose parents have participated in a parent education program are likely to exhibit moderately increased levels of performance on IQ or achievement tests, but there is limited information about maternal behavior and other family factors, or the child's non-cognitive behavior. There is no definitive information regarding effectiveness of program curricula, instructional methods, or length or intensity of contact with the child's home. There is limited understanding of how the process of change that occurs in parent education is facilitated. While the assumption has often been that the direction of change is from program planner and curriculum to mother and from mother to child, these assumptions remain generally untested. Evidence has not supported the suggestion that parent-focused (parent education) programs are more effective than those involving the child or focused exclusively on the child, such as early childhood education (Clarke-Stewart, 1983).

Most program evaluations have not considered the larger social environments in which families function, even though environmental factors such as personal social networks have an important influence on family functioning and on parent behavior (Powell, 1983). Parents bring various levels of knowledge, attitudes, and child rearing practices to the educational program setting. Collecting baseline data on these characteristics in relation to program participation experiences and outcomes and assessing parent-child interaction styles as an antecedent of program involvement may improve program evaluation (Powell, 1983).

Available research indicates that the effectiveness of PET as a means to elicit positive change in parent-child relationships is still under question. Parents who have participated in the program report more family cohesion and less family conflict than before the program. Parents give more positive statements about their children's behavior but there is no significant decrease in children's actual problem behavior (Pinsker & Geoffery, 1981).

Unfortunately, data on program outcomes suggests that programs such as PET have a greater influence on parental attitudes than on parental behavior. The parents who enroll in parent education programs are usually more educated and have a higher than average educational status. Differences in behavior between trained and untrained parents tend to be associated with socioeconomic status more than program participation.

This resistance to behavioral change was recently demonstrated in an investigation by James, Kennedy, and Schumm in 1986. The researchers examined parents behavior and attitudes before and after participation in a parent education program. They found that parental satisfaction was influenced most by the program and parental behavior was influenced least. The parents least effected by the program were those most frustrated by their parental roles. The researchers conclude that parent education programs, to be effective, must have more reinforcement for good parental roles built into the program and more opportunities for further intervention after the program.

Financial Counseling

Financial problems affect the physical and mental well-being of individuals and their family members (Blood & Blood 1978; Feldman, 1976; Landis & Landis, 1968). In our society financial stability is a significant measure of success in people's lives, and the inability to maintain economic independence and some amount of financial achievement can promote low self-esteem.

Financial counseling is a process by which individuals and their families are helped to become economically independent and stable. The main goal of financial counseling is to help people develop skills in money management by helping individuals to create their own budget. Creating a budget means developing decision making skills that integrate personal values and goals with the resources available (Bratton, 1971).

There are two major approaches to the delivery of financial counseling, services: education and individual counseling. An educational approach to financial counseling is the most frequently used method. Individuals and families are coached in new skills in money and credit management. In an educational approach the counselor/teacher assumes that the basic economic problems result from a lack of understanding of financial issues (Bagarozzi & Bagarozzi, 1980). In the armed services, financial education is often provided by trained personnel in the units and it is offered to spouses through a variety of support organizations, such as Army Community Services. The approach in the military tends to be preventative, providing the skills necessary to young adults, many of whom have had no experience in managing an income prior to military service.

The counseling approach is particularly useful when an economic crisis has arisen, resulting from financial resources that either decreased or increased dramatically. In these situations, people are faced with new, often uncomfortable decisions that can cause significant amounts of stress (Guadagno, 1983). Given the financial resources that are available, an outside consultant can help put these new problems into a clearer perspective.

Financial counseling can also be integrated with more general personal and family counseling. As suggested earlier, economic problems may reflect deeper personal and relational problems. These problems need the special skills of the mental health professional. There are a broad array of skilled people such as social workers, counselors, marital and family therapists, psychologists and psychiatrists who deal with such problems. Most of these professionals understand the importance of financial counseling as part of their intervention.

In most military and civilian communities there are a diverse group of providers of financial counseling. Public services tend to be provided by local departments of social services, clergy and cooperative extension agents. Private services are usually available from banks, credit unions and professional counselors. Although these services may vary depending on the population's needs, the basic financial counseling is very similar.

Data on the effectiveness of financial counseling services to individuals or families is largely anecdotal. There are no controlled investigations in the literature on persons who have received counseling or educational services and their effects on subsequent financial decisions, behavior or attitudes (Bagarozzi & Bagarozzi, 1985).

Across the Army, most married persons are aware that financial counseling services are available from post agencies. Three out of four soldiers and two out of three spouses reported awareness of this service in the 1985 DoD survey (Griffith, Lavange, Gabel, Doering, & Mahoney, 1986). Still, comparatively few persons take advantage of the service: only 4 percent of the soldiers and 6 percent of the spouses in the Families in Green research (Orthner et al., 1985). Among those who had received financial counseling in the DoD survey, 54 percent were satisfied with the service they received.

Child Development Services

Child development services in the military community are provided for various reasons, including reduction in lost duty time and provision of employment opportunities for military family members (Vernez, Meredith, & Praskac, 1986). In the civilian community, company-sponsored child care is offered to improve employee morale, reduce absenteeism, and to attract and retain quality employees.

The range of child care assistance is extensive and growing. Direct care services, voucher plans, reimbursement plans, discount programs, and information and referral assistance are the major types of child care offered in the civilian community. Center-based and quarters-based Family Child Care are the primary options in the military community.

An investigation was conducted by Emlen and Koren (1984) to determine the effects of child care on the work place. This investigation was based on a May, 1983 survey of a work force of 20,000 from 33 companies and agencies. Two major findings that emerged from the research were that child care is both hard to find and difficult to manage. The authors concluded that the way in which families manage child care affects the ability of employees to be at work without carrying stress related to their child care arrangements. In addition, family structure and the ability to arrange child care both have an impact on the work place in the form of absenteeism and stress. Two major determinants of absenteeism rates were family difficulty in managing child care, and company flexibility and accommodation.

Fernandez (1986) recognized that the problems of finding and financing quality child care and resolving work/family issues are problems of American society as a whole. He concluded that only a collective effort of working parents, employers and public support will be successful in alleviating these dilemmas. He further stated that both family stability and corporate productivity are diminished by parental stress and the demands of living with family/work conflicts.

The potential for child care related work-family conflicts is growing, in both military and civilian families. Over the past two decades there has

been a dramatic increase in the number of working mothers. In 1976 only 35% of mothers with children under 3 were employed. By 1986, 51% of these mothers were employed as well as 60% of the mothers whose youngest child was between the ages of 3 and 5 (Galinsky, 1986). In the Army, the employment rate for mothers is also high. All active duty mothers (and fathers) must find acceptable ways to care for their children. In addition, 40 percent of the civilian wives of enlisted personnel and 44 percent of the wives of officers are now in the labor force as well. In the Army today, 30 percent of the civilian mothers with children under six years of age are employed (Griffith et al., 1986).

