Methods for Preventing and Reducing Violence by At-risk Adolescents: Common Elements of Empirically Researched Programs

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Abstract

Youth violence is a significant problem. Reports of school shootings, continued inner city violence related to drugs and gangs, and youth’s increasing use of violence to resolve conflicts have raised the alarm. Identifying and implementing effective methods for preventing and reducing youth violence, particularly among adolescents who are at-risk for violence is essential. At-risk youth are characterized by poor school performance, limited family support, delinquent behavior, and influential relationships with anti-social peers (Dryfoos, 1993). They also are over represented in juvenile and family courts, foster and residential care, and in mental health programs. Research has demonstrated the effectiveness of many interventions that prevent or reduce violence in at-risk adolescents. A review of these programs identified eight common elements that impact effective outcomes (anger management and problem solving; consequences of violence and refuting beliefs supporting violence; prosocial skills and choosing prosocial peers; positive relationships with parents and non-parental adults; effective use of structure and limit setting; focus on strengths and resilience; use of multiple domains – individual, family, peer, and community; and treatment matching the adolescent’s individual needs). These eight elements provide a useful framework for developing effective practice interventions with at-risk adolescents.
Youth violence is a significant problem. Reports of school shootings, continued inner city violence related to drugs and gangs, and youth’s increasing use of violence to resolve conflicts have raised the alarm. The U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention (U.S. Department of Justice, 1996), the U.S. Surgeon General (United States Surgeon General, 2000), the Center for Disease Control (Thornton, Craft, Dahlberg, Lynch, & Baer, 2000; U. S. Department of Health and Human Services, 1993), the American Medical Association (American Medical Association, 1992), and the University of Colorado’s “Blueprints for Violence Prevention” (University of Colorado Center for the Study and Prevention of Violence, n.d.) have all addressed youth violence and have encouraged and described programs that prevent or reduce youth violence.

Although it is necessary to address issues that influence youth violence, such as poverty, discrimination, urban decay, and family dysfunction (Limber & Nation, 1998), it is also essential to identify and implement effective methods for preventing and reducing youth violence, particularly among adolescents who are at-risk for violence. In addition to the influencing factors discussed above, at-risk youth are characterized by poor school performance, limited family support, delinquent behavior, and influential relationships with anti-social peers (Dryfoos, 1993). They also are over represented in juvenile and family courts, foster and residential care, and in mental health programs.

Research has demonstrated the effectiveness of many interventions that prevent or reduce violence in at-risk adolescents. A previous report (Coyle, 2001) identified and reviewed empirically based programs for preventing and reducing adolescent violence. That report discussed 43 different, empirically researched programs, which included three
categories of interventions. Primary prevention programs, primarily school-based, educational programs, were presented to adolescents in general. Program content included primarily anger management and problem solving methods, prosocial skills, and alternatives to violence. Secondary prevention programs focused on at-risk teens or specific types of violence, such as bullying, dating or gang violence. The content was similar to primary prevention programs but was more likely to include additional components, such as mentoring, community service, relaxation or assertiveness training. Tertiary prevention programs provided treatment for adolescents with serious problems with violence. These interventions used individual and family therapy, individualized treatment plans, a broad range of community-based services, and services set in individual, family, peer, and community domains.

Common Elements of Empirically Researched Programs

A review of researched programs focusing on at-risk adolescents identified common program elements that impact effective outcomes. The following criteria were used to choose programs for this review: (a) program studies that used experimental or quasi-experimental designs; (b) program research that indicated effective outcomes (statistically significant differences in measured variables); (c) the intervention was described in enough detail that associations between methods and outcomes were possible; (d) measured variables addressed intervention content or methods (not just arrest rates or generalized measures of client success); (e) interventions focused on at-risk adolescents (found in secondary or tertiary prevention studies).

