Couple and Family Psychology: Research and Practice
2012, Vol. 1, No. 2, 120–133
© 2012 American Psychological Association
2160-4096/12/$12.00 DOI: 10.1037/a0028832

Common Elements of Family-Based HIV Interventions for Adolescents

Marguerita Lightfoot
University of California, San Francisco

Norweeta Milburn
University of California, Los Angeles

Family-based interventions are an efficacious and effective way to prevent negative developmental outcomes for adolescents. This article reviews the family-based interventions that have been found to be efficacious in improving protective factors and reducing HIV-related risks and behaviors in parents and their adolescents. The review is the foundation for an examination of the common elements across the efficacious family-based interventions. There are a number of common strategies and elements encompassing these evidence-based interventions that provide direction about effective practices for families that can assist providers and clinicians to incorporate evidence-based content or elements and processes into their work with families.

Keywords: adolescents, parents, family, interventions

Developmental and other research suggests the need for and importance of family-based interventions for adolescents who are at risk for HIV (Taylor & Biglan, 1998). Positive, warm, and nurturing parent–child relationships support the safe trajectory of adolescents into adulthood and deter risky behaviors that can derail a smooth transition (Sandler, Schoenfelder, Wolchik, & MacKinnon, 2011; Steinberg & Morris, 2001). Adolescents do best when their relationship with their parents is positive (Dittus & Jaccard, 2000) and communication is open (Akers, Holland, & Bost, 2011). Parents who engage in what are viewed as good parenting practices, such as continuing to monitor their adolescents and establishing family routines and rituals, usually have adolescents with healthier developmental outcomes (e.g., engage in more prosocial behaviors and fewer behavioral problems) (Grusec, 2011). These parenting practices, however, are often the most difficult to continue when children become adolescents because parent–child relationships can be more conflictual, less warm, and less cohesive during adolescence, especially early adolescence (Smetana, Campione-Barr, & Metzger, 2006). Families clearly need support during this transitional period when adolescents are also maturing sexually and may engage in unsafe behaviors that put them at increased risk for HIV infection (Sandler et al., 2011).

Family-based interventions are an efficacious and effective way to intervene and assist parents and adolescents in managing the transition to adulthood (Taylor & Biglan, 1998). Family-based interventions have been used across racial and ethnic groups (Baptiste et al., 2009; Pantin et al., 2003) and with many different high-risk adolescent populations including adolescents who are delinquent (Henggeler, Melton, & Smith, 1992), suicidal (Rotheram-Borus, Piacentini, Miller, Graae, & Castro-Blanco, 1994), substance users (Dishion & Owen, 2002; Hawkins & Fitzgibbon, 1993; Kumpfer, Alvarado, Tait, & Turner, 2002), homeless (Milburn et al.,2012), and have parents living with HIV (Rotheram-Borus et al., 2003; Rotheram-Borus, Lee, Lin, & Lester, 2004). Consequently, family-based interventions are increasingly being used to prevent HIV infection in adolescents (Milburn et al., 2012).

While research has underscored the importance of family-based interventions, their widespread adaptation by providers and clinicians for HIV prevention has been slow. This article intends to help accelerate the adaptation and

Marguerita Lightfoot, Department of Medicine, University of California, San Francisco; Norweeta Milburn, Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles.

Correspondence concerning this article should be addressed to Marguerita Lightfoot, UCSF Center for AIDS Prevention Studies, 50 Beale Street, Suite 1300, San Francisco, CA 94105. E-mail: mal@ucsf.edu

implementation of evidence-based approaches. First, we provide a brief general overview of the seven family-based interventions that have been found to be efficacious in improving protective factors and reducing HIV-related risks and behaviors. We then identify the common elements across these efficacious family-based interventions that are grounded in the strong literature on family practice that support healthy child development. Understanding common elements that encompass these evidence-based interventions can facilitate greater implementation by providing direction to and assisting providers and clinicians in incorporating evidence-based practices into their work with families. We conclude with a discussion of the implications for clinical practice, as well as adaptation and dissemination, of identifying the common elements in family-based interventions.

Overview of Family-Based HIV Interventions

We begin with an overview and discussion of efficacious family-based HIV interventions. Most HIV interventions for adolescents that involve parents focus on teaching parents how to communicate with their adolescents about sexual topics and substance use and often include media campaigns, videos, and workshops (Coyle et al., 1999; Crawford et al., 1990; Dilorio, McCarty, Resnicow, Lehr & Denzmore, 2007; Dilorio, Resnicow, McCarty, De, Dudley, Wang, & Denzmore, 2006; Forehand et al., 2007; Guilamo-Ramos et al., 2011; Huston, Martin, & Foulds, 1990; Miller et al., 1993; O'Donnell, 2010; Schuster et al., 2008). These interventions have been efficacious in increasing knowledge about safe sex practices or intention to communicate about sex and some have positive behavioral outcomes, such as delaying initiation of sex and increased condom use. One could argue, however, that most of these interventions are not truly family-based because parents and adolescents are treated separately and not as a family unit. It is more accurate to classify them as parent-based (or parenting) interventions. Very few interventions bring parents and adolescents together in at least one session (Baptiste et al., 2009; Brody, Kogan, Chen, & McBride Murry, 2008; Milburn et al., 2012; Pantin et al., 2003).

This overview only focuses on family-based interventions that included at least an equal number of conjoint and separate sessions. For example, we included a 16-session intervention where the parents and adolescents were together for 8 sessions (Rotheram-Borus et al., 2003). We did not include an eight-session intervention intended to increase communication about sex and condom use that was delivered only to parents at their workplace (Schuster et al., 2008). Further, all of the identified interventions have been efficacious in increasing protective factors for adolescents (e.g., Brody et al., 2004) or decreasing sexual and substance use risk behaviors (e.g., Milburn et al., 2012). The interventions are presented in chronological order of development, starting with the earliest to provide a historical perspective that demonstrates how intervention content and delivery has evolved with changes in social and public policy (e.g., degree of specific information about sexual behaviors) and technology (e.g., use of videotapes). Table 1 provides a summary of the seven interventions.

FACTS & *feelings*

One of the first family-based HIV prevention interventions is the FACTS *& feelings* program (Miller et al., 1993), which focused on parent-adolescent communication about sex to promote abstinence among early adolescents, ages 12 to 14 years. The intervention consisted of six videotaped units about sex that range from less threatening to more threatening topics (1, Changes—changes associated with puberty such as physical changes; 2, Values—values pertaining to sexual behavior such as abstinence and core values such as "respect for oneself" and "respect for others"; 3, Facts—facts such as anatomy and reproduction; 4, Meanings—what sexuality means and the importance of abstinence and delaying sexual intercourse; 5, Choices—consequences of early initiation of sexual behaviors including intercourse; and 6, Skills—refusal skills). Brief printed materials were provided with the videotapes. The videotapes were designed for parents and adolescents to watch together. The videotapes were delivered to the home and collected at the end of three months. Biweekly reminder phone calls to watch the videotape were made by the