The very selection of a child care method can be a stressful one for a family. Families must assess the type of child care available, the cost of that care and the quality. Parents have basically three types of child care from which to choose: in home care, family care arrangements, and day care centers. In-home care, care in which parents hire adults to come into their homes, probably provides the most control over child care, but the costs are inhibiting: \$165-340 each week. Family day care typically offers a small group environment within the caretaker's home, with costs ranging from \$50 to \$100 a week. Day care centers offer professional child care workers in a large group environment with costs comparable in price to family day care (Chapman, 1987).

Perhaps the most difficult assessment in choosing a method of child care is the quality of that care. The inability of young children to accurately report on their care makes assessment even more difficult. This issue is compounded by the problem that most parents lack the knowledge necessary to make judgments on the quality of child care. Parents tend to choose child care based on reports of friends or professionals, newspaper advertisements, yellow pages, or convenience of location rather than an understanding of what qualities actually indicate a good child care environment (Bradbard & Endsley, 1979; Fuqua & Labensohn, 1986).

The lack of knowledge on the part of parents relates directly to the findings on the effect of day care. It is generally acknowledged that good quality day care is not harmful to children (Kiestler, 1970; Kegan, Kearsley, & Zelazo, 1976; Belsky & Steinberg, 1978; Rutter, 1981). Directly related to this finding are investigations that illustrate that variation in the quality of day care can affect the child's cognitive, socioemotional and physical development (Caldwell, 1986; McCartney, Scarr, Phillips, Gratjek, & Schwarz, 1982).

Even after a type of day care is selected families are faced with the additional on-going stress that comes from trying to balance the needs of children with the demands of the work place. Research indicates that managing this conflict is extremely difficult for families. In the National Survey on Working Women (National Commission on Working Women, 1977), 33 % of women with dependent children reported problems with child care. A recent issue of Fortune magazine (Chapman, 1987) presented the results of a poll of dual-career couples in which spouses both had MBA degrees. In that investigation, husbands reported more anxiety about their children than their

wives, indicating that the consequences of inadequate care now affect the whole family, not just mothers.

It is becoming increasingly apparent that child care is not solely a parental concern. In fact, when parents are under stress, these concerns tend to show up at the work place as well. Research indicates that parents concerned about child care miss more days, arrive late and leave early more often and take off more time during the day Fernandez (1986). Both employee productivity and morale are affected (Emlen & Koren, 1984). Stress over child care was even identified as a salient factor in the occurrence of industrial accidents (U.S. Commission on Civil Rights, 1981).

Research investigations consistently indicate that the availability of adequate day care service is beneficial both to employees and their companies. Many businesses have conducted feasibility investigations as well as cost-effectiveness investigations of day care efforts. Results of these investigations indicate that day care has a positive impact on corporate morale and productivity (Galinsky, 1986). Control Data Corporation compared groups of mothers whose children were using different types of day care resources over a 20 month period. The average number of work hours lost per month was lower for users of on-site care (4.40 hours) compared to non-center users (6.02 hours). Day care center participants also had a lower monthly turnover rate compared to non-participants.

Three national investigations have also focused on the effects of day care services on business. Perry (1978) reported that a majority of companies felt that day care helped to attract new employees, lowered absenteeism and improved morale. In an investigation by Magid (1983), businesses reported that child care support gave them a recruitment advantage, improved morale, and lowered absenteeism and turnover rates.

Military child care and youth programs have many of the same potential benefits for service members and spouses as have programs in the private sector. Although the consequences of those programs for service members and for job performance and readiness is as yet unclear, each of the services has now developed extensive child care programs.

Surveys of military parents indicate that the majority are satisfied with their child care programs. In 1985, the worldwide survey of Army spouses indicated that 66 percent of the mothers were satisfied with the quality of Army child care services (Griffith et al., 1986), and only 19 percent were dissatisfied. Parents were most likely to be satisfied with the facilities and personnel in the centers. They were least satisfied with the hours of operation. After school and youth programs are somewhat less likely to be highly rated. Data from Navy surveys have found similar results with 73 percent of the parents satisfied with their child care programs (Orthner & Kingery, 1987).

Relocation Assistance Programs

Relocation has been identified as one of the major stress-inducing events in life, similar in effects to the death of a loved one or to divorce

(Catalyst, 1983). According to Packard (1972), employee relocation contributes to stress and breakup of families, increased isolation of individuals, and disruption of social continuity and personal stability. Ammons and his colleagues (1982) report that geographic mobility undermines interpersonal relationships by cutting off access to supportive networks. Corporate wives are likely to feel particular vulnerability due to an unfamiliar environment causing a decrease in adaptive resources. These pressures contribute to employees' growing reluctance to relocate, with this reluctance cited as one of the major problems confronting business in the next decade (Catalyst, 1983).

There are several potentially dislocating aspects to relocation for families. Working-spouse considerations are a particularly strong source of family resistance as well as concern for the disruption of social support networks for the family, changes in the standard of living, and the desire to be close to parents or extended family members. Each year between 300,000 and one half million people are relocated by their employers. It is reported that the average person entering the job market today can expect to move 13 times and to change jobs seven times during their career, with the young, upwardly mobile executive moving most frequently (Ammons, Nelson, & Wodarski, 1982). The major problem for employers is expense, with the average relocation of an employee in 1984 costing about \$33,000 per transferee, with other estimates running as high as \$35,000 to \$40,000 (Catalyst, 1983).

Military families are especially impacted by relocation issues. In their recent "Youth In Transition" report, Orthner, Gaddings, and Quinn (1987) reported that military families move twice as often as their civilian counterparts. While youth from civilian families move approximately every 5.8 years, youth from military families move on the average every 2.9 years. In this investigation, military teens reported significantly more difficulty leaving old friends than their civilian counterparts did. The investigation found that female youth from both civilian and military families experience more adjustment problems than males. Higher levels of stress were found to be associated with difficulties in leaving old friends, and when making new friendships was delayed, teens were more likely to experience loneliness, depression, and alienation (Orthner, Giddings, & Quinn, 1987).

Dual-career families present tremendous problems in relocation, resulting, in companies addressing the issue of spousal counseling. Merrill Lynch Relocation Management, a major corporate relocation firm, found that 60% of corporate moves involve dual-income couples and by 1990 the proportion is predicted to be 75% (Catalyst, 1983).

A small but growing number of companies are developing formal spouse assistance programs. A formal spousal assistance program, according to Resource, often involves a variety of services: supportive counseling to deal with negative emotions resulting from disruption of spouses' careers; assessment of spouses' skills, education level, work experience, and career goals; assistance in developing a job search strategy and resume' preparation; job placement assistance; and follow-up services.