Fourteen programs from the previous report met these criteria (see Table 1). They were analyzed and common methods of intervention were determined. Further
information about those methods was gathered from a literature search that focused on the specific interventions. This research identified three additional programs (Arbuthnot & Gordon, 1986; Hawkins, Jenson, Catalano, & Wells, 1991; and Jackson, 2002) and one study that further researched Aggression Replacement Training (Nugent, Bruley, & Allen, 1998) that met the criteria described above and are also summarized in Table 1.

Also, research about effective services for at-risk youth was analyzed in order to further suggest effective methods for preventing and reducing adolescent violence. This literature suggested that effective services for at-risk youth included early intervention, collaborative, community-based services that use multiple domains, use of mentoring relationships, parental involvement, social skills and career training, and service provision by expert, supervised professionals (Dryfoos, 1993; Morley & Rossman, 1997). Particular emphasis on cognitive learning style (Kelley, 1993), moral reasoning (Arbuthnot & Gordon, 1986), empowering youth using a strengths approach (Laveman, 2000; Ungar & Teram, 2000), and use of socially supportive environments (Bender & Lösel, 1997; Richman, Rosenfeld, & Bowen, 1998; Rosenfeld, Richman, & Bowen, 1998; Royse, 1998; Tracy, Whittaker, Boylan, Neitman & Overstreet, 1995) was also found to be helpful.

The review of these literatures suggests that the following elements, present in numerous, researched programs, influence effective outcomes:

1. Anger management and problem solving skills training
2. Awareness of the consequences of violence and refuting beliefs supporting violence
3. Prosocial skills training and choice of prosocial peer relationships
4. Development of positive teen relationships with parents and with non-parental adults
5. Effective use of structure and limit setting
6. Focus on strengths and resilience
7. Interventions that use multiple domains (e.g., individual, family, peers, community)
8. Treatment that matches the adolescent’s individual needs

Although there is significant overlap between these elements, each will be discussed individually and program examples will be used to describe specific interventions used in each of these areas. Strengths and limitations associated with each of these elements will be noted.

*Anger management and problem solving* is the cornerstone of most programs that seek to prevent or reduce teen violence, either through educational methods or modeling improved approaches. Studies that indicated improved behavior following anger management training (Borduin, et al., 1995; Chamberlain & Reid, 1998; Eddy & Chamberlain, 2000; Guerra & Slaby, 1990; Hammond & Yung, 1991; Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993; Hovell et al., 2001; Huey; 1983; McCarthy-Tucker, Gold, & Garcia, 1999; Nugent, Bruley, & Allen, 1998) taught teens the difference between anger and aggression, how to express anger appropriately, resisting taunts, responding to other’s anger without using aggression, and appropriately giving and accepting negative feedback. Awareness of triggers, body sensations associated with anger, and resources for self control, assertiveness, and relaxation techniques were also used in some of the programs.
All of these studies showed improvement in anger management, although some had small samples (7 had less than 100 subjects; 3 had less than 50 subjects). The observational measures were not as significant as self-report measures; and the follow-up measures were less than posttest. But the broad-based use of this element suggests that it is an important part of effective intervention.

Problem solving skills helped teens with decision-making by helping them identify options, resist peer pressure, and develop alternatives to violent responses. Esbensen and Osgood (Esbensen & Osgood, 1997) used improved problem solving skills to help youth avoid gang membership and two other studies (Morrissey, 1997; Hawkins, Jenson, Catalano, & Wells, 1991) rewarded teens in residential care who chose behavior that followed institutional rules. Cognitive Mediation Training (Guerra & Slaby, 1990) improved social problem solving by helping teens question their perception of others’ hostility, search for further information about the situation, generate alternative solutions, identify consequences of violent solutions, and prioritize solutions according to the effectiveness of the desired outcome or goal. Methods were primarily cognitive-behavioral and educational; using role-plays and multimedia examples, although one program (Presley & Hughes, 2001) used peers to teach and model improved anger management. Other programs provided suggestions for interventions with emotionally disturbed adolescents (Kellner & Bry, 1999), developmentally delayed adolescents (Kellner & Tutin, 1995), and parent-child conflict (Stern, 1999). Female aggression was found to be different from males (Owens, Shute, & Slee, 2000), with females using more indirect methods of aggression, such as exclusion and telling false stories about others.
This indirect form of aggression requires educational approaches to discuss different examples, problem solving skills, and beliefs supporting the aggressive behavior.