Table 1
Family-Based HIV Interventions

Intervention	Sample	Site	Findings
FACTS & *feelings*	n = 548 Adolescent, mother and father 12 to 14 years	UT	Increased frequency and quality of parent-adolescent communication
ImPACT (Informed Parents and Children Together)	n = 237 Adolescent, parent/ guardian 12 to 16 years	Mid-Atlantic city	Increased adolescent and parent condom use skills
Project TALC (Teens and Adults Learning to Communicate)	n = 412 Adolescent, parent 12 to 18 years	NY	Decreased adolescent drug use, number of sexual partners and pregnancies
Familias Unidas	n = 242 Adolescent, primary caregiver 12 to 17 years	FL	Reduced substance use and unprotected sex
Strong African-American Families	n = 332 Adolescent, mother 11 years	GA	Improved communication
Caribbean Family HIV Workshops	n = 180 Adolescent, primary caregiver 12 to 14 years	Trinidad and Tobago	Increased parent HIV knowledge and attitudes, parent communication, and parental monitoring
STRIVE (Support to Reunite, Involve, and Value Each Other)	n = 151 Adolescent, parent/ guardian 12 to 17 years	CA	Decreased substance use and number of sexual partners

interventionists who delivered the videotapes. Data on use of the videotape were collected at that time.

A randomized control trial (RCT) of FACTS & *feelings* was conducted with a predominately European-American sample of parents and adolescents with three months and delayed (12 months) follow-up assessments (Miller et al., 1993). Families of seventh and eighth grade students were recruited through the schools in rural and urban school districts in Utah. Families were randomly assigned to one of three intervention or control conditions: videotapes and newsletters, videotapes, and control that did not receive the videotapes or the newsletters. Both interventions improved the frequency of parent–adolescent communication for the adolescents and their parents, both fathers and mothers, compared with the control group. Comparing the two treatment groups, the use of videotapes and newsletters improved the frequency of parent-adolescent communication for the adolescents slightly more than the use of videotapes alone. There was no difference for the parents. Both interventions also improved the quality of parent-adolescent communication for the fathers and mothers in the treatment groups compared to the control groups.

ImPACT (Informed Parents and Children Together)

The ImPACT program (Stanton et al., 2000) targeted parental monitoring and parent-adolescent communication about HIV, and safe sex practices (e.g., abstinence, condom use and not combining sex and substance use) to improve condom use skills (e.g., how to put condom on properly without tearing it, etc.). Similar to the FACTS & *feelings* program, a videotape was used to present the content of the intervention. The videotape, which provided examples and information on HIV risks and parental monitoring via interviews, conversations between parents and adolescents, and discussions among adolescents, was shown in homes by an interventionist. Families watched the videotape with the interventionist, role played with scripted vignettes, demonstrated how to use a condom, listened to the interventionist (e.g., facilitator) highlight the most salient points of the videotape, and did another role play.

A RCT of ImPACT was conducted with African-American adolescents, ages 12 to 16 years, and their parents/guardians with two- and six-month follow up assessments (Stanton et al., 2000). Families were recruited from public housing sites. Participants were randomized to the ImPACT intervention condition or a control

condition that consisted of another video that focused on education and career planning (the Goal for IT program developed by the same research team that developed ImPACT). The duration and implementation of each condition were the same including a video, exercises, and printed materials. ImPACT had a positive effect on condom use skills for both adolescents and parents. Adolescents and parents in the intervention group were more likely to engage in the skills necessary to use a condom correctly than their counterparts in the control group.

Project TALC (Teens and Adults Learning to Communicate)

The earlier family-based interventions rely on videotapes for fidelity, but more recent and current family-based interventions, such as Project TALC and the remaining interventions that will be discussed in this article, ensure fidelity by providing manualized group or individual family sessions delivered by trained facilitators. Project TALC consisted of 24 sessions that are delivered in groups; 16 of these sessions included the parent and adolescent together in the group (Rotheram-Borus, Lee, Gwadz, & Draiman, 2001; Rotheram-Borus, Lee, Leonard, Lin, Franzke, et al., 2003). The first eight sessions focused on the HIV+ parent dealing with adapting to being HIV+, maintaining a healthy lifestyle, addressing stigma, and disclosure issues. The remaining sessions for both the parent and adolescent targeted parent–child relationships, avoiding risky sexual behaviors, refusal, and condom use skills. Problem-solving and goal setting activities were integral to all the sessions.

A RCT of Project TALC was conducted with predominantly ethnic/racial minority (35% African American and 50% Latino/a) adolescents, ages 11 to 18 years, with a parent living with HIV/AIDS (Rotheram et al., 2003). Adolescents with an HIV positive parent were recruited through an AIDS services program. Families were randomly assigned to the Project TALC intervention group or a usual care control group. Comparing the intervention and control groups, Project TALC produced improved mental health in parents (e.g., reduced anxiety) and adolescents (e.g., reduced conduct disorders, anxiety and depression), and decreased drug use, the number of sexual partners, and pregnancies among adolescents and the effects lasted for at least four years.

Familias Unidas

Family-based interventions that target specific ethnic/racial minority groups have also emerged. The Familias Unidas intervention was designed for Hispanic families (Pantin, Coatsworth, Feaster, Newman, Briones et al., 2003; Prado et al., 2007; Prado & Pantin, 2011). The intervention consisted of three primary components: (1) parent groups wherein parents learn from other parents to develop skills to address sexual risk behaviors and substance use with their adolescent children; (2) home visits from a highly trained facilitator who works with the parents to teach the skills that they have learned to their adolescent children; and (3) having parents engage in all the major areas of the adolescents' life (family, peer, school). The intervention provided opportunities for parents to interact with their adolescents' peers and conducted visits to school counselors to increase understanding of school life. The intervention has been found to be efficacious in reducing substance use and unprotected sex at three months follow up (Prado et al., 2012) in a recent RCT with a sample of at-risk Hispanic delinquent adolescents recruited in schools and referred by juvenile services.

Strong African-American Families

The Strong African-American Families program consisted of seven weekly separate sessions for parents and adolescents and joint parent-adolescent sessions (Brody et al., 2004). The sessions were done consecutively so that parents and adolescents meet in their respective groups and then came together to practice and rehearse what was learned in the separate sessions. Parents learned about parental monitoring, racial socialization, how to communicate about sexual issues, and how to set expectations about alcohol use. Adolescents learned about following household rules, how to cope with racism, goal setting, substance use, and how to resist negative influences. Information was provided to parents and adolescents in the sessions via videotapes, guided discussions and role-plays.

The efficacy of the Strong African-American Families program intervention has been examined in a RCT with African-American adolescents, age 11 years, and their mothers with a seven-month follow assessment (Brody et al., 2004). Families were randomly selected at the county level after randomization from school-provided lists of 11-year-old students. The control condition did not receive intervention. Comparing the intervention and control groups suggested the Strong African-American Families program improved communication and increased adolescent protective factors such as having goals, being accepting of parental influence about alcohol, having a negative image of drinkers, and feeling efficacious about resisting substance use.

Caribbean Family HIV Workshop

The Caribbean Family HIV Workshop was a 12-module intervention with core elements that include the following: (1) multifamily groups with parent and youth breakout groups and individual family discussions, (2) parent-adolescent communication about sex, puberty, cultural influences, and HIV risks, (3) clear and accurate information on HIV, (4) workbook activities, and (5) concrete HIV prevention tips and action steps (Baptiste et al., 2007).