Catalyst (1983) reported that the executive transfer refusal rate was 24%. Even still, in 1984, a survey of corporations conducted by the Employee Relocation Counsel revealed that only one-third had programs that included career and job counseling for spouses. According to Catalyst, spousal assistance, if offered at all, is often inadequate, inappropriate, or provided in a patronizing and insensitive manner.

An investigation conducted by Ammons et al., (1979) on transferred male executives found significant differences between the degree of feelings experienced by male and female respondents after location, with women experiencing boredom, loss, depression, and loneliness significantly more than men (Ammons et al., 1982). Men reported feeling more enthusiastic than their wives. Personal adjustment and finding a suitable neighborhood were found to be more stressful for wives than husbands. The authors suggested that a supportive group experience might be helpful in dealing with these negative feelings, with such groups being sponsored by a variety of agencies, including mental health and local family service agencies.

Home interview data indicated that families demonstrating clear joint perceptions concerning demands of husband's career adjusted more readily than those who did not. Accordingly, those wives who desired to fit into the corporate lifestyle were able to promote adaptation (Ammons et al., 1982). The data from this investigation suggest that families adjust more readily when they acquire accurate information about the new community, monitor the move carefully, take the initiative for community involvement, and obtain information about education, child care, and medical services. Other findings of the research indicate that collective group activities involving newcomers need to be provided by the community in order to increase group cohesion and to lessen the emotional impact of relocation.

There is almost no data on the effectiveness of relocation support programs. According to Catalyst (1983) and other providers of corporate relocation services, the primary motivation behind these services is to reduce the stress on the employee and to increase the productivity of the employee in the new job and location. Support for families is considered incidental and usually provided because of anticipated employee pressure. There is also the growing belief that such support helps to maintain corporate morale, but humanitarian considerations are usually secondary.

Relocation services in the military generally lag behind those of the corporate sector. However, it should be noted that the military services relocate their entire active duty forces while corporations are most likely to move their executives. Thus, the scope and cost of organizational relocations are much more extensive in the military.

Military personnel and spouses tend to give mixed reviews to the relocation services that are provided them. In a recent investigation of families at Fort Benning, Georgia, fewer than 10 percent of the spouses indicated that they had participated in an orientation program (Orthner et al., 1985). Croan and Orthner (1987) found a similarly small percentage of Army families were taking advantage of the ACS relocation assistance program at the ten installations they reviewed worldwide. According to these

investigations, the major problems are that the programs are not that well known among family members, spouses are not strongly encouraged to participate, and the orientation programs are often limited in their assistance to working spouses. The advantage of advance planning and knowledge, however, was aptly demonstrated in an investigation of families relocating to Europe. Those who felt they had been properly prepared were much more likely to be supportive of the Army than those who were not prepared (McCubbin, Patterson, & Lavee, 1983).

Therapy/Treatment Programs

This section includes those programs that provide direct treatment or counseling to individuals and families in times of need or crisis. There are a growing number of services and programs that provide intervention strategies to alleviate or improve identified individual and relationship problems or deficits. These treatment programs are designed to help people resolve crises in their lives and move back into their communities and work organizations as productive members. Some of these programs depend on people recognizing their needs and acting in their own behalf or self-referring to an appropriate agency. Other services may be sought through a referral by someone else (such as a hotline) or by a supervisor (through one of the Army agencies on post).

Marital and Family Therapies

Over the past decade there has been a significant and steady increase in the use of marital and family therapy to treat individual and relational problems. Professional training programs in family therapy are becoming increasingly prominent and other professionals such as psychologists, psychiatrists, pastoral counselors and social workers have begun to accept this type of therapy as valuable for many types of problems. In the Army, marital and family therapy may be offered by agencies as diverse as Army Community Services, social work services, or by individual chaplains who have been trained in these methods.

According to Gurman and Kniskern (1981), there are numerous family and marital therapies. Marital and family therapy is very different from individually oriented intervention; it utilizes the couple or family as the focus for intervention and adopts a systemic framework that emphasizes interdependence between persons, information exchange, and circular feedback mechanisms (Huber & Baruth, 1987).

The most popular frameworks for providing marital therapy include behavioral, systems, psychodynamic, communication, cognitive, and experiential approaches (Baucom & Hoffman, 1986). The majority of controlled-outcome investigations have involved behavioral marital therapy (BMT).

The primary skills taught to couples in BMT are communication, problem-solving and behavior change, usually based on contracts. In comparison to couples on a waiting list, couples who received BMT showed decreases in negative communication in the therapy session, decreases in problem areas and requests for behavior change, and increases in overall marital adjustment (Baucom & Hoffman, 1986). Compared to other treatment approaches, few significant differences have been found between BMT and the following intervention strategies: systems approach, group-analytic strategy, group interaction strategy, communication training, cognitive restructuring plus BMT, and experiential intervention. Hahlweg and Markman (1983) found, with some exceptions, that BMT and other approaches produce generally equivalent effects, with BMT showing more stable effects at follow-up.

Communication therapy (CT) has generally been found to result in improved communication skills but has limited overall effect on marital adjustment,

compared to no treatment. When CT has been compared to treatment approaches other than BMT, no significant differences have been found between treatments in increasing marital adjustment (Baucom & Hoffman, 1986). These authors also reported that conclusions about the effectiveness of systems, insight-oriented, and cognitive approaches in comparison to waiting list couples is premature, due to the limited amount of available data. In general, the current research findings tend to indicate that if the unique characteristics and needs of the couple are not considered, no particular approach is considered superior (Baucom & Hoffman, 1986).

Family therapy, in contrast to marital therapy, involves more family members in the intervention. Usually two generations are included but a growing number of therapists are including a wider range of kin in the therapy environment. Family therapy is now used with quite acceptable rates of success for problems such as alcoholism and even serious psychological problems such as anorexia.

Research in the area of family therapies is generally divided into process and outcome research. Research on the process of family therapy is quite limited with few researchers having done more than a single investigation. Most of these investigations used new instruments with no replication of research; also there was usually poor communication between research groups involved in this type of investigation (Pinsof, 1981).

There are at least three factors that contribute to the limited research on family oriented therapies: the inherent complexity of analyzing this particular type of social interaction and interpersonal communication; lack of adequate theory in the family therapy field; and historically, psychotherapy researchers have been individually-oriented, and research generally reflects this bias (Pinsof, 1981).

There are two basic research strategies for measuring therapeutic intervention: use of self-report measures and direct observation measures. While some researchers tend to use one strategy or the other, a number of researchers have argued for use of both strategies. Unfortunately, self-report research on the process of family therapy has typically yielded few significant results or limited generalizability, often due to poor research designs and measures that are not reliable (Pinsof, 1981).

