THE PAST, PRESENT, AND FUTURE OF BEHAVIORAL PARENT TRAINING: INTERVENTIONS FOR CHILD AND ADOLESCENT PROBLEM BEHAVIOR

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Behavioral parent training has emerged as one of the most successful and well-researched interventions to date in the treatment and prevention of child and adolescent problem behaviors, with extensive empirical support for its clinical utility having been obtained over the last several decades. At this point in time, it is useful to consider the development of behavioral parent training and to review the current status of research and practice in the field. We begin by giving a historical overview of behavioral parent training, followed by a review of the "core issues" of these parenting interventions. We then present the current state of the art in behavioral parent training, including challenges frequently faced by clinicians in accessing and implementing these parenting programs. Finally, we turn our attention to the future of parent training research.

Behavioral parent training has emerged as one of the most successful and well-researched interventions to date in the treatment and prevention of child and adolescent problem behaviors, with extensive empirical support for its clinical utility (e.g., Kazdin & Weisz, 1998; Lonigan, Elbert, & Bennet-Johnson, 1998; McMahon & Wells, 1998). As a recent meta-analysis of 26 controlled studies by Serketich and Dumas (1996) indicates, behavioral parent training is associated with improvements in child behavior and parent personal adjustment. However, parent training is not uniformly successful, and there remains much to learn about the myriad factors that affect the implementation of these interventions. At this point in time, it is useful to consider the development of behavioral parent training—where advances in the field have led us, and where the field is going.

In this article, we will begin by giving a historical overview of how parents came to be involved in the treatment of child problem behaviors, followed by a review of the "core issues" that are central to these parenting interventions, including a discussion of developmental and contextual variables. We then present the current state of the art in

behavioral parent training, including challenges frequently faced by clinicians in accessing and implementing these parenting programs. Finally, we turn our attention to the future of parent training research.

THE PAST: A HISTORICAL OVERVIEW OF PARENTING INTERVENTIONS

While parenting interventions for child problem behaviors are largely a product of the last 30 years, their guiding principles were established early in the 20th century. Behavior modification techniques were first developed in the 1920s (Graziano & Diament, 1992). More importantly, researchers at that time began to recognize the integral role that a child's environment plays in the development and maintenance of antisocial behaviors. In their detailed review of thousands of case studies, Healy and Bronner (1926) concluded that family environment, and parenting practices in particular, was perhaps the most important predictor of delinquent behaviors. Based on their findings, they conclude, "…where to direct a strong attack in treatment and prevention of delinquency stands out with striking clearness" (p.129)—in other words, parents should be a primary target for intervention with antisocial youth.

Given the current climate for treating child problem behaviors, the conclusions of researchers in 1926 seem surprisingly modern. However, these suggestions were not immediately implemented, in part because the psychological treatment of children was not widely practiced. Additionally, treatment of children through the 1950s typically occurred via less empirically-based psychodynamic approaches, employing a traditional one-on-one encounter between the therapist and child, and addressing more

global, intrapsychic issues rather than specific behavior problems (e.g., Berman, 1959; Sternbach, 1947). In the early 1960s, however, a "paradigm shift" in child treatment occurred. Traditional psychodynamic approaches were not very successful in addressing the immediate issues of a child's behavior problems; any changes that did occur in the "artificial" therapeutic situation did not generalize to settings outside the clinic (e.g., home, school); and perhaps most importantly, parents' non-involvement in the child's treatment meant that little change was effected in the home environment (see Berkowitz & Graziano, 1972; Graziano & Diament, 1992 for further discussion).

In contrast, principles of behavior modification were beginning to find success in managing child behavior in multiple settings, such as classrooms, hospitals, and other institutions (Kazdin, 1978). Due to this confluence of factors, the idea of therapists training parents in techniques to modify their children's behavior was met with much enthusiasm. This partnership between the parent and therapist was probably also possible because it was concurrent with a broader trend toward the "deprofessionalization" of psychotherapy (as evidenced by the increasing popularity of "self-help" books, etc.), which has served to increase the efficiency and accessibility of treatment among a larger pool of consumers (Kazdin, 1985).