The efficacy of the Caribbean Family HIV Workshop has been examined in a RCT with a six-month follow-up assessment. Parents of adolescents were recruited through flyers and open houses at community settings such as schools and churches. Parents and their adolescents, aged 12 to 14 years, were randomized to the intervention or control group. The control group attended a workshop on family-related topics and received printed materials including information on HIV and other STI. Parents who participated in the intervention, when compared with those in the control group, showed improvements in HIV knowledge and attitudes, general communication and communication about sex, as well as parental monitoring.

STRIVE (Support to Reunite, Involve and Value Each Other)

The STRIVE (Support to Reunite, Involve, and Value Each Other) (Milburn et al., 2012) program is a brief five-session intervention that targets homeless adolescents and a parent or guardian. The sessions' content based upon cognitive–behavioral theories was designed to improve problem solving and conflict resolution skills. The intervention tools included the following: tokens to reinforce desired behaviors, a feeling thermometer to teach emotional regulation, a "think-feel-do" problem-solving model to operationalize and tackle problems, role playing, and reframing to conceptualize problems and solutions in a way that does not blame the parent or the adolescent.

A RCT of the STRIVE intervention was conducted with predominantly ethnic/racial minority (Latino/a 62% and African American 21%) sample of homeless adolescents, ages 12 to 17 years, and their parents. Homeless adolescents were recruited from community-based settings (e.g., shelters and schools) and direct recruitment (e.g., advertisements and flyers). Families were randomly assigned to the intervention or control condition. The control condition was standard care or referrals for services. The STIVE intervention was found to be efficacious over 12 months; adolescents in the intervention group reported engaging in less sexual risk behaviors (e.g., fewer sexual partners), substance use, and delinquent behaviors than those in the control group.

Common Elements of HIV Family-Based Interventions

Identifying the seven efficacious family-based interventions allows us to consider the commonalities across these programs that are grounded in the strong literature on the family practices that support healthy child development. The success of these interventions in assisting families to improve protective factors (e.g., communication) and adolescents to reduce sexual risk behaviors provides valuable insight for how to successfully work with families to reduce the HIV-related risk behaviors of their children. We identify the common elements or those family practices and constructs that are targeted to produce change across these evidence-based interventions to inform providers and clinicians in their own work to improve protective factors and reduce adolescent risk behaviors. The common elements provide direction on what should be targeted and encouraged in families to im-

prove adolescent outcomes. Currently access to evidence-based family programs is limited; however, the reach of these interventions into practice can be extended by the identification of the elements that are common across interventions to further build evidence-based practice with families.

The examination of common elements across evidence-based interventions has precedence in the child and youth treatment literature (Chorpita, Becker, & Daleiden, 2007; Chorpita, Daleiden, & Weisz, 2005) and more specifically in HIV prevention (Rotheram-Borus, Ingram, Swendeman, & Flannery, 2009; Rotheram-Borus, Swendeman, et al., 2009). Recurring findings indicate different psychotherapeutic models (e.g., cognitive–behavioral, psychodynamic) have resulted in common outcomes (Bickman, 2005), suggesting there are underlying common elements, effective practices, and constructs in these interventions that extend beyond the theoretical or conceptual approach (Chorpita et al., 2005) (e.g., problem-solving and self-monitoring). For example, Rotheram-Borus, Swendeman, and colleagues (2009) identified common elements at the highest level of abstraction (e.g., establish a framework to understand behavior change). By distilling evidence-based interventions into core elements, the focus of assisting families can move beyond implementation of specific evidence-based interventions toward the incorporation of effective, evidence-based practices. We extend this work by identifying the core and common elements in each of the identified interventions.

Although some of the evidence-based family-based interventions are founded on common theories and conceptual models to inform the design of the interventions (e.g., Social Cognitive Theory, Health Belief Theory), some family-based interventions are also uniquely shaped by other theories (e.g., Ecodevelopmental Framework, Prototype/Willingness Model), and many identify multiple theories or models that guide the intervention. However, their implementation has resulted in common outcomes, increasing protective behaviors and reducing HIV-related risk behaviors. In addition, because each of these family-based interventions is behavioral in nature, seeking to teach skills in parenting and risk reduction., commonalities in the interventions' approaches would be expected. Our overview of these family-based interventions does not focus on identifying the theoretical constructs or the specific techniques (e.g., role-playing activities) that are common across interventions. Rather, we conducted a global review of the intervention manuals and/or the article that described the family-based intervention and its theorized change mechanisms to identify the family practices or constructs common across these efficacious programs. We have identified four common elements contained in each of the seven evidence-based interventions. Although the techniques to address the elements might have differed across interventions, the following common elements were targeted in each of the seven programs. We provide empirical evidence for the focus on each common element, supporting their likelihood as meaningful contributions to the positive outcomes of these family-based interventions, and discuss examples from the programs to illustrate how the common elements are implemented.

Parental Knowledge, Attitudes, and Values

Universally, the evidence-based family-based interventions sought to address parental knowledge, attitudes and values about sex, sexual and reproductive health, and HIV. The interventions acknowledged parents as the primary and preferred providers of sexual information (Martinez, Abma, Copen, & National Center for Health Statistics, 2010) and that parents providing accurate and up-to-date information to their children is crucial. Provision of accurate information is particularly important as prior research has found that parents, even when they provide information to their adolescents, often have inaccurate or incomplete knowledge about contraception and other sexual health topics (Eisenberg, Bearinger, Sieving, Swain, & Resnick, 2004). Parents require accurate information regarding adolescent development to help place their adolescents' behavior into a healthy context.

Further, parents' attitudes toward adolescent sexual activity influence their adolescents' behavior. Prior research has found that adolescents who perceive their parents as permissive about adolescent sexual activity are more likely to engage in sexual risk behaviors. Conversely, parental disapproval of adolescent sexual activity is associated with lower sexual risk behav-

iors (Cox, 2007; Dittus & Jaccard, 2000; Miller, Kotchick, Dorsey, Forehand, & Ham, 1998; Parkes, Henderson, Wight, & Nixon, 2011). Adolescents are least likely to engage in sexual risk behaviors when parents are clear about their attitudes and expectations and discuss them with their adolescents (Rotheram-Borus, Stein, & Lester, 2006).

All of the interventions incorporated activities that addressed parents' knowledge, attitudes, and values. For example, in the Caribbean Family Workshop, parents and adolescents are presented with a vignette of a young woman who begins her period and her friends tell her that means she will be engaging in sex. The young lady is confused—possibly about the relationship between having her period and sex, whether she can get pregnant, and if her period means she should have a boyfriend. The parents and teens engage in multifamily discussions about what the adolescents know, want to know, and should know about sex.