Problem solving and anger management skills overlap each other, and in many instances were presented together.

*Consequences of violence and changing beliefs that support aggression* are also topics that are presented, to some degree, in most programs. The Gang Resistance Education and Training (G.R.E.A.T.) Program (Esbensen et al., 1997) used uniformed police officers to discuss the impact of violence and drugs on the community, cultural sensitivity and prejudice, personal responsibility and meeting own needs without gang membership. They also discussed conflict management and problem solving. Since a decrease in gang membership was the only measured outcome, the direct effect on attitudes and behavior is less clear.

The Bullying Prevention (BP) Program (Melton et al., 1998; Olweus, 1993, 1994; Olweus, Limber & Mihalic, 1998) focused on changing beliefs about violence through specific, enforceable rules in schools (at the school, classroom and individual levels). Olweus (1993) reported that bullies had a need for power, hostility toward others – perhaps related to anti-social family patterns – and received a benefit from bullying. They tended to react aggressively, have little empathy, and have the strength or size to use physical coercion. The program therefore emphasized responsibility for actions, enforcement of consequences, and attempted to eliminate the benefits of bullying behavior. School enforcement of rules against bullying also empowered students to resist bullying.
Cognitive Mediation Training (CMT, Guerra & Slaby, 1990) sought to change student beliefs that aggression is acceptable and discussed the consequences of violent versus non-violent options. Participants were asked to present arguments refuting beliefs that aggression is a legitimate response to conflict, that it enhances self-image, and does not significantly affect the victim.

CMT, G.R.E.A.T. and BP have all shown significant results with samples of more than 100 subjects, although replications of BP have been less effective than the original researcher’s studies. BP also tended to focus on younger children, and use with adolescents may be less effective, since teens may not respond as positively to the limit setting used.

Changing beliefs about aggression involves assessment of the adolescent’s learning style and moral reasoning. Kelley (1993) described how an “alienated frame of reference” (p. 440-2) increased the likelihood of perceiving another’s actions as hostile, which then leads to hostile responses. Kelley suggested that staff that modeled non-aggressive responses and showed unconditional positive regard and emotional support were necessary additions to behavioral training in order to change this frame of reference. Arbuthnot and Gordon (1986) found that improved behavior was associated with cognitive interventions that focused on improving moral reasoning, such as guided discussions of examples of moral dilemmas, e.g., witnessing shoplifting; modeling openness, acceptance, and respect for other’s views; and listening and communication skills training.

Prosocial skills and choosing prosocial peer relationships are associated with reducing antisocial behavior in adolescents (Kazdin, 1985). Aggression Replacement
Training (Coleman, Pfeiffer, & Oakland, 1992) used role plays and exercises to teach ten social skills: “expressing a complaint, responding to the feelings of others; preparing for stressful conversation; responding to anger, keeping out of fights; helping others; dealing with an accusation; dealing with group pressure; expressing affection; and responding to failure” (p. 54). Although participants showed a significant increase in knowledge of social skills, observed behavior did not change. This is possibly explained by a meta-analysis of social skills training for adolescents with behavioral disorders (Magee Quinn, Kavale, Mathur, Rutherford, & Forness, 1999), which suggested that social skills training is not effective enough by itself to result in more than modest outcomes.

The Youth Relationships Project (YRP) focused on reducing violence in teen dating relationships during the middle adolescent years (age 14 to 16) for teens who experienced maltreatment during childhood (Wolfe et al., 1997). YRP discussed power differences related to gender, breaking the cycle of relationship violence, skills for healthy relationships, societal influences on violence, and social action in communities for nonviolent relationships.