Although basic behavior modification techniques were effective for managing less severe problem behaviors, therapists and researchers quickly realized that they were not sufficient for dealing with more extreme child behavior problems, such as chronic noncompliance or antisocial behavior. According to Kazdin (1985), in these situations, "it became evident that deviant behavior required more than simple alterations of a few consequences.… Sequences of interaction between parents and children in the home emerged as important" (p. 161). This led to the establishment of behavioral parent training, as it is widely known. Parent training, based on Tharp and Wetzel's (1969) triadic model, employs the therapist as a consultant who works directly with the parent (mediator) to alleviate the problem behavior of the child (target). In the clinic, the basic parent training presentation consists primarily of instruction by the therapist in parenting techniques, with structured behavioral modeling, role plays, and practice sessions, as well as homework assignments for the parent to practice with the child. This format

was based on the assumption that parenting skills deficits are at least partly responsible for the development and/or maintenance of child problem behaviors, and thus provides parents with a repertoire of skills with which to manage, and eventually improve, the child's behavior as well as broader parent-child interactional patterns (Forehand, 1993).

As noted elsewhere (e.g., McMahon & Forehand, 2001), the development of parent training as an empirically validated practice has occurred in three distinct stages. The first stage (from 1960 to 1975) involved the establishment of the parent training format, as discussed above, and tests of its efficacy as a treatment for child problem behaviors. Early studies, which included a large number of descriptive studies and single-case designs, found good support for the short-term efficacy of parent training in reducing negative child behaviors (e.g., noncompliance, aggression, destructiveness) and improving parenting practices. Based on these successes, further research was conducted in broader terms between 1975 to 1985, with the primary focus being to test for the generalization of parent training effects. Generalization has been shown to occur in at least four areas: setting (e.g., transfer of behavior changes from the clinic to home or school), temporal (e.g., maintenance for behavior change over time), sibling (e.g., application of new parenting skills with non-targeted children), and behavioral (e.g., concomitant improvements in non-targeted behaviors; see Forehand & Atkeson, 1977). The empirical demonstration of the generalization of treatment effects has served to enhance the perceived social validity of parent training (i.e., whether the treatment effects are considered to be "clinically or socially important" to the client (Kazdin, 1977, p. 429) as well as the clients' satisfaction with the treatment.

While parent training is not universally effective in treating child problem behaviors, the research conducted between 1975 and 1985 greatly increased our understanding of the general mechanisms and outcomes of this treatment approach. Following this period, clinical researchers began to examine ways to expand the parent training curriculum. This line of research has considered a wider range of factors that can impact the implementation and outcomes of parent training. For example, the role of developmental variables has been emphasized in developing and tailoring behaviorally-oriented interventions (Eyberg, Schuhmann, & Rey, 1998; Forehand & Wierson, 1993). Other researchers

have considered the contextual factors that can affect parent training, such as parental and marital adjustment or socioeconomic factors (Griest & Wells, 1983). More recently, interventions have been designed to involve and coordinate multiple levels of the child's environment, including the home, school, clinic, community, or juvenile justice system (e.g., Henggeler, Schoenwald, Bordrun, Rowland, & Cunningham, 1998; Blechman, 1998).

THE PRESENT: CORE ISSUES IN TREATING ANTISOCIAL CHILDREN AND ADOLESCENTS

Central to the development and implementation of parent training programs for child antisocial behavior has been the study of how such behavior develops and is maintained. In order to effectively address child behavior problems, it is necessary to understand these issues, as they have direct application to all of the parenting interventions discussed in this article. Thus, in this section, we will briefly summarize from Forehand and Long (1996; 2002) how child characteristics and parenting interact to create family processes that can place a child on a trajectory from early noncompliance to severe antisocial behavior, and how these characteristics are addressed in parent training interventions.

The roots of antisocial behavior often are found in a child's temperament. Thomas and Chess (1977) identified some children as having "difficult" temperaments early in life. From their infancy, these children are usually restless, intense, distractible, and moody, tend to sleep irregularly, and to have problems adjusting to changes. Longitudinal research has shown that, without intervention, a difficult temperament is often a predecessor to later antisocial behavior (e.g., Moffitt, 1993). Fortunately, effective parenting can improve many of these negative behaviors. However, parenting a temperamentally difficult child is not an easy process and many parents unfortunately fall into unwise parenting practices, known as "traps." As Wierson and Forehand (1994) have delineated, there are two reinforcement "traps" that often disrupt parenting behavior. Both serve to exacerbate the child's problematic behavior, particularly noncompliance which has been viewed as a keystone behavior in the development of antisocial behavior of children (Loeber & Schmaling, 1985; Patterson, 1982).