Foster Positive Relationships

A warm, nurturing, supportive relationship between parent and adolescent has been associated with delayed sexual initiation, increased condom and contraceptive use, and lower pregnancy rates (Cox, 2007; Dittus & Jaccard, 2000; Donenberg, Paikoff, & Pequegnat, 2006; Jaccard & Dittus, 2000; Miller et al., 1998; Parkes et al., 2011). In general, families that report a warm bond and feel close to each other are less likely to have adolescents with negative developmental outcomes (Braverman, 1999; Cox, Brooks-Gunn, & Research Consortium on Family Risk & Resilience Summer Institute, 1999). Furthermore, the amount of conflict in and satisfaction with the parent/adolescent relationship is associated with level of engagement in sexual behaviors (Dittus & Jaccard, 2000; McBride, Paikoff, & Holmbeck, 2003). A supportive relationship allows parents to set and enforce rules with their adolescents, which is also important in maintaining positive adolescent behaviors (Parkes et al., 2011). Having a positive parent/adolescent relationship creates the foundation for communicating, conveying, reinforcing, and internalizing parental values and providing parental support.

All of the family-based interventions used various activities and created experiences within the family to foster and build positive relationships between the parent and adolescent. For example, the Project TALC intervention engaged parents and adolescents in activities such as having the parents and adolescents identify and share positive qualities about each other and their family's strengths, creating a family crest, and having each parent and adolescent write and share a heartfelt, positive letter to the other family member. STRIVE has parents and adolescents remember and share a positive experience at the beginning of the first session to start the intervention with a positive frame, assigns a fun no-cost activity that the adolescent and parent could do together for homework, and uses tokens to affirm any positive connection (e.g., eye contact, head nod, smile, etc.) that is made both in the intervention sessions and at home.

Increase Parent/Adolescent Communication

A construct known to be protective for adolescents and universally incorporated in efficacious family-based interventions is increasing the quantity and quality of communication between parents and their adolescents. Prior studies have found that when adolescents can recall a parent communicating with them about sex that they are more likely to report condom use and delay sexual initiation (Huebner & Howell, 2003; Hutchinson, Jemmott, Jemmott, Braverman, & Fong, 2003; Longmore, Manning, & Giordano, 2001; Meschke, Bartholomae, & Zentall, 2002). Further, parents must learn that effective communication also includes listening to their adolescent. Prior research has found that when a parent dominates the conversation and talks more, the adolescent is less knowledgeable about sexual health (Lefkowitz, Kahlbaugh, Au, & Sigman, 1998; Whalen, Henker, Hollingshead, & Burgess, 1996).

To varying degrees, each of these family-based interventions focuses on five aspects of communication (Akers et al., 2011): (1) frequency of communication, particularly about sexual behaviors, reproductive health and condoms; (2) communication skills, such as asking open-ended questions, active listening, providing verbal support and nonjudgmental responses; (3) content of the communication by assisting parents to determine and rehearse what they would like to convey to their adolescent; (4) communication self-

efficacy for parents to feel more confident, competent, and comfortable having discussions about sexual behaviors and other HIV-related topics; and (5) intentions to communicate about sexual behaviors, reproductive health, and/or condoms and contraception.

The interventions used a number of techniques to increase a parent's skills for communicating with their adolescent. For example, in the Familias Unidas intervention, parents organized discussion circles with their adolescents to enhance parent–adolescent communication within a safe and supportive environment. The discussion circles were an initial step toward establishing regular discussions between parent and adolescent, as well as increase the adolescent's comfort about having conversations with their parent about difficult topics. In the FACTS & *feelings* intervention, parents and adolescents watched a video in the first session that addressed the social, emotional, and physical changes in puberty as well as the stress that those changes cause. To increase communication skills, vignettes illustrated less effective and more effective communication skills followed by a discussion between parent and adolescent. Each of the family-based interventions provided a safe and supportive space to begin conversations about sexual behaviors and reproductive and sexual health that carried over at home between sessions and once the intervention was completed.

Foster Parental Monitoring

All of these interventions focus on providing experiences and skills that increase parental monitoring. Parental monitoring has been found to be protective against adolescent risk behaviors, including inconsistent condom use, multiple sex partners, recent marijuana and alcohol use and STIs (Baptiste, Miller, McBride, McKay, 2007; DiClemente et al., 2001; Li, Feigelman, & Stanton, 2000). Monitoring operates by minimizing opportunity and involvement of adolescents in risky situations and reduces unsupervised exposure to negative media content and peer influences (Brown et al., 2006; Huebner & Howell, 2003; Li, Feigelman, et al., 2000; Li, Stanton, & Feigelman, 2000; Wight, Williamson, & Henderson, 2006).

The Strong African-American Families intervention families were taught to use nurturant-involved parenting along with high levels of monitoring and control (Brody et al., 2008). One way this was accomplished was through family discussions and role-plays within a small group setting about the rules and expectations of the parent. In the ImPACT intervention, parents and adolescents watched videos that showed parent–adolescent conversations and adolescent–adolescent discussions about parental monitoring. After the review of the video, parents and adolescents were encouraged to talk about the importance of parental monitoring and collaboratively created family rules and expectations around monitoring. Although the interventions addressed parental monitoring in a number of different ways, attending to the construct appears to be the key.

In addition to identifying the common elements of these interventions, it is important to note that all the programs used interactional techniques. All interventions shared common techniques for discussing and conveying information and addressing the common elements. Each of the interventions prioritized the interaction between the parent and the adolescent to build a sense of self-efficacy and competence. Whether the families were watching videos, reading vignettes, or explaining their perspective to each other, they were engaged in a practice that incorporated interactive discussions, demonstrations, role-plays, media, and take-home activities. Similar to the common techniques identified in other evidence-based adolescent HIV prevention programs, the family-based interventions also included activities to assist families in processing and integrating the information and skills that were discussed in each intervention session (Ingram, Flannery, Elkavich, & Rotheram-Borus, 2008).

Implications

Implications for Practice With Families

It is important to note that the identified common elements were not reflected in a single activity or interaction. Rather, the elements were integrated across multiple activities and implemented in a variety of ways (e.g., parents and adolescents together, parents alone, game, role-play). The diversity in strategies to com-

municate these common elements suggests there may be multiple means for shifting a family's behavior. Therefore, there is flexibility in the manner in which a clinician or provider attempts to meet the goal of reducing the adolescents' sexual risk behaviors. It may be less important whether a specific role-play or discussion is used. Rather, ensuring that an activity appropriately and competently addresses the common elements within the context of a particular family may be what is most important.

A foundational construct in all the interventions was addressing parental knowledge, attitudes, and values. Strikingly, this was often addressed with parents, without their adolescent children present. Having parents discuss these issues without their adolescents helps to ensure misconceptions and misperceptions are identified and corrected, understanding and expectations about developmentally appropriate adolescent behavior is established, and parents are allowed to clarify values. Discussions often included consideration of which parental values and expectations were most important and the optimal ways to communicate these values to their adolescent children. As such, these discussions often developed into consideration of strategies and interactions aimed at strengthening and fostering positive parent/child relationships and communication. Often clinicians and providers focus on educating adolescents; however, this focus should not be at the expense of providing parents the vital information they need to assist their adolescents. Thus, consideration should be given to spending time alone with parents to address their knowledge, attitudes, and behavior.