A study of an Afrocentric social skills training found no differences when compared to an intervention that was culturally relevant but not Afrocentric (Banks, Hogue, Timberlake, & Liddle, 1996), suggesting that interventions need to be aware of cultural differences but different programs are not needed for different populations.

Multisystemic Therapy (Borduin, 1999; Borduin & Shaeffer, 1998; Borduin et al. 1995; Henggeler, Melton, & Smith, 1992; Henggeler et al., 1993) presented interventions that included reducing associations with deviant peers, and Esbensen & Osgood (Esbensen et al., 1997) also focused on reducing antisocial peer relationships in a
program for reducing gang membership. These programs encouraged prosocial peer relationships through membership in church youth groups, organized sports programs, and after school activities. They emphasized parental monitoring of peer relationships, since lack of monitoring is associated with deviant peer relationships (Ary, Duncan, & Hops, 1999; Simons, Chao, Conger, & Elder, 2001). Although this literature showed improved adolescent behavior, it did not have specific measures of changes in peer relationships and the results of those changes. Alternatives to violence training, the reciprocal effect that subjects have on their peers, presence of community recreational resources, and community values may all influence the outcomes. Further research about peer relationship choices and the influences of those choices could help improve understanding of this process.

Positive relationships with parents and with non-parental adults are important in violence prevention and reduction programs and also in services for at-risk youth, since effective programs have noted the association between adult modeling and mentoring and youth behavior. Multisystemic Therapy (Borduin et al., 1995, Henggeler et al., 1992; Henggeler et al., 1993) and Functional Family Therapy (Alexander, Pugh, Parsons, & Sexton, 2000; Parsons & Alexander, 1973) included a family focus that sought to improve family relationships and parenting skills. Results indicated improved family functioning, decreased family conflict, and decreased adolescent aggressive behavior both at home and in the community.

In addition to discussions of normal adolescent development and effective parental limit-setting, the family counseling intervention included a family interactional module, which focused on helping teens and parents work together to increase family cohesion, problem solving, and communication. Families receiving the intervention reported increased levels of family cohesion and decreased acting-out behavior in teens.

These studies used multiple measures (e.g., psychometric, parent and youth self report, and observation) that demonstrated that improved parent-child relationships result in improved family functioning and reduced violent behavior.

Big Brothers Big Sisters (Tierney, Grossman, & Resch, 2000) and the Quantum Opportunities Program (QOP; Hahn, Leavitt, & Aron, 1994; Lattimore, Mihalic, Grotpeeter, & Taggart, 1998) have found that positive relationships with non-parental adults influenced improved youth behavior and could also compensate for poor family relationships. Both programs used relationships with volunteer adult mentors as their primary intervention, with QOP including various other community interventions (primarily remedial education and career preparation) in its program. Although both programs reported positive outcomes, their affect on violence is indirect, and the association with violence reduction or prevention is unclear. Another mentoring program that matched young adolescents with college students for 15 to 20 hours per week (Jackson, 2002) found decreases in externalizing and internalizing behavior by teens from parental reports but found no differences from teacher reports.

A number of studies examined the impact of social support on at-risk youth (Bender et al., 1997; Richman et al., 1998; Rosenfeld et al., 1998; Royse, 1998; Tracy et al., 1995). Although Royse (1998) discussed the difficulty of measuring successful
outcomes of mentoring relationships, in general, these studies indicated that supportive relationships outside of the family were associated with improved outcomes, particularly for those youth with unsupportive nuclear families. They suggested that interventions include mentoring relationships, social skills training to increase use of supportive relationships, and enhancing community and neighborhood resources.

*Effective use of structure and limit setting* is an important component of many of the intervention programs. Programs that include family interventions (Alexander et al., 2000; Borduin et al., 1995; Henggeler et al., 1992; Henggeler et al., 1993; Parsons & Alexander, 1973) stress the importance of parenting skills that include clear descriptions of expectations, specific consequences, open discussions and contracting between parents and adolescents, and flexibility based on ultimate goals rather than rigid rules and consequences. Improved parental monitoring of peer relationships can indirectly affect aggressive behavior that is influenced by antisocial peers (Murray, Kelder, Parcel, Frankowski, & Orpinas, 1999). Anger management for parents and adolescents (Stern, 1999), and behavior management programs for families of teens with Attention Deficit Hyperactive and Oppositional Defiant Disorders (Barkley, Edwards, Laneri, Fletcher, & Metevia, 2001) were also found to be effective.