The negative reinforcement trap, as described by Patterson (1982), occurs when a parent issues a direction to a noncompliant child (e.g., "Johnny, please pick up your toys."). The child is likely to respond by whining, protesting, or refusing to comply with the direction. A parent may "give in" or "give up" by withdrawing the direction, to stop the child's protesting or to complete the task more quickly. However, doing so unintentionally reinforces the very behavior that the parent is attempting to avoid. The child learns that loud protestation and defiance nullify undesirable parental directions (i.e., negative reinforcement). Thus, not only does noncompliance increase, but so do other behaviors that are precursors of antisocial behavior. Frustrated, the parent may then try to "get tougher" by yelling or even becoming physically aggressive with the child when he or she is noncompliant. In this case, the child stops protesting and complies out of fear, thereby negatively reinforcing the parent's "tough" behavior. Over time, both parent and child escalate their negative behavior via the negative reinforcement processes; this results in a coercive and destructive cycle within the parent-child relationship. The goal of a behavioral parent training program is to stop this coercive cycle by teaching the parent more adaptive responses to the child's noncompliant behaviors. The effectiveness of such a program, in part, lies in how well these new parenting behaviors are learned and implemented.

Another factor contributing to the development of problem behaviors of children is the positive reinforcement trap, described by Wahler (1976). In such cases, oppositional behavior is reinforced because a parent responds with attention most frequently when the child misbehaves (e.g., spending time with the child talking about why he or she is not complying). Although parental attention is a necessary feature of good parenting, using it in response to undesirable behavior creates problems rather than solves them. Even if given intermittently, parental attention to such behavior becomes a powerful reward for difficult children. As a result, the second goal of a parent training program is to help parents prevent the positive reinforcement trap by paying attention to positive, rather than negative, behaviors of their child. For example, attention is given to compliance instead of noncompliance and for cooperative play instead of fighting. Thus, effective behavioral parent training depends, in part, on how well parents can use positive reinforcement strategies to increase the frequency of appropriate child

behaviors; as desirable behavior increases, negative behavior is likely to decrease.

The effectiveness of behavioral parent training is also determined by its timing, as far as the child's development is concerned. Early intervention with difficult behavior, particularly noncompliance, is important because such behavior can set a child on a path to increasingly antisocial behavior. Certainly not all difficult children continue on this trajectory to its end; however, the longer that a child's misbehavior is addressed maladaptively, the more difficult it will become to modify both parenting and child behavior. In addition, research has shown that older children and adolescents who exhibit persistent antisocial behavior (as opposed to antisocial behavior which first begins in adolescence) tend to have behavior problems which are more severe and difficult to treat (Moffitt, 1993). When parenting programs intervene early and address the precursors to antisocial behavior, such as child noncompliance, increasingly serious problems can be prevented.

IMPLEMENTATION OF PARENTING PROGRAMS

Assessment.

A significant first step in implementing a parenting program for child antisocial behavior is conducting a thorough assessment of relevant child, parent, family, and community variables that may need to be addressed in the intervention. Systematic assessment is vital for the identification of intervention targets as well as the measurement of change resulting from intervention (ascertained by pre- and post-intervention assessments).

We will provide only a brief overview of the most critical aspects of assessment. Readers should refer to McMahon and Forehand (2001) and McMahon and Estes (1997) for more comprehensive discussions of assessment methods and available instruments.