Another important aspect of effectively addressing adolescent sexual risk behaviors is fostering positive relationships and communication between parents and their adolescent children. Learning to appreciate the strengths of individual family members, as well as the family as a whole, lays a foundation for open, truthful, and respectful communication between parents and their adolescent children. In working with families, an effective practice is likely to include creating opportunities for families to identify these strengths, either through guided discussions or activities such as writing a letter of gratitude to other family members. The feelings of comfort, safety, and appreciation reinforced within the family allow both parents and adolescents to more effectively communicate. Clinicians and providers should strive to create such a space.

Increasing the quality and quantity of communication between parents and their adolescents was integral in these interventions. Those programs that measured parent–adolescent communication noted improvement in frequency, quality, intentions, comfort, and self-efficacy for communicating about sex (Akers et al., 2011). Further, communication skills apply to the breadth of issues and conflicts that parents and adolescents experience, from parental monitoring to condom use. Some of these interventions also have families recognize and discuss where flexibility exists (e.g., curfew, when chores are completed) and initiating manageable negotiation between parents and adolescents. Effective communication is necessary for addressing potentially volatile topics, such as rule enforcement, monitoring, and romantic relationships. Although clinicians can serve as mediators between parents and adolescents, consideration should also be paid to spending time fostering effective communication within families and creating a safe space where families are able to practice, receive feedback, and improve their communication skills. This often requires the clinician's involvement in providing supportive feedback to families.

The common elements also appear relevant for a wide variety of families. These family-based interventions have successfully targeted adolescents of color, a vulnerable population that is often hard to reach and engage in services. The outcomes from the identified interventions suggest that family-based strategy in general, and by extension the common elements in particular, appear to be an effective way to reach this population. Engaging adolescents of color by involving their families in prevention programs is particularly salient given that about 25% of new infections in the United States are among adolescents, and African-American and Latino/a young people, in particular, continue to be disproportionately represented (Morris et al., 2006; Rangel, Gavin, Reed, Fowler, & Lee, 2006). African Americans accounted for 55% of all HIV infections reported among young people aged 13 to 24 years (Centers for Disease Control, 2005) and the rates of HIV infection among Latino/a young people was 2.5 times that of European Americans (Centers for Dis-

ease Control, 2010). The success of these preventive interventions suggests the common elements are potentially useful with families from different ethnic, racial, and cultural backgrounds.

Implications for Adaptation and Dissemination of Evidence-Based Interventions

The need to identify common elements is driven by the major challenge of widespread adoption and promotion of empirically supported interventions. The challenge of dissemination of evidence-based HIV prevention interventions has been discussed elsewhere (Collins, Harshbarger, Sawyer, & Hamdallah, 2006; Eke, Mezoff, Duncan, & Sogolow, 2006) and has been an issue for psychological treatments in general and in children's mental health in particular (Barlow, 1997; Schoenwald & Hoagwood, 2001; Weisz, Donenberg, Han, & Weiss, 1995). Challenges have included a disconnection between the evidence-based intervention and community practice, the relative cost of implementing the interventions (Holtgrave & Kelly, 1996; Pinkerton, Johnson-Masotti, Otto-Salaj, Stevenson, & Hoffmann, 2001), intervention complexity and the lack of resources for training providers to deliver the intervention, and implementation and maintenance costs.

Furthermore, when evidence-based interventions are implemented in community and clinical settings, they are often modified or adapted (Dworkin, Pinto, Hunter, Rapkin, & Remien, 2008; Rebchook, Kegeles, & Huebner, 2006; Rohrbach, Grana, Sussman, & Valente, 2006) to meet the needs of clients or consumers. Consequently, a pressing need to identify the active elements of the interventions and how to address questions of intervention fidelity has emerged. In response, the Centers for Disease Control, who are disseminating efficacious HIV prevention interventions through their Replicating Effective Programs (REP) and Diffusion of Effective Behavioral Interventions (DEBI) initiatives, have developed an adaptation guide to assist health departments and community-based agencies to adapt the interventions for specific target groups (e.g., gay and bisexual Latino and Black men). Therefore, clinicians and community partners have specific, efficacious HIV prevention interventions and some guidance about how to adapt those interventions to their clients. Unfortunately, although eight of the current 28 DEBI programs being disseminated focus on youth, only one program includes parents (Wu et al., 2003). Furthermore, that particular intervention is not family based, rather it is parent-based and includes a video and discussion with parents separate from the eight sessions of intervention delivered to the youth.

Although vehicles exist to assist providers in identifying and adapting evidence-based interventions into their practice, a gap exists for family-based programs. While dissemination of these interventions remains an important priority, identification of the common elements from these programs can be beneficial. By distilling these evidence-based interventions into core elements and processes, the focus of assisting families can progress beyond implementation of specific evidence-based interventions toward a direction of adapting evidence-based interventions and the incorporation of effective, evidence-based practices. Furthermore, identification of universal constructs can assist providers and clinicians to incorporate evidence-based content or elements and processes into their work with families.

Conclusions

A long series of studies has demonstrated that adolescent sexual knowledge and practices are associated with parent characteristics, underscoring the need for and importance of a family-based focus to address adolescent HIV risk behaviors (DiClemente et al., 2001; Dittus, Jaccard, & Gordon, 1997; Fisher, 1987; Fox & Inazu, 1980; Leland, Barth, & Cunningham, 1993; Newcomer & Udry, 1985; Pick & Palos, 1995). As reviewed here, family-based interventions have been successful in improving the immediate and distal HIV-related outcomes of adolescents, including condom use, family communication, and substance use.

The current article identified the common elements of those efficacious family interventions. The common elements can assist providers and clinicians to incorporate evidence-based practices and constructs into their work with families. Clinical practice with families can benefit by focusing on increasing parental knowledge and clarifying values, fostering positive parent and adolescent relationships,

strengthening the communication skills of parents and adolescents, and fostering parental monitoring in work with families. In addition, identification of the common elements can assist clinicians and providers in adapting evidence-based programs once they are disseminated and become available.

The constructs identified in this article are not intended to be a definitive list of strategies necessary for taking a family approach in reducing the sexual risk behaviors of adolescents. Rather, the core elements represent components of an efficacious approach and present an effort to reach providers with evidence-based strategies.

References

Akers, A. Y., Holland, C. L., & Bost, J. (2011). Interventions to improve parental communication about sex: A systematic review. *Pediatrics, 127,* 494–510. doi:10.1542/peds.2010-2194

Baptiste, D. R., Kapungu, C., Miller, S., Crown, L., Henry, D., Martinez Dda, C., & Jo-Bennett, K. (2009). Increasing parent involvement in youth HIV prevention: A randomized Caribbean study. *AIDS Education and Prevention, 21,* 495–511. doi:10.1521/aeap.2009.21.6.495

Baptiste, D. T.-S., Miller, S., McBride, C., & McKay, M. (2007). Predictors of parental monitoring and sexual risk taking among urban African American youth. *Journal of Child and Family Studies, 16,* 261–274. doi:10.1007/s10826-006-9083-4

Barlow, J. (1997). Evidence-based health care: Management and practice. *Journal of Health Services Research & Policy, 2,* 251–252.