Institutional constraints in foster care and residential treatment facilities have also been effective in shaping adolescent aggressive behavior (Chamberlain et al., 1998; Chamberlain & Mihalic, 1998; Eddy & Chamberlain, 2000; Morrissey, 1997; Scholte & van der Ploeg, 2000). Specific limit setting and enforcement of consequences, particularly when the average level of structure is balanced with an average amount of emotional support (Scholte & van der Ploeg, 2000), were associated with improved
behavior. These programs were also able to use structural constraints to offset the negative effects of using group treatment with adolescents, which in community settings often results in increased acting-out behaviors.

A Bullying Prevention Program (Melton et al., 1998; Olweus, 1993, 1994; Olweus et al., 1998) used limit setting in schools to change bullying behavior and change responses by victims through the use of increased monitoring and enforcement of consequences for bullying behavior.

Although behavioral changes resulting from these interventions may be influenced by skills training components, maturation effects, individual youth differences, or possible mentoring relationships, it seems likely that the structural constraints do have some independent impact on aggressive behavior. Further understanding of the relative impact of these influences would help develop more effective programs. Also, longitudinal research would be helpful to determine the extent that behavior change continues once youth have left the constraints in institutional settings.

*Focus on strengths and resilience* helps at-risk teens and families discover and use the skills and capacities that already exist. The Harmonium Project (Laveman, 2000) was a collaborative, community-based intervention that used solution focused counseling to help at-risk adolescents experience a greater connection with their communities leading to more meaning in their lives. Empowerment resulted from collaboration, use of strengths, a reciprocal link between individuals and their environment, and personal responsibility for actions. This strengths-based approach helped youth identify specific
behavior that got them into trouble and the personal, family and community resources that helped ameliorate that behavior.

Ungar and Teram (2000) described how empowering youth to redefine their personal identity improved their overall mental health and worldview. This process used a narrative approach in which high-risk youth, through a social discourse method, changed the perspective of their personal stories from negative and helpless to strong and healthy.

Functional Family Therapy (Alexander et al., 2000; Parsons & Alexander, 1973), Multisystemic Therapy (Borduin et al. 1995; Henggeler, 1992, 1993; Huey et al. 2000), and Multidemensional Treatment Foster Care (Chamberlain and Reid, 1998; Eddy & Chamberlain, 2000) are all broad-based treatment programs that included assessment and use of individual and family strengths. These strengths were seen as protective factors that offset the risk factors that influenced violent and other problem behavior. This is the process of resilience: the ability to bounce back after adversity. It is characterized by individual qualities such as insight, independence, relationship skills, initiative, sense of humor, creativity, and moral foundation (Wolin & Wolin, 1993), and family and community factors such as positive relationships with parents, effective parental monitoring of youth activities, and presence of supportive relationships in schools and in the neighborhood (Kirby & Fraser, 1997). These strengths and resources help adolescents have positive expectations for the future, which results in decreased problem behavior and reduced negative peer influence (Dubow, Arnett, Smith, & Ippolito, 2001). Positive family relationships and effective parental monitoring are also associated with reduced problem behavior (Dishion & Andrews, 1995). Although research measuring the
specific association between strengths and resilience focus and aggressive or acting-out behavior is limited, this approach underlies the interventions of much of the effective programs that target at-risk youth.