Observational research in this area typically involves separate coding systems for the therapist and family members. There are at least eight different coding systems that have been used to investigate the therapist and family members respectively (Pinsof, 1981). Nearly all the research in this area can be described as exploratory or pilot research.

Family therapy outcome research examines the outcome of the various types of marital and family therapies. For example, research on the consequences of behavioral family therapy has demonstrated fairly impressive gains with mildly or moderately distressed couples, but this method is not as impressive with severely disturbed couples or couples with one or more severely disturbed individuals (Gurman & Kniskern, 1981).

Across investigations that have assessed relational improvements as a result of treatment, marital therapy has demonstrated an improvement rate of 61 percent compared to 73 percent for family therapy. Conjoint therapy appears to be the most effective treatment among the marital therapies that are not entirely behavioral, with conjoint group therapy also receiving high marks (Gurman & Kniskern, 1981). Individual psychotherapy for the treatment of marital problems generally has a poor record.

While behavioral marital therapy is considered about as effective for minimal to moderately distressed couples as non-behavioral methods, behavioral and non-behavioral investigations often use different outcome criteria. Treatment strategies that increase communication skills receive consistent positive empirical support regardless of the mode of therapy, although the data does not necessarily support intervention that is limited to enhancing communication skills. Tentative evidence to date indicates that, marital therapy in a group context may be an effective adjunct treatment for couples with an alcoholic spouse. Conjoint, behaviorally-oriented therapies for sexual dysfunction have received significant empirical support and should be considered the treatment of choice, especially with the inclusion of communication training as a component of these sex therapy programs.

Family therapies are often as effective or more effective than other types of interventions for marital and family conflicts as well as problems that are presented as more individualized. Structural family therapy has appeared quite effective for treating various childhood and adolescent problems, including anorexia and asthma, as well as adult drug addiction. Operantly oriented behavioral family therapy has been effective for changing frequency of intra-family childhood behaviors, such as aggressiveness (Gurman & Kniskern, 1981).

While this discussion has focused on the effectiveness of marital and family therapy in civilian populations, it should be noted that a growing number of clinical professionals in the military services are being trained and are using these types of treatment programs. Active duty persons and their families are participating in marriage and family counseling and therapy and the levels of satisfaction with this program are quite high.

In the Families in Green research on Army families (Orthner et al., 1985), over half of those surveyed were aware that marriage and family counseling services were available at their post. About eight percent of the families had received this type of counseling at the time of the survey. Army-wide, 52 percent of those who had participated in marriage and family counseling felt satisfied with the results (Griffith et al., 1986).

Crisis Hotlines

Hotlines are becoming an increasingly important means by which intervention services are provided for individuals and families in crisis. Whether these services are offered by medical or mental health professionals, they provide a quick, anonymous means through which people in need can either get temporary relief from their problem or a referral to someone who can help them.

Hotlines are becoming increasingly common in both military and civilian communities. They are sometimes staffed by volunteers but usually they are backed by professionals who assist with difficult cases. Hotlines are often used for crisis intervention to such groups as victims of crime, persons with suicide intentions, those suffering from abuse; the elderly; grieving families; persons with venereal disease; and single parents.

Modern telephone counseling or "hotline" intervention began in the late 1950s, and became the backbone of the suicide prevention movement (Slaikeu & Leff-Simon, 1984). The Los Angeles Suicide Prevention Center is credited with first developing techniques to perform life-saving intervention by telephone, laying the groundwork for rapid development of centers all over the country. There were at least 500 known suicide prevention and crisis centers in the United States and Canada by 1980 (Slaikeu & Leff-Simon, 1984).

There are several distinguishing features of telephone counseling that are different from more traditional types of counseling:

1. Assistance offered to a person in crisis over the telephone relies exclusively on words spoken between the helper and caller (content) and the way the words are spoken (non-content). There is increased client control over an interview compared to that which would normally take place in the counselor's office, since the client begins the interview and can terminate the interview at any time.
2. Client anonymity is preserved, which likely results in greater self revelation and openness.
3. Counselors are anonymous, which likely facilitates positive exchange between caller and counselor.
4. Telephone counseling reduces dependency by caller on counselor.
5. Telephone counseling is low in cost and easily accessible, with accessibility being critical for crisis intervention.
6. Telephone counseling is available round the clock, with limited waiting time (Slaikeu & Leff-Simon, 1984).

While several aspects of telephone counseling have been researched, including characteristics of volunteer telephone workers, selection criteria for telephone workers, relationship between training and worker performance, training models for telephone workers, characteristics of callers, problem contents of calls, and outcome measures of telephone counseling, there are few investigations investigating the relationship between process and caller outcome (Slaikeu & Leff-Simon, 1984). Auerbach and Kilmann (1977) reported that many of the outcome investigations were limited to outcome of training programs only, answering the question of whether workers had performed on the phones as they had been trained to do.

Because of the anonymity given to persons who call hot lines, there have been no systematic investigations which have collected data on outcomes for

callers in the following days, weeks, and months after telephone crisis intervention. Investigations which have tried to establish a link between the process variables (in call) and outcome variables (after call) have also been inconclusive to date. Therefore other than anecdotal data there is little information available on the actual impact of telephone counseling on how the caller resolves their crises.

There is little data on the use or effectiveness of crisis hotlines in the military services. Manuals for the development of these services have been distributed in all branches; and many military hospitals have crisis lines, as well as other support agencies. In the 1985 DoD survey, fewer than one-third of the respondents indicated awareness of crisis referral services (hotlines included), and less than half of those who had used them (46 percent) were satisfied with the results. These data are clearly tentative but they indicate that the need for this type of service is not currently being met.

Shelters

Shelters are often viewed as a short-term refuge for wives and children to escape from an episode of domestic violence. Shelters are a fairly new development in the area of crisis intervention programs, with the first shelter for battered women established in England in 1971. There are currently over 700 shelters in the United States alone (Berk, Newton, & Berk, 1986). Most large Army posts also have shelters operated under the Family Advocacy Program and managed by Army Community Services.

There is limited systematic research on how shelters function and the impact of shelters on family violence. However, Berk, Newton, and Berk (1986) conducted an investigation during 1982 and 1983 on wife battery in Santa Barbara County, California, obtaining face-to-face interviews with 155 wife-battery victims in a two-wave panel. The research examined a single outcome variable, the shelter's impact on new violence. General findings of the investigation were that shelters appear to have beneficial effects on violent households, but these effects are dependent on attributes of the victim. If victims are taking control of their lives, a shelter stay was found to limit probabilities for new violence. For other victims, shelters may have no impact or a detrimental impact by triggering retaliation for disobedience. The authors suggest that combining several intervention strategies could be most effective in preventing new violence, such as coupling shelter stay for the victim with a restraining order for the assailant.