Bickman, L. (2005). A common factors approach to improving mental health services. *Mental Health Services Research, 7,* 1–4. doi:10.1007/s11020-005-1961-7

Braverman, M. T. (1999). Research on resilience and its implications for tobacco prevention. *Nicotine & Tobacco Research, 1 Suppl, 1,* 67–72. doi:10.1080/14622299050011621

Brody, G. H., Kogan, S. M., Chen, Y. F., & McBride Murry, V. (2008). Long-term effects of the strong African American families program on youths' conduct problems. *Journal of Adolescent Health, 43,* 474–481. doi:10.1016/j.jadohealth.2008.04.016

Brody, G. H., Murry, V. M., Gerrard, M., Gibbons, F. X., Molgaard, V., McNair, L., . . . Neubaum-Carlan, E. (2004). The Strong African American Families Program: Translating research into prevention programming. *Child Development, 75,* 900–917. doi:10.1111/j.1467-8624.2004.00713.x

Brown, J. D., L'Engle, K. L., Pardun, C. J., Guo, G., Kenneavy, K., & Jackson, C. (2006). Sexy media matter: Exposure to sexual content in music, movies, television, and magazines predicts black and white adolescents' sexual behavior. *Pediatrics, 117,* 1018–1027. doi:10.1542/peds.2005-1406

Centers for Disease Control. (2005). *HIV prevention in the third decade.* Atlanta, GA: US Department of Health and Human Services.

Centers for Disease Control. (2010). HIV among Hispanics/Latinos. Retrieved December 1, 2011, from http://www.cdc.gov/hiv/hispanics/index.htm

Chorpita, B. F., Becker, K. D., & Daleiden, E. L. (2007). Understanding the common elements of evidence-based practice: Misconceptions and clinical examples. *Journal of the American Academy of Child & Adolescent Psychiatry, 46,* 647–652. doi:10.1097/chi.0b013e318033ff71

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Identifying and selecting the common elements of evidence based interventions: A distillation and matching model. *Mental Health Services Research, 7,* 5–20. doi:10.1007/s11020-005-1962-6

Collins, C., Harshbarger, C., Sawyer, R., & Hamdallah, M. (2006). The diffusion of effective behavioral interventions project: Development, implementation, and lessons learned. *AIDS Education and Prevention, 18,* 5–20. doi:10.1521/aeap.2006.18.supp.5

Cox, M. F. (2007). Maternal demandingness and responsiveness as predictors of adolescent abstinence. *Journal of Pediatric Nursing, 22,* 197–205. doi:10.1016/j.pedn.2006.08.005

Cox, M. J., Brooks-Gunn, J., & Research Consortium on Family Risk and Resilience. Summer Institute. (1999). *Conflict and cohesion in families: Causes and consequences.* Mahwah, NJ: Lawrence Erlbaum Associates.

Coyle, K., Basen-Engquist, K., Kirby, D., Parcel, G., Banspach, S., Harrist, R., . . . Weil, M. (1999). Short-term impact of safer choices: A multicomponent, school-based HIV, other STD, and pregnancy prevention program. *The Journal of School Health, 69,* 181–188. doi:10.1111/j.1746-1561.1999.tb06383.x

Crawford, I., Riordan, N., Kaufman, J., Sawalski, L., Jason, L. A., Salina, D., . . . Zolik, E. (1990). A Multimedia-based approach to increasing communication and the level of AIDS knowledge within families. *Journal of Community Psychology, 18,* 361–373. doi:10.1002/1520-6629(199010)18:4<361::AID-JCOP2290180409>3.0.CO;2-X

DiClemente, R. J., Wingood, G. M., Crosby, R., Sionean, C., Cobb, B. K., Harrington, K., . . . Oh, M. K. (2001). Parental monitoring: Association with adolescents' risk behaviors. *Pediatrics, 107,* 1363–1368. doi:10.1542/peds.107.6.1363

Dilorio, C., McCarty, F., Resnicow, K., Lehr, S., & Denzmore, P. (2007). REAL men: A group-randomized trial of an HIV prevention intervention for adolescent. *American Journal of Public Health, 97,* 1084–1089. doi:10.2105/Ajph.2005.073411e

Dilorio, C., Resnicow, K., McCarty, F., De, A. K., Dudley, W. N., Wang, D. T., & Denzmore, P. (2006). Keepin' it REAL! Results of a mother-adolescent HIV prevention program. *Nursing Research, 55,* 43–51.

Dishion, T. J., & Owen, L. D. (2002). A longitudinal analysis of friendships and substance use: Bidirectional influence from adolescence to adulthood. *Developmental Psychology, 38,* 480–491. doi:10.1037/0012-1649.38.4.480

Dittus, P. J., Jaccard, J., & Gordon, V. V. (1997). The impact of African American fathers on adolescent sexual behavior. *Journal of Youth and Adolescence, 26,* 445–465. doi:10.1023/A:1024533422103

Dittus, P. J., & Jaccard, J. (2000). Adolescents' perceptions of maternal disapproval of sex: Relationship to sexual outcomes. *Journal of Adolescent Health, 26,* 268–278. doi:10.1016/S1054-139X(99)00096-8

Donenberg, G. R., Paikoff, R., & Pequegnat, W. (2006). Introduction to the special section on families, youth, and HIV: Family-based intervention studies. *Journal of Pediatric Psychology, 31,* 869–873. doi:10.1093/jpepsy/jsj102

Dworkin, S. L., Pinto, R. M., Hunter, J., Rapkin, B., & Remien, R. H. (2008). Keeping the spirit of community partnerships alive in the scale up of HIV/AIDS prevention: Critical reflections on the roll out of DEBI (Diffusion of Effective Behavioral Interventions). *American Journal of Community Psychology, 42*(1–2), 51–59. doi:10.1007/s10464-008-9183-y

Eisenberg, M. E., Bearinger, L. H., Sieving, R. E., Swain, C., & Resnick, M. D. (2004). Parents' beliefs about condoms and oral contraceptives: Are they medically accurate? *Perspectives on Sexual and Reproductive Health, 36,* 50–57. doi:10.1363/3605004

Eke, A. N., Mezoff, J. S., Duncan, T., & Sogolow, E. D. (2006). Reputationally strong HIV prevention programs: Lessons from the front line. *AIDS Education and Prevention, 18,* 163–175. doi:10.1521/aeap.2006.18.2.163

Fisher, T. D. (1987). Family communication and the sexual behavior and attitudes of college students. *Journal of Youth and Adolescence, 16,* 481–495. doi:10.1007/BF02202942

Forehand, R., Armistead, L., Long, N., Wyckoff, S. C., Kotchick, B. A., Whitaker, D., . . . Miller, K. S. (2007). Efficacy of a parent-based sexual-risk prevention program for African American preadolescents: A randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine, 161,* 1123–1129. doi:10.1001/archpedi.161.12.1123

Fox, G. L., & Inazu, J. K. (1980). Patterns and outcomes of mother-daughter communication about sexuality. *Journal of Social Issues, 36,* 7–29. doi:10.1111/j.1540-4560.1980.tb01896.x

Grusec, J. E. (2011). Socialization processes in the family: Social and emotional development. *Annual Review of Psychology, 62,* 243–269. doi:10.1146/annurev.psych.121208.131650

Guilamo-Ramos, V., Bouris, A., Jaccard, J., Gonzalez, B., McCoy, W., & Aranda, D. (2011). A parent-based intervention to reduce sexual risk behavior in early adolescence: Building alliances between physicians, social workers, and parents. *Journal of Adolescent Health, 48,* 159–163. doi:10.1016/j.jadohealth.2010.06.007

Hawkins, J. D., & Fitzgibbon, J. J. (1993). Risk Factors and Risk Behaviors in Prevention of Adolescent Substance Abuse. *Adolescent Medicine, 4,* 249–262.