The assessment of child or adolescent antisocial behavior must include the following elements. First, a detailed description of problematic behavior and the circumstances of its occurrence must be obtained. Specifically, information should be obtained regarding the nature of problem behavior, its frequency and severity, its history and development, and the contexts in which it tends to occur. Second, because the focus of parent training programs is on

the modification of parent behaviors that may contribute to the development or maintenance of child antisocial behavior, assessment of parenting attitudes, styles, and skills should be very thorough. In particular, an assessment of the antecedents and consequences of child antisocial behavior, with an emphasis on parental responses, should be conducted. Third, the content of the assessment should also include measures of potential internalizing difficulties (e.g., depressive symptoms, anxiety symptoms), as these often co-occur with antisocial behavior (McMahon & Wells, 1998). Fourth, specific areas of competence (e.g., sports, music), prosocial interactional skills (e.g., ability to form friendships, ability to relate to peers, teachers, & coaches), and academic performance should be assessed, as the goal in treatment is not simply to eliminate antisocial behavior but also to increase the prosocial functioning of these children. Lastly, other risk factors often associated with child antisocial behavior, such as parental depressive symptoms, parental excessive alcohol/drug use, marital conflict, divorce, and community factors (e.g., neighborhood crime, gangs; see Forehand & Long, 2002; Long & Forehand, 2002; McMahon & Forehand, 2001), should be assessed.

Assessment should also include the use of multiple reporters, meaning that parents, the child (when she or he is old enough to provide valid information), and, in some cases, others (e.g., grandparent, teacher) should serve as sources of data. Each person provides a unique perspective, and each perspective is important to consider in designing an intervention. Furthermore, data should be collected through multiple methods of assessment: (a) interviews; (b) questionnaires; and (c) behavioral observation by the therapist or another person in the clinic and/or home. One method is not necessarily better than another, as each has strengths and weaknesses. By employing multiple methods, the strengths of each are utilized while the weaknesses are minimized.

Intervention.

Parent training programs all share several common or core elements, summarized by various investigators, including Kazdin (1985), Dumas (1989), McMahon and Wells (1998), and McMahon and Forehand (2001). These core elements include: (1) focusing more on parents than the child; (2) moving from a preoccupation with antisocial behavior to an emphasis on prosocial behavior; (3) teaching

parents to identify, define, and record child behavior; (4) instructing parents in social learning principles (e.g., reinforcement of prosocial behavior, withdrawal of attention for misbehavior through the use of ignoring or time-out); (5) teaching new parenting skills via didactic instruction, modeling, role playing, practicing with the child in the clinic and home; (6) discussing ways to maximize generalization of skills from the clinic to the home; and when necessary, (7) addressing parental (e.g., depressive symptoms), family (e.g., marital conflict), and community (e.g., neighborhood violence) risks which may interfere with acquisition or maintenance of new parenting skills and *adaptive child behavior.*

Though the core elements are present in all parent training interventions, programs may differ in their emphasis on each component. For example, Patterson (1975a, 1975b) has stressed the importance of parents learning the language of social learning principles, as well as learning to define and count behavior. In both the first (Forehand & McMahon, 1981) and second (McMahon & Forehand, 2001) editions of the book delineating their program, McMahon and Forehand stress the importance of teaching procedures (didactic instruction, modeling, role-playing, practice with child in clinic and at home, programming generalization to the home). In contrast, Webster-Stratton (1996) emphasizes the demonstration of parenting skills through videotaped modeling of skills rather than therapist teaching. In addition, Sanders and colleagues have used print and televised media as an avenue for intervention (Sanders, Markie-Dadds, Tully & Bor, 2000). It is important to point out that the variations across programs are probably of less significance than their common elements. A clinician choosing among programs should look at the available empirical support for a program more than these relatively minor variations across programs.

One characteristic that does influence the type of intervention utilized is the age of the child. As a child increases in age, her or his cognitive abilities and source of reinforcement (e.g., parents, peers) change, which leads to changes in intervention strategies (see Forehand & Wierson, 1993, for more details). As McMahon and Wells (1998) report, several investigators have found that parent training is more effective with younger children and their families are less likely to drop out of treatment. With older children and particularly adolescents, parent training interventions may not only be less effective

but are more difficult to implement. As a result, alternative family-based treatments for adolescent antisocial behavior have been designed in recent years that incorporate individual, peer, and community level interventions into the parent training model. For example, Chamberlain has begun utilizing an alternative intensive intervention, Treatment Foster Care (TFC), for difficult-to-treat delinquent adolescents (Moore & Chamberlain, 1994). In this approach, adolescents are placed with community families who are experienced with teenagers, have good parenting skills (i.e., behavior management strategies) and are willing to work as part of a treatment team. In most cases, the goal is to have the adolescent return to live with his or her family, which receives substantial intervention during and after the adolescent is in treatment foster care. Of importance, even with innovative programs such as the one developed by Chamberlain, the basic model of parent training remains the centerpiece component.