Each of the military services has been actively developing family shelters for the past several years. With the formal introduction of Family Advocacy programs in the early 1980s, shelter programs have gradually expanded to include most installations. These programs are not that well known by family members, however, with only 31 percent of the wives of enlisted Army personnel and 20 percent of the officer's wives aware of their existence. Among those who had used these shelters, approximately 50% felt satisfied with their experience (Griffith et al., 1986).

A family violence shelter is a major component of Project SAFE (Services Assisting Family Environments), which is a joint Military Services family violence project. The shelter is a facility for abused military spouses and their children. In addition to providing emergency shelter for these family members, developmental screening for physical and emotional problems is provided for children remaining at the shelter over 72 hours. This service is considered preventative in nature, since the purpose of the screening is to prevent more serious problems by early detection of learning disabilities, developmental delays, or emotional problems.

The SAFE Project has been fully operational for over three years, and has become an institutionalized part of the Pacific Command organization in fiscal year 1986. This decision was made by the U.S. Commander in Chief, Pacific, (USINCPAC) Surgeon, with the approval of each of the military services, and was based on need, numbers served, user satisfaction, and intervention success (McNelis & Awalt, 1986).

Adult Alcohol and Drug Treatment

Williams (1985) estimates that there are 13.5 million alcoholics in the United States. It is generally believed that 6.2 percent of the population exhibits this disease. As of 1982 (the last year for which information is available) 17,584 individuals were being treated in hospitals, 17,390 were being treated in rehabilitation centers, 14,648 were being treated in halfway or quarter-way facilities, and 280,326 were being treated in outpatient centers. Nearly all military installations have drug and alcohol programs that serve military personnel, although these programs may not be available to family members on a routine basis.

In civilian mental health centers, anyone having a substance abuse problem is eligible for services. Treatment typically begins with detoxification or "drying out" - being free of the abused substance. The next phase of the process is learning to live without chemicals. This process requires long-term group treatment. Additional services are available for referral to halfway houses or other long-term treatment programs. Individual or family therapy, and treatment contracts with employers are other treatment options. In some centers, antabuse, a prescription drug, is a required part of the treatment program.

There are generally considered to be three formal categories of alcohol treatment: hospital inpatient, residential treatment centers, and outpatient treatment or a combination of more than one method. Recovery rates vary widely, with claims ranging from 40-90 percent depending on the program evaluated. Williams (1985) reported that the U.S. Office of Technology has concluded that the overall recovery rate is 67 percent from all types of programs. Experts in the field tend to agree that the upper ranges of recovery are obtained by centers that utilize a strong post-treatment link between the patient and Alcoholics Anonymous (Graham & Brook, 1985). Socially stable clients were more likely to be involved with non-addiction specific services such as medical or general counseling services. The average "success rate" (those abstaining or who have improved after one year) was found to be 26 percent.

There is an increasing impetus not only to determine the most effective way of treating addictions, but also to look for programs that are the most cost effective. Many recent investigations are available which deal with the issue of addiction program evaluation.

Annis (1986) analyzed the cost effectiveness of inpatient alcohol treatment. She concluded that: (1) hospital alcohol programs (lasting from a few weeks to a few months) show no higher success rates than hospitalizations lasting a few days; (2) the majority of alcoholics can be safely detoxified in non-hospital units at one-tenth of the cost; (3) partial hospitalization or day treatment has been found to have equal or superior results to inpatient hospitalization at one-half to one-third of the cost; (4) well-controlled trials have demonstrated that outpatient programs can produce comparable results to inpatient programs. One estimate places cost savings at \$3,700 per patient.

Beshai (1984), in a demographic investigation of over 7,000 alcoholics, found that employed alcoholics were more likely to receive outpatient treatment while those admitted to inpatient units had heavier prior involvement with alcohol and more severe alcohol-related problems. An alcohol treatment program led by senior patients was compared to treatment led by therapists in an attempt to compare the cost-effectiveness of the two methods. There were no differences between the groups in terms of retention and visit rates during the course of a year. However, the engagement of inpatients into ambulatory care was more effective for the patient-led group.

Glaser, Greenberg, and Barrett (1978) concluded that there should be multiple types of interventions available for meeting client needs. One major problem in evaluating addiction services has to do with the high recidivism rate. In an analysis of one community's resources to deal with addictions problems (termed an addictions treatment system), 1500 individuals were tracked and 250 received services from more than one provider. In addition, this systems analysis revealed that the addictions resources were oriented toward unemployed, unmarried male abusers in their 30's and 40's.

Other investigations have addressed the issue of whether certain types of clients respond more favorably to specific treatment settings. Stinson, Smith, Amidjaya, and Kaplan (1979) found that clients who were more socially stable with shorter drinking histories fared better in less intensive treatment. Beshai (1984) reported that employed alcoholics were more likely to receive outpatient treatment while those with heavier prior involvement and more severe problems were more often admitted to inpatient units. Miller and Hester (1986) in reviewing a large number of investigations concluded that outpatient settings were more appropriate for socially stable individuals whereas less socially stable individuals did better in more intense treatment programs. Length of inpatient care was not found to affect treatment outcome, but successful cases were found to have participated in outpatient aftercare (Pittman & Tate, 1972; Walker, Donovan, Kivlahan, & O'Leary, 1983).

Armor, Johnson, Polich, and Starbul (1977) reported that there was a bewildering array of possible alcohol treatment methods with little rationale and no general scientific approach. Babow (1975) noted the competition

present among for-profit treatment entrepreneurs for whom their particular program was "the only effective way." To add to the confusion, Hadley and Hadley (1972) investigated ten alcohol treatment programs and found each characterized by different attitudes and beliefs. In addition, within each program were staff members whose philosophies were at variance with one another and with the program.

Evaluation of AA programs is likewise difficult. Ogbourne and Glaser (1985) reviewed research done on AA and found that alcoholics who affiliate with AA tend to exhibit different characteristics from those who do not affiliate. Many of the investigations of AA were found to be flawed in their research design and consequently have added little to the overall knowledge of the effectiveness of AA as a treatment (Bebbington, 1976). It is still unclear from an empirical perspective whether benefits from AA are greater than benefits from other treatment programs.

Richman (1983) emphasized the importance of evaluating cost-effectiveness for particular addiction programs. He pointed out that most program evaluations only took the initial drug admission into consideration and did not consider readmission rates. Such a method overlooks the fact that 53 percent of all addiction admissions are readmissions.

Families have increasingly become a part of the alcoholic treatment plan. Orford (1975) found that the family context was frequently an important target for interpersonal interventions. Moos, Bromet, Tsu, and Moos (1977) concluded that the family environment was a major determinant in successful treatment outcome.