Henggeler, S. W., Melton, G. B., & Smith, L. A. (1992). Family preservation using multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology, 60,* 953–961. doi:10.1037/0022-006X.60.6.953

Holtgrave, D. R., & Kelly, J. A. (1996). Preventing HIV/AIDS among high-risk urban women: The cost-effectiveness of a behavioral group intervention. *American Journal of Public Health, 86,* 1442–1445. doi:10.2105/AJPH.86.10.1442

Huebner, A. J., & Howell, L. W. (2003). Examining the relationship between adolescent sexual risk-taking and perceptions of monitoring, communication, and parenting styles. *Journal of Adolescent Health, 33,* 71–78. doi:10.1016/S1054-139X(03)00141-1

Huston, R. L., Martin, L. J., & Foulds, D. M. (1990). Effect of a program to facilitate parent-child communication about sex. *Clinical Pediatrics, 29,* 626–630. doi:10.1177/000992289002901101

Hutchinson, M. K., Jemmott, J. B., 3rd, Jemmott, L. S., Braverman, P., & Fong, G. T. (2003). The role of mother-daughter sexual risk communication in reducing sexual risk behaviors among urban adolescent females: A prospective study. *Journal of Adolescent Health, 33,* 98–107. doi:10.1016/S1054-139X(03)00183-6

Ingram, B. L., Flannery, D., Elkavich, A., & Rotheram-Borus, M. J. (2008). Common processes in evidence-based adolescent HIV prevention programs. *AIDS and Behavior, 12,* 374–383. doi:10.1007/s10461-008-9369-1

Jaccard, J., & Dittus, P. J. (2000). Adolescent perceptions of maternal approval of birth control and sexual risk behavior. *American Journal of Public Health, 90,* 1426–1430. doi:10.2105/AJPH.90.9.1426

Kumpfer, K. L., Alvarado, R., Tait, C., & Turner, C. (2002). Effectiveness of school-based family and children's skills training for substance abuse prevention among 6–8-year-old rural children. *Psychology of Addictive Behaviors, 16,* S65–S71. doi: 10.1037/0893-164X.16.4S.S65

Lefkowitz, E. S., Kahlbaugh, P., Au, T. K., & Sigman, M. (1998). A longitudinal study of AIDS conversations between mothers and adolescents. *AIDS Education and Prevention, 10,* 351–365.

Leland, D. S., Barth, K. A., & Cunningham, E. B. (1993). Comparison of the Seradyn color vue passive agglutination-test and complement-fixation for detection of mycoplasma-pneumoniae antibodies. *Journal of Clinical Microbiology, 31,* 1013–1015.

Li, X., Feigelman, S., & Stanton, B. (2000). Perceived parental monitoring and health risk behaviors among urban low-income African-American children and adolescents. *Journal of Adolescent Health, 27,* 43–48. doi:10.1016/S1054-139X(99)00077-4

Li, X., Stanton, B., & Feigelman, S. (2000). Impact of perceived parental monitoring on adolescent risk behavior over 4 years. *Journal of Adolescent Health, 27,* 49–56. doi:10.1016/S1054-139X(00)00092-6

Longmore, M. A., Manning, W. D., & Giordano, P. C. (2001). Preadolescent parenting strategies and teens' dating and sexual initiation: A longitudinal analysis. *Journal of Marriage and Family, 63,* 322–335. doi: 10.1111/j.1741-3737.2001.00322.x

Martinez, G., Abma, J. C., Copen, C. E., & National Center for Health Statistics (U. S.). (2010). *Educating teenagers about sex in the United States.* Hyattsville, MD: U.S. Department of Health and Human Services.

McBride, C. K., Paikoff, R. L., & Holmbeck, G. N. (2003). Individual and familial influences on the onset of sexual intercourse among urban African American adolescents. *Journal of Consulting and Clinical Psychology, 71,* 159–167. doi:10.1037/0022-006x.71.1.159

Meschke, L. L., Bartholomae, S., & Zentall, S. R. (2002). Adolescent sexuality and parent-adolescent processes: Promoting healthy teen choices. *Journal of Adolescent Health, 31,* 264–279. doi: 10.1016/S1054-139X(02)00499-8

Milburn, N. G., Iribarren, F. J., Rice, E., Lightfoot, M., Solorio, R., Rotheram-Borus, M. J., . . . Duan, N. (2012). A family intervention to reduce sexual risk behavior, substance use, and delinquency among newly homeless youth. *Journal of Adolescent Health, 50,* 358–364. doi:10.1016/j.jadohealth.2011.08.009

Miller, B. C., Norton, M. C., Jenson, G. O., Lee, T. R., Christopherson, C., & King, P. K. (1993). Impact evaluation of facts and feelings: a home-based video sex-education curriculum. *Family Relations, 42,* 392–400. doi:10.2307/585339

Miller, K. S., Kotchick, B. A., Dorsey, S., Forehand, R., & Ham, A. Y. (1998). Family communication about sex: What are parents saying and are their adolescents listening? *Family Planning Perspectives, 30,* 218-, 222, 235. doi:10.2307/2991607

Morris, M., Handcock, M. S., Miller, W. C., Ford, C. A., Schmitz, J. L., Hobbs, M. M., & Udry, J. R. (2006). Prevalence of HIV infection among young adults in the United States: Results from the ADD Health study. *American Journal of Public Health, 96,* 1091–1097. doi:10.2105/AJPH.2004.054759

Newcomer, S. F., & Udry, J. R. (1985). Oral sex in an adolescent population. *Archives of Sexual Behavior, 14,* 41–46. doi:10.1007/BF01541351

O'Donnell, L., Myint-U, A., Duran, R., & Stueve, A. (2010). Especially for daughters: Parent education to address alcohol and sex-related risk taking among urban young adolescent girls. *Health Promotion Practice, 11,* 70S–78S. doi:10.1177/1524839909355517

Pantin, H., Coatsworth, J. D., Feaster, D. J., Newman, F. L., Briones, E., Prado, G., . . . Szapocznik, J. (2003). Familias Unidas: The efficacy of an intervention to promote parental investment in Hispanic immigrant families. *Prevention Science, 4,* 189–201. doi:10.1023/A:1024601906942

Parkes, A., Henderson, M., Wight, D., & Nixon, C. (2011). Is parenting associated with teenagers' early sexual risk-taking, autonomy and relationship with sexual partners? *Perspectives on Sexual and Reproductive Health, 43,* 30–40. doi:10.1363/4303011

Pick, S., & Palos, A. (1995). Impact of the family on the sex lives of adolescents. *Adolescence, 30,* 667–675.