*Use of multiple domains* suggests that interventions that target individual, family, peer, and community relationships are more effective, particularly when these interventions are coordinated and collaborative (Morley et al., 1997). This is particularly important for adolescents who have severe problems with violence. The broad-based treatment programs discussed in the previous section (Alexander et al., 2000; Borduin et al. 1995; Chamberlain and Reid, 1998; Eddy & Chamberlain, 2000; Henggeler, 1992, 1993; Huey et al. 2000; Parsons & Alexander, 1973) acknowledged this. They provided individual behavioral training and therapy, family treatment and linkage with community resources in order to compensate for the significant risk factors that were already present for these teens. The previous discussion about the benefits of positive relationships with parents and with non-parental adults also supports the use of these domains for effective interventions.

*Matching adolescent’s individual needs* is another factor that is present in many treatment programs for high-risk adolescents. Although more generic interventions that include anger management, problem solving, and changing beliefs that support violent solutions may be effective for at-risk youth who have yet to exhibit severe violent behavior, the more problematic the youth’s behavior is, the more individualized the treatment program needs to become. It needs to address different factors that support violent behavior, such as family dysfunction, history of maltreatment, mental health and substance abuse, influence of antisocial peers, or lack of positive role models and
community recreational resources. Functional Family Therapy (Alexander et al., 2000), Multisystemic Therapy (Borduin et al., 1995; Henggeler, 1992, 1993; Huey et al. 2000), and the Quantum Opportunities Program (Hahn et al., 1994) assessed the individual and family needs and arranged services that met those needs. The predominant use of individual treatment plans in programs that treat delinquent and conduct disordered youth suggests that this is an important element when planning treatment for a range of at-risk teens.

These eight program components with suggested interventions for each component is provided in Table 2.

Modalities for Delivering Interventions

The components discussed above primarily describe the content of program interventions. Various modalities were used to present this content to at-risk adolescents and their families. Behavioral training methods included didactic, experiential, and multimedia approaches. Many of the studies suggested that the use of role-plays and other experiential exercises improved learning. Most of the training interventions used a cognitive-behavioral approach in which attitudes, perceptions, judgments and behavior were all targeted for change. Individual and family therapy were part of the intervention strategy used in all the broad-based programs for youth with violent histories. Three programs used financial incentives (Hahn et al., 1994; Hammond & Yung, 1991; Morrissey, 1997).

Although some of the programs lasted a school year or more, most of the programs included approximately 12 training and/or therapeutic sessions, suggesting that longer-term interventions are not necessary for effective change. For those teens with a
more extensive history of violent behavior, multiple interventions, in multiple domains, used simultaneously, were effective, even in short time spans (3 to 6 months). Although such programs (Alexander et al. 2000; Borduin et al., 1995; Henggeler et al., 1992, Henggeler et al., 1993) reported that intensive treatment was important, the absence of longitudinal studies of youth violence intervention leaves questions about the need for ongoing services or support mechanisms in order to continue improved behavior.

Implications

Concerns about violent youth are present in schools, communities, mental and physical health programs, social service programs, foster care and residential treatment facilities, and in the juvenile justice system, and programs addressing those concerns are being developed and implemented. The empirical research has suggested effective strategies for preventing and reducing violence by at-risk adolescents. These strategies have behavioral training components, use supportive relationships, and focus on individual needs and strengths. Programs addressing adolescent violence should refer to these empirically based models in order to increase effective outcomes and expand awareness and understanding of treatment components that work.

The eight common program elements suggest important areas to include in interventions addressing youth violence. Anger management, problem solving, awareness of the consequences of violence, challenging beliefs that support violence, and prosocial skills are essential for at-risk teens who need to be able to choose alternative methods of problem solving and develop personal qualities that help them choose non-violent methods. Prosocial peer relationships, positive relationships with parents, and supportive relationships with non-parental adults provide guidelines for social
interactions that prevent or replace violent interchanges. Clear limits, consequences, and structure help young people learn prosocial decision-making prior to the painful life experiences that could ultimately inform and motivate such decisions. Structure and education can also help challenge previous life experiences that can lead to angry misinterpretations and little hope for a positive future. Individual and family strengths, community resources, and collaborative services that meet individual needs increase the possibility of positive outcomes, particularly when there are significant risk factors associated with increased use of violence.