Of considerable interest to employers, including the military services, is the estimate that 97 percent of substance abusers are currently in the workforce. The disease of addiction robs employees of their health and is estimated to cost U.S. industry as much as \$120 billion annually (Wiedrick, 1986). Because of this, an extensive body of literature has evolved around the problem of addiction in industry. In the past, employees' personal problems placed them in danger of being fired. Companies are now increasingly offering assistance to their troubled employees in the form of Employee Assistance Plans (EAPs).

One of the major assumptions upon which EAP programs are built is that it is cost effective to reduce employee turnover, thereby preserving the organizations training investment in its personnel (Roman, 1988). Another assumption is that alcoholics can recover, can regain control of their lives and can return to work as effective employees. There are several different types of EAP's including in-house assessment, open-ended assessment, prepaid assessment, and telephone counseling (Lydecker, 1985).

Although many companies tend to use residential treatment facilities for key employees with substance abuse programs, United Technologies Corporation (UTC) has found that treatment by a hospital in an intensive day or evening treatment setting is the preferred way. Intensive treatment involves structured, regular treatment in lieu of work. UTC has concluded that the day

treatment program is only a fraction of the cost of a residential program (Bensinger & Pilkington, 1985).

One management consulting firm, People to People Associates, reported that the recovery rate for those referred to a rehabilitation program through their company was 70-90 percent as compared to 20-25 percent for those seeking outside help. The researchers hypothesized that employers tended to exert strong leverage over their employees, who often valued their jobs even more than family or friends (MacDonald, 1985).

While claims for success in treatment are often given, there appear to be few EAP cost-effectiveness investigations based on sound social science research methodology. Myers (1984) reported that few of the available investigations included adequate documentation of research methodology or the exact variables that were considered. Nevertheless, Roman (1988) surveyed 480 private companies and found a high degree of reported success with these programs. He concluded that work place referral, inpatient or outpatient treatment and mixtures of work place, treatment center and AA aftercare combined to produce high recovery rates and a return to effective job performance. Approximately 70 percent of alcohol-related cases had returned to effective functioning within a 12-month period.

Adult Individual Therapy

In a given year an estimated 15 percent of the population suffers from a mental disorder (Regier, Goldberg, & Tauge, 1978). Of those, about 60 percent received care in the non-psychiatric medical sector. Only about 20 percent received care in a specialized mental health setting, a fact which documents the well-known under utilization of such specialty services (Stefl & Prosperi, 1985). Many chose to seek no care at all.

There are a variety of settings in which mental health services are provided. A major distinction in settings is made between inpatient and outpatient treatment. Inpatient units can be found in psychiatric units of general hospitals, in private or public psychiatric hospitals, and in private residential psychiatric facilities. On an outpatient basis, aside from the large number of patients treated by non-psychiatric physicians, clients are treated in community mental health centers (CMHC), private counseling clinics, university-related teaching-training clinics, and by private practitioners or groups of practitioners including psychiatrists, psychologists, social workers, pastoral counselors, marital and family therapists, educational counselors, and others.

In individual treatment, one patient is typically treated by one therapist for a specified length of time, usually ranging from 50 minutes to an hour. The individual thus becomes the primary treatment unit unlike those who view the marital dyad or family as the primary treatment unit. The actual techniques or method used in individual treatment is dependent upon the therapist's orientation, a reflection of his or her education, experience, and training. The major therapeutic orientations are identified as follows:

1. Psychoanalytic psychotherapy. Psychoanalysis is included within this approach as well as neo-Freudian psychoanalytic psychotherapy, the most common type of psychotherapy practiced in the U.S. today (Luborsky & Spence, 1971).
2. Client-centered therapy (Rogers). Therapy focuses on helping clients become aware of the incongruence between his/her self-concept and life experiences (Smith, Glass & Miller, 1980).
3. Behavioral therapies. These therapies are based on the assumption that behavior occurs in response to internal or external stimulation. Common techniques include: assertiveness training, token economies, contingency contracting, systematic desensitization, implosion, aversive techniques, etc. (Kimble, Garnezy, & Zigler, 1984).
4. Transactional analysis (Eric Berne). Clients are taught to become aware of the intrapsychic and interpersonal problems that they face. These therapists emphasize personal responsibility (Zastrow, 1985).
5. Reality therapy (William Glasser). The main goal of reality therapy is to help clients reject irresponsible behavior and to teach them more effective ways of functioning (Zastrow, 1985).
6. Rational-emotive therapy (Ellis). This type of therapy seeks to challenge and change irrational beliefs. Patients are encouraged to take control of their lives (Kimble, Garnezy, & Zigler, 1984).
7. Gestalt therapy (Perls). Gestalt approaches tend to focus on the "here and now", or patterns that the patient is exhibiting currently. The overall goal is to help individuals mature and become independent.
8. Drug therapy. Treatment with prescription drugs is widely used as both a therapy in and of itself and as an adjunct to other forms of treatment.

There have been numerous research attempts to examine the efficacy of psychotherapy and to compare the effects of different types of treatment. Luborsky, Singer, and Luborsky (1975) compared all investigations of psychotherapy outcomes that were reasonably controlled. When varying treatments were compared, the authors reported the "dodo-bird" effect - all approaches won and all must have the prize. There were no significant differences in the proportions of patients who improved by the time of treatment termination.

Similar results were reported in a thorough review of the psychotherapy and drug therapy literature (Smith, Glass, & Miller, 1980). They, too, concluded that psychotherapy was affective by using a meta-analysis of 475 controlled outcome investigations. In terms of psychological well-being, a person who engaged in psychotherapy was better off than 85 percent of those who needed therapy and remained untreated. In a simple uncontrolled comparison of different therapies the most effective types appeared to be cognitive, cognitive behavioral, hypnotherapy and systematic desensitization. On a

well-controlled comparison, however, no significant differences were found between behavioral and verbal therapies.

As a result of this investigation, Smith and colleagues (1980) suggested that the choice of outcome criteria, experimental rigor, and client characteristics all appear to influence the magnitude of effects whereas the duration of therapy did not. An experimenter's association with a particular therapeutic orientation also tended to be associated with larger effects.

When psychotherapy is compared with pharmaco-therapy (drug treatment) the dodo-bird effect does not apply (Luborsky & Spence, 1975). Drug therapy was found to be more effective than psychotherapy unless the two treatments were combined. In the latter case, the combination of methods was more effective than either alone.

Adult Group Therapy

Group therapy emerged as a method of treatment during World War II when the number of therapists available to handle soldiers with combat fatigue was insufficient (Kimble, Garnezy, & Zigler, 1984). Use of this treatment mode has continued to grow in recent years. Group therapy is used as a treatment of choice for a variety of mental health and substance abuse problems and is used in many different treatment settings.