Pinkerton, S. D., Johnson-Masotti, A. P., Otto-Salaj, L. L., Stevenson, L. Y., & Hoffmann, R. G. (2001). Cost-effectiveness of an HIV prevention intervention for mentally ill adults. *Mental Health Services Research, 3,* 45–55. doi:10.1023/A:1010112619165

Prado, G., Pantin, H., Briones, E., Schwartz, S. J., Feaster, D., . . . Szapocznik, J. (2007). A randomized control trial of a parent-centered intervention in preventing substance use and HIV risk behaviors in Hispanic adolescents. *Journal of Consulting and Clinical Psychology, 75,* 914–926. doi: 10.1037/0022-006X.75.6.914

Prado, G., Pantin, H., Huang, S., Cordova, D., Tapia, M. I., . . . Estrada, Y. (2012). Effects of a family intervention in reducing HIV risk behaviors among high-risk Hispanic adolescents. *Archives of Pediatrics and Adolescent Medicine, 166,* 127–133. doi:10.1001/archpediatrics.2011.189

Prado, G., & Pantin, H. (2011). Reducing substance use and HIV health disparities among Hispanic youth in the U.S.A.: The Familias Unidas program of research. *Intervencion Psicosocial, 20,* 63–73. doi:10.5093/in2011v20n1a6

Rangel, M. C., Gavin, L., Reed, C., Fowler, M. G., & Lee, L. M. (2006). Epidemiology of HIV and

AIDS among adolescents and young adults in the United States. *Journal of Adolescent Health, 39,* 156–163. doi:10.1016/j.jadohealth.2006.02.011

Rebchook, G. M., Kegeles, S. M., & Huebner, D. (2006). Translating research into practice: The dissemination and initial implementation of an evidence-based HIV prevention program. *AIDS Education and Prevention, 18,* 119–136. doi:10.1521/aeap.2006.18.supp.119

Rohrbach, L. A., Grana, R., Sussman, S., & Valente, T. W. (2006). Type II translation: Transporting prevention interventions from research to real-world settings. *Evaluation & the Health Professions, 29,* 302–333. doi:10.1177/0163278706290408

Rotheram-Borus, M. J., Ingram, B. L., Swendeman, D., & Flannery, D. (2009). Common principles embedded in effective adolescent HIV prevention programs. *AIDS and Behavior, 13,* 387–398. doi:10.1007/s10461-009-9531-4

Rotheram-Borus, M. J., Lee, M., Leonard, N., Lin, Y. Y., Franzke, L., Turner, E., . . . Gwadz, M. (2003). Four-year behavioral outcomes of an intervention for parents living with HIV and their adolescent children. *AIDS, 17,* 1217–1225. doi:10.1097/00002030-200305230-00014

Rotheram-Borus, M. J., Lee, M., Lin, Y. Y., & Lester, P. (2004). Six-year intervention outcomes for adolescent children of parents with the human immunodeficiency virus. *Archives of Pediatrics & Adolescent Medicine, 158,* 742–748. doi:10.1001/archpedi.158.8.742

Rotheram-Borus, M. J., Lee, M. B., Gwadz, M., & Draiman, B. (2001). An intervention for parents with AIDS and their adolescent children. *American Journal of Public Health, 91,* 1294–1302. doi:10.2105/AJPH.91.8.1294

Rotheram-Borus, M. J., Piacentini, J., Miller, S., Graae, F., & Castro-Blanco, D. (1994). Brief cognitive-behavioral treatment for adolescent suicide attempters and their families. *Journal of the American Academy of Child & Adolescent Psychiatry, 33,* 508–517. doi:10.1097/00004583-199405000-00009

Rotheram-Borus, M. J., Stein, J. A., & Lester, P. (2006). Adolescent adjustment over six years in HIV-affected families. *Journal of Adolescent Health, 39,* 174–182. doi:10.1016/j.jadohealth.2006.02.014

Rotheram-Borus, M. J., Swendeman, D., Flannery, D., Rice, E., Adamson, D. M., & Ingram, B. (2009). Common factors in effective HIV prevention programs. *AIDS and Behavior, 13,* 399–408. doi:10.1007/s10461-008-9464-3

Sandler, I. N., Schoenfelder, E. N., Wolchik, S. A., & MacKinnon, D. P. (2011). Long-term impact of prevention programs to promote effective parenting: Lasting effects but uncertain processes. *Annual Review of Psychology, 62,* 299–329. doi:10.1146/Annurev.Psych.121208.131619

Schoenwald, S. K., & Hoagwood, K. (2001). Effectiveness, transportability, and dissemination of interventions: What matters when? *Psychiatric Services, 52,* 1190–1197. doi:10.1176/appi.ps.52.9.1190

Schuster, M. A., Corona, R., Elliott, M. N., Kanouse, D. E., Eastman, K. L., Zhou, A. J., & Klein, D. J. (2008). Evaluation of Talking Parents, Healthy Teens, a new worksite based parenting programme to promote parent-adolescent communication about sexual health: Randomised controlled trial. *British Medical Journal, 337,* 7664). doi:10.1136/bmj.39609.657581.25

Smetana, J. G., Campione-Barr, N., & Metzger, A. (2006). Adolescent development in interpersonal and societal contexts. *Annual Review of Psychology, 57,* 255–284. doi:10.1146/Annurev.Psych.57.102904.190124

Stanton, B. F., Li, X., Galbraith, J., Cornick, G., Feigelman, S., Kaljee, L., & Zhou, Y. (2000). Parental underestimates of adolescent risk behavior: A randomized, controlled trial of a parental monitoring intervention. *Journal of Adolescent Health, 26,* 18–26. doi:10.1016/S1054-139X(99)00022-1

Steinberg, L., & Morris, A. S. (2001). Adolescent development. *Annual Review of Psychology, 52,* 83–110. doi:10.1146/annurev.psych.52.1.83

Taylor, T. K., & Biglan, A. (1998). Behavioral family interventions for improving child-rearing: A review of the literature for clinicians and policy makers. *Clinical Child and Family Psychology Review, 1,* 41–60. doi:10.1023/A:1021848315541

Weisz, J. R., Donenberg, G. R., Han, S. S., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. *Journal of Consulting and Clinical Psychology, 63,* 688–701. doi:10.1037/0022-006X.63.5.688

Whalen, C. K., Henker, B., Hollingshead, J., & Burgess, S. (1996). Parent-adolescent dialogues about AIDS. *Journal of Family Psychology, 10,* 343–357. doi:10.1037/0893-3200.10.3.343

Wight, D., Williamson, L., & Henderson, M. (2006). Parental influences on young people's sexual behaviour: A longitudinal analysis. *Journal of Adolescence, 29,* 473–494. doi:10.1016/j.adolescence.2005.08.007

Wu, Y., Stanton, B. F., Galbraith, J., Kaljee, L., Cottrell, L., Li, X., . . . Burns, J. M. (2003). Sustaining and broadening intervention impact: A longitudinal randomized trial of 3 adolescent risk reduction approaches. *Pediatrics, 111,* e32–e38. doi:10.1542/peds.111.1.e32

Received February 8, 2012
Revision received May 2, 2012
Accepted May 2, 2012 ■