There are some limitations in these program elements. Although they are well researched, some of the outcome measures relate to knowledge learned or responses to role-play examples rather than specific changes in observed behavior. And although interventions that include multiple areas of content in multiple domains are considered beneficial, it is difficult to assess the impact of any single element on the adolescents’ behavior change. The multiple elements also lead to more complex program interventions, which may make planning, implementing and evaluating interventions more difficult. Finally, no intervention works for all youth, and further exploration for promising interventions should continue.

In the meantime, these eight common program elements can provide a useful tool for organizing effective interventions for preventing and reducing violence by at-risk adolescents.
Table 1

*Empirical Programs for Preventing and Reducing Violence by At-risk Adolescents*

<table>
<thead>
<tr>
<th>References</th>
<th>Intervention</th>
<th>Primary Outcomes</th>
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<tbody>
<tr>
<td>Alexander et al., 2000; Parsons &amp; Alexander, 1973</td>
<td>Functional Family Therapy (FFT): targets risk and protective factors in youth &amp; families using 3 phases: engagement &amp; motivation, behavior change, and generalization. Uses a multisystemic context for assessment and intervention.</td>
<td>Reductions in re-arrests; improvement in family communication and interactions, including reduced family conflict.</td>
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<tr>
<td>Borduin et al., 1995; Henggeler et al., 1992, Henggeler et al., 1993; Huey et al., 2000.</td>
<td>Multisystemic Therapy (MST): focuses on individual, family, peer, school &amp; neighborhood factors that influence antisocial behavior. Individual treatment plans are pragmatic and goal oriented, using multiple levels of support. Treatment is intensive and uses primarily cognitive-behavioral therapy approaches.</td>
<td>Reductions in criminal activities including violent offenses. Reductions in externalizing symptoms, primarily aggression and violent attitudes.</td>
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<tr>
<td>Chamberlain &amp; Reid, 1998; Eddy</td>
<td>Multidimensional Treatment Foster Care (MTFC) is an alternative to institutional care. It is a structured, individualized</td>
<td>Reduction in days of incarceration, arrests, self-reported delinquency, &amp;</td>
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Preventing and Reducing Adolescent Violence 20
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<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>Aggression Replacement Training (ART)</td>
<td>has 3 components: social skills training, anger control, and moral education.</td>
<td>Improved social skills knowledge (Coleman et al.), &amp; decreased antisocial behavior (Nugent et al.).</td>
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<tr>
<td>Gang Resistance Education &amp; Training (G.R.E.A.T.)</td>
<td>Uniformed police officers teach about crime, victims, cultural sensitivity, conflict resolution, meeting needs without gang membership, goal setting and personal responsibility.</td>
<td>Lower levels of gang affiliation and delinquency. Reductions in impulsive behavior, improved communication with families, and enhanced self-esteem.</td>
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<tr>
<td>Cognitive Mediation Training (CMT)</td>
<td>Includes social skills training, changing beliefs supporting aggression, and problem solving training.</td>
<td>Improved social problem solving, beliefs about aggression, and prosocial behavior.</td>
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<tr>
<td>Quantum Opportunities Program (QOP)</td>
<td>Is a multi-year, comprehensive service program using adult mentors and individual treatment plans including</td>
<td>Increased high school graduation, post high school education, volunteering in community</td>
</tr>
<tr>
<td>Study</td>
<td>Intervention</td>
<td>Description</td>
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<tr>
<td>Hammond &amp; Yung, 1991</td>
<td>Positive Adolescent Choices Training (PACT)</td>
<td>Includes education about communication, negotiation, problem solving, and resisting peer pressure.</td>
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<tr>
<td>Hovell et al., 2001</td>
<td>Anger Management Skills Training (AMS)</td>
<td>Measures ability to resist taunts, recognize negative and positive responses, use aggressive behavior, and assertiveness.</td>
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<tr>
<td>Jackson, 2002</td>
<td>Mentoring program</td>
<td>Matching college students with youth who had conduct problems for 15–20 hours per week.</td>
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<tr>
<td>McCarthy-Tucker et al., 1999</td>
<td>Anger Management Training (AMT)</td>
<td>Discusses what is anger, what causes anger, difference between anger &amp; aggression, internal &amp; external cues, assertiveness, communication &amp; relaxation skills.</td>
</tr>
<tr>
<td>Source</td>
<td>Program Description</td>
<td>Outcome</td>
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<tr>
<td>Melton et al., 1998, Olweus,</td>
<td>Bullying Prevention Program (BP) is a school-based program using increased supervision of individuals, classrooms, and school “hot spots,” including school wide educational conference and establishment &amp; enforcement of rules.</td>
<td>Reduced reports of bullying and other antisocial behavior. Increased student reports of school order, discipline, positive attitudes towards school.</td>
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<tr>
<td>Morrissey, 1997.</td>
<td>Multimodal Approach (MM): behavioral point system used in residential treatment setting, individual &amp; group counseling, and behavioral skills training.</td>
<td>Decrease in violent incidents &amp; assaults, and decreased assigned room time for violent behavior.</td>
</tr>
<tr>
<td>Scholte &amp; van der Ploeg, 2000</td>
<td>Residential Care (RC) using flexible structure and support. Components: structure and behavioral regulation, consistency and predictability of adaptive demands, autonomy &amp; individuality, emotional support, &amp; trustworthiness.</td>
<td>Decreased aggressive behavior; increased skills in independent living, education &amp; work; and improved relationship with parents for program completers.</td>
</tr>
<tr>
<td>Tierney et al., 2000.</td>
<td>Big Brothers Big Sisters (BBBS): mentoring program with 5 goals: develop successful relationship; provide social, cultural &amp; recreational enhancement; improve peer relationships &amp; self-concept; improve motivation &amp; attitude; and schoolwork achievement.</td>
<td>Reduced drug/alcohol abuse, hitting someone, lying. Increased schoolwork completion, school attendance, parental relationship, emotionally supportive peers.</td>
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Table 2  