Five stages of group development were described by Garland, Jones, and Kolodny (1965): pre-affiliation, power and control, intimacy, differentiation and separation. These stages appear to be particularly applicable to therapy and encounter groups. Leaders were viewed as facilitating a group's progression through these stages. Slater (1958) found that groups of five were considered most satisfactory by group members themselves. Research indicates that about one-third of patients beginning, group therapy drop out unimproved within the first 12 meetings (Yalom, 1966).

Yalom (1975) wrote that the aim of group therapy was to remove the effects of individual's negative experiences with their first important group the primary family. According to Yalom, groups offer an unusual opportunity for behavioral change. Groups challenge the behavior of members, encourage more adaptive behaviors, and allow social learning to occur through imitation, modeling, or by rapid, personal feedback.

The effectiveness of group therapy as compared to other modalities remains unclear. Smith, Glass, and Miller (1980) found that the average effects of group and individual therapy were remarkably similar. In general, the mode in which the therapy was delivered was not a significant factor. In a comparison of group and individual psychotherapy (Luborsky, Singer, & Luborsky, 1975), few significant differences in outcome were observed. The authors concluded that the result was surprising, in light of the general opinion that group psychotherapy is less intensive than individual treatment. In an investigation of high-ego strength children, the children were equally responsive to group and individual psychotherapy (Sommers et al., 1966).

Children's Treatment Programs

Children, according to Friedman (1986) have traditionally been one of the most neglected groups in mental health. The President's Commission on Mental Health (1978) estimated that between 5 and 15 percent of all children suffer from some sort of emotional disturbance. The prevalence of "clinical maladjustment" in children was estimated to be 11.8 percent of all children (Gould, Wunsch-Hitzig, & Dohrenwend, 1981).

Children from military families are not without their problems as well. In a comparative investigation of 2,400 adolescents from military and civilian families, it was found that 21 percent of the boys and 41 percent of the girls from the military families self-reported low self-esteem on a standardized measure. The girls from these families, in particular, exhibited significantly lower scores on every measure of psychological well-being compared to those from civilian families. The authors of the research conclude, "Youth stress levels are very capable of negatively impacting on their parents' job performance" (Orthner, Giddings, & Quinn, 1987).

In reviewing clinical responses to children's problems, an examination of the treatment setting would appear to be more worthwhile than an examination of therapeutic orientation. Children's services can best be viewed on a continuum ranging from outpatient, home-based treatment to residential treatment, from least to most restrictive. Ideally, this continuum of care should be available in a local community. The reality is that the majority of services for children and youth have been either fragmented among agencies or simply nonexistent. Consequently the mental health needs of many children and youth have not been met, whether they live in military or civilian communities.

There is an emergent philosophy among those involved in children's mental health to view child and adolescent programming in the framework of a "system of care" (Friedman, 1985, 1986; Stroul & Friedman, 1986). The system is defined as both child-centered and community-based. The former focus emphasizes the need to adjust services to the family rather than demanding that families conform to preexisting services. Secondly, the focus emphasizes caring for children in the least restrictive, most normative environment. This type of mental health system would encompass a network of agencies within a single community (Stroul & Friedman, 1986). The system's concept of care provides a helpful way to consider existing programs.

Outpatient Care for Children

Outpatient treatment is the most commonly used intervention with children and youth. Typically clients are seen in regularly scheduled appointments, usually once a week, and are treated individually, in groups or in family therapy (Friedman, 1985).

Outpatient services tend to be nonrestrictive, fairly inexpensive, flexible, and adaptable (Stroul & Friedman, 1986). They encompass a variety of primary approaches: psychodynamic, behavioral, and family systems, although frequently with children, these approaches are combined. The Joint

Commission on Mental Health of Children (1969) found that there had been few investigations conducted on the effectiveness of different psychotherapies on children.

Among the two most common therapeutic orientations are the psychodynamic and the behavioral orientation. The psychodynamic approach focuses on underlying causes rather than overt symptoms. The goal of therapy is to explore feelings and attitudes and fears and to bring repressed material into conscious awareness. The main therapeutic ingredients include a trusting child-therapist relationship, parent consultation, play therapy, and interpretation by the therapist (Schaefer & Milman, 1977). Parent consultation is an important adjunct to individual psychotherapy (Lesser, 1972).

The behavioral approach is typically based on learning theory. Children are assumed to have learned maladaptive responses or to have failed to have learned appropriate behaviors or skills. Therapists focus on overt symptoms and attempt to manipulate behavior. Cognitive behavioral approaches have also been used with children (Meichenbaum, 1977).

A particularly effective behavioral therapy program called the "Parent Training Program" was developed by Forehand, Rogers, Steffe, and Middlebrook (1984). This program treats non-compliant children (between 3-8 years) and their parents. The goal of the program is to educate parents in how to change maladaptive patterns of interaction with the child. Sessions are conducted in a clinic setting twice a week for 8-10 sessions. In Phase I, parents are taught to be more effective reinforcing agents for their children and in Phase II, parents are taught how to decrease non-compliant behavior (Forehand, Rogers, Steffe & Middlebrook, 1984).

Outcome investigations of this program have been conducted since the program began. Results indicate that behavior change generalized from the clinic to the home, from treated to untreated behaviors, and from the identified patient to siblings for at least 3 1/2 years after termination (Peed, Roberts & Forehand, 1977; Wells, Forehand, & Griest, 1980). In addition, characteristics of parents were found to play a significant role in therapy (Richard, Forehand, Wells, Greist, & McMahon, 1981). This program is believed to be cost-effective because parents are taught to function as their child's therapist.

Child psychotherapy is another major treatment program directed toward children. Casey and Berman (1985) reviewed 75 investigations of psychotherapy conducted with children and found that children who were treated showed greater improvement than those who were not. As was the case with adult therapies, there was little evidence to suggest that some forms of treatment were better than others. The authors concluded that outcome investigations of behavioral treatment tended to report better outcomes than investigations of non-behavioral treatment, but this effect is complicated by the fact that children with different types of problems were treated in the two therapies and different measures of treatment effectiveness were used.

There was no evidence that play techniques or treatment of parents produced positive outcomes. In addition, no differences were found between individual and group therapies. The authors reported that children with somatic problems, phobias, and hyperactivity demonstrated the greatest improvement, and all were treated with behavioral therapies. Sowder (1979) reported that the effectiveness of treatment tended to depend on characteristics of both the client and the therapist, and on the quality of the interaction between them.

Homebound Services

A new constellation of outpatient services has arisen in recent years in response to efforts to reduce use of residential services for children and youth. These services are provided in the home for families in the midst of crisis.

Although the individual programs vary, they all contain some common elements: (1) they accept only families with a child that is about to be removed; (2) there is a crisis-orientation and families are seen quickly; (3) staff hours are flexible and 24 hour coverage is often available; (4) no child is left in a potentially dangerous situation; (5) treatment is focused on the family; (6) staff carries small caseloads; (7) interventions are brief and time-limited; and (8) a team approach is used (Friedman, 1985).

The best known model program is the Homebuilders of Tacoma, Washington. The goal of the program is to prevent placing children away from their families. The service employs six full-time therapists and is funded by the state. The team attempts to diffuse the immediate crisis and teach new problem-solving skills. Staff are on-call 24 hours a day from 4-6 weeks for each family. Therapists use an eclectic therapeutic approach and are also trained in budgeting, advocacy and referral assistance.

The Homebuilders program is considered to have been quite effective. It served 1436 cases between 1975 and 1983. Three months after termination, 94% of children were still in the home. According to program evaluations, the difference in cost in Homebuilders and out of home placement was over \$16 million for those 8 years (Homebuilders of Tacoma, WA, 1985).

Residential or Inpatient Treatment for Children

Residential treatment facilities are designed to provide services for youngsters with serious emotional problems. They are likely to have a strong medical component. Friedman (1985) pointed out that there has been an increasing trend toward chains of such treatment centers. These programs are primarily supported by third party payments from private insurance companies. Most residential centers charge from \$100-300 a day.

Apparently there are few investigations that have addressed the effectiveness of residential treatment vis a-vis other treatment resources (Friedman, 1985). Prentice-Dunn, Wilson, and Lyman (1981) reported no differences between children who received day as compared to residential treatment. Bloom and Hopewell (1982) examined the long-term effects of

residential treatment on children and found that the major differences between the recivist and non-recivist groups had to do with the adequacy of post-discharge resources available.

In light of both the empirical results and the growing emphasis on use of the least restrictive method of care for children and youth, the dramatic increase in private residential care for teens is thought provoking. Admissions to these facilities rose 350 percent from 1980 to 1984 (Program Update, 1985). The U.S. House Select Committee on Children, Youth and Families has been conducting hearings to examine these trends.

Conclusions

Community and family support programs are generally regarded as important components of a community's formal support system. The quality of formal supports as well as informal supports is believed to influence perceptions of the quality of a community and therefore satisfaction with it. In the military these factors are linked with retention and readiness.

Most of the research on community support has been conducted with civilian samples. Nevertheless, military communities share many similarities with nonmilitary communities, and increasingly, the barriers between the military post and the off-post community are becoming much more permeable. Military communities are no longer, if they ever were, isolated systems with only tangential ties to local institutions and agencies. Today, these communities are characterized by the constant flow of personnel, family members, support systems and organizational cultures between military and civilian systems. Evaluation of many of these community support programs is limited. However, the preceding review of the literature offers five general conclusions:

1. The number of personal, family and community support services has grown dramatically. There are now a wider range of support services in both the military and civilian communities than ever before in history. Major reasons behind this growth appear to be: greater dependence on formal support systems because of the decline of informal support networks, increase in specialization on the part of professionals who provide services, increased recognition of the needs of special groups in communities, and increased pressure from family support organizations to demonstrate accountability to their clients, including the organizations that financially support them.

This trend toward diversification of support systems has resulted in many more individuals and families having access to and taking advantage of support programs and services. The number of people seeking and receiving assistance for personal family concerns has increased dramatically in almost all areas of support. While it might be argued that these expanded services are simply marketing themselves well in order to attract clients, this does not appear the case. People who have needs are now receiving services instead of having their problems or concerns fester with no solution.

2. Public awareness of support programs is very uneven. Both military and civilian investigations indicate that high proportions of community residents are unaware of the support services and programs that are available to them. They are more likely to be aware of normative programs and services such as fire and police protection and child care services but they are most often unaware of programs that provide preventative or crisis response type of service. These services usually require a longer time and investment in the community for people to become knowledgeable about them. Unfortunately, those who are most likely to have the needs are usually the ones who are least likely to be aware of the support programs that are designed to address those needs.

3. Support services tend to have short-term outcomes, unless reinforcements are built into the program. Most individual and family support programs, especially those that are oriented toward changing relationships between people, do not have a good record of providing long-term benefits. This is especially true of preventative programs that are designed to improve the skills of individuals or families in areas such as parenting, marital relationships or building informal support networks. Even clinically-oriented programs do not tend to have good results, unless there is some type of post-intervention training and reinforcement built into the program itself. The positive consequences of these programs may last only days or weeks unless individuals or groups are brought back together for encouragement, re-training or some other form of reinforcement.

4. Programs that meet the needs of individuals tend to be more effective than those that meet the needs of groups or relationships. While this conclusion should be considered tentative at this time, it appears from the evidence to date that efforts to improve the quality of interpersonal relationships have been somewhat less successful than improving negative characteristics in individuals. To a large degree, this is the logical consequence of an inherent complexity in relationships compared to individuals. Individual change can be behaviorally manipulated more easily than behaviors that are the consequence of relationships between individuals.

This does not mean that efforts to improve the quality of relationships should be abandoned. Quite to the contrary, much more effort needs to be given to strengthening relationships but it should be noted that more resources will typically be necessary to do this than is required for individual therapy. As an example, the best strategies for treating major individual problems, such as alcoholism or anorexia have come through interventions in relationships. Family and group therapy tend to be much more successful in the treatment of these than is individual psychotherapy. But the resources necessary to do this are quite demanding, both on support services and the individuals and families involved. Likewise, marital or parental preparation and marriage and family therapy require significant advanced training and professional skill in order to accomplish positive consequences. As the number of relationships between individuals within a family or group increases, the ability to bring about positive changes in each of those relationships becomes much more complex and the likelihood for success in systemic intervention begins to drop off.

4. Research on program effectiveness is still in its infancy. The conclusions we have made thus far are dependent on a relatively small body of literature on family and community programs and services. There are many programs and services that have practically no data on their consequences for effectiveness, other than perceptions of client satisfaction. It is very common for services to be rendered with no evaluation or assessment component built into the program delivery system. This means that services are very often developed, implemented and institutionalized before any significant attempt is made to determine whether the program is indeed meeting the needs it was designed around.

This lack of ongoing program assessment is common in both military and civilian community and family support programs. Even though many of these programs have been in the field for many years, data on the consequences of most of these programs are simply not available. Perhaps because they require more resources treatment programs are more likely to be evaluated than are preventative or normative programs. Prevention programs rarely include follow-ups of those who were served and normative programs such as child care or recreation often depend solely on anecdotal data from patrons to justify their continuance. Clearly, much more needs to be done to demonstrate the accountability of these programs than is currently evident in the literature.

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