*Common Youth Violence Prevention Program Components with Suggested Interventions*

**Anger management and problem solving skills training**
- Definition of anger and how anger is different from aggression
- Internal and external cues that trigger anger and aggressive behavior
- Self-control and relaxation skills
- Resisting taunts, accepting negative feedback, responding appropriately to negative feedback
- Stop and think: why is there a conflict and what do I want?
- Getting further information, challenging perceptions of hostility, identifying alternative responses, prioritizing potential responses according to effectiveness

**Awareness of the consequences of violence and refuting beliefs supporting violence**
- Information about the impact of violence on victims, families, neighborhoods
- Violence as a loss of self-control
- Reframing beliefs supporting violence, such as cultural, gender, and peer group issues that suggest violence is an acceptable solution for conflict
- Identifying and evaluating alternatives to violence

**Prosocial skills training and choice of prosocial peer relationships**
- Communication skills, accepting and giving positive and negative feedback
- Negotiating skills, assertiveness skills, identifying own needs & goal setting
- Participation in organized youth organizations and activities
- Parental monitoring of peer relationships
Development of positive teen relationships with parents and with non-parental adults
  - Family communication, listening skills, negotiation and contracting skills
  - Emotional support from parents and non-parental adults
  - Regular, planned involvement with adult mentors

Effective use of structure and limit setting
  - Effective parenting skills, including flexible limit setting, and predictable and consistent consequences
  - Clear rules and consequences in schools and community settings

Focus on strengths and resilience
  - Strengths, skills, talents, capacities identified in individuals, families, peers, neighborhoods, communities
  - Treatment plans focus on using and developing strengths and resilience

Interventions that use multiple domains (e.g., individual, family, peers, community)
  - Services and treatment plan identify and use resources in all available domains

Treatment that matches the adolescent’s individual needs
  - Assessment of adolescent’s and families specific needs
  - Treatment plans that address specific needs
References