Clinical Challenges in Behavioral Parent Training

Although behavioral parent training programs have been widely supported as efficacious interventions for preventing and treating child and adolescent problem behavior (Kazdin & Weisz, 1998; Lonigan, Elbert, & Bennet-Johnson, 1998), there remain many barriers to their effective implementation by clinical practitioners. This section will review some of the challenges commonly faced by practitioners who are working with noncompliant or antisocial youth and their families, and offer suggestions for overcoming these obstacles in order to deliver parent training interventions to those families who may benefit from them.

Challenge: Practitioners are faced with a multitude of programs claiming to be parenting interventions, but do not always have information regarding which ones have been empirically supported. As we have stated, parent training is the best empirically evaluated intervention for child and adolescent problem behavior (Brestan & Eyberg, 1998; Kazdin & Weisz, 1998). Unfortunately, treatment programs which have the best empirical support are often the ones that are most poorly disseminated among practitioners. Often, the "publicity" directed toward such programs is limited to the attention they receive in peer-reviewed scientific journals or professional conferences. What many practitioners have easy access to, however, are various parenting programs that are advertised by

mailings or brochures designed to catch the clinician's eye, but which have little or no data supporting their efficacy.

Fortunately, there are now several resources to help clinicians select an age appropriate, empirically validated program. First, Brestan and Eyberg (1998) identified programs which they classified as well established or probably efficacious, including those based on Patterson and Gullion's (1968) manual Living with Children (designed for parents of pre-adolescents), Webster-Stratton's (1996) The Incredible Years (designed for parents of 3-10 year olds), McMahon and Forehand's (2001) Helping the Noncompliant Child (designed for parents of 2-8 year olds), Eyberg, Boggs, and Algina's (1995) Parent-Child Interaction Therapy (designed for parents of 2-8 year olds), Tremblay and colleagues' (1995) Delinquency Prevention Program (designed for parents of preschoolers through adolescence), and Henggeler and colleagues' (1998) Multisystemic Therapy (designed for parents of adolescents).

Second, the Office of Juvenile Justice and Delinquency Prevention and the Center for Substance Abuse Prevention have produced Strengthening America's Families: Model Family Programs for Substance Abuse and Delinquency Prevention (Alvarado, Kendall, Beesley, Lee-Cavaness, 2000), which showcases research-based prevention programs that are family-focused and have demonstrated effectiveness. Seven programs have been assigned the highest rating (Exemplary I) because of use of an experimental design with a randomized sample, replication by an independent investigator, and multiple studies demonstrate clear evidence of program effectiveness. Among these are three programs which also were identified by Brestan and Eyberg (1998): McMahon and Forehand (2001), Webster-Stratton (1996), and Henggeler and colleagues (1998). Strengthening America's Families also describes a number of other programs with varying degrees of empirical support, and provides contact information for all programs. Readers interested in this excellent resource are directed to their website for further information [http://www.strengtheningfamilies.org].

Challenge: *The broader social context in which a family functions interferes with treatment or maintenance of treatment gains*. While parenting interventions may appear as though they were developed to be delivered in a vacuum, clinical researchers and practitioners alike have long recognized that broader social and environmental factors influence parenting behavior and response to treatment. Perhaps the best example of this is the socioeconomic status of a family. Many researchers have noted that greater socioeconomic stress is associated with treatment dropout and poorer outcomes at the conclusion of parent training interventions (e.g., Henggeler, Melton, & Smith, 1992; Kazdin, 1990; Kazdin, Mazurick, & Bass, 1993; McMahon, Forehand, Griest, & Wells, 1981). Practitioners must recognize that families of lower SES face numerous stressors that may interfere with their ability to complete a parenting intervention and which may ultimately compromise any therapy gains. These stressors include poverty, substandard housing, residence in crowded and high crime neighborhoods, lower education, single parenthood, and lack of social support.

When working with lower SES families, practitioners should keep in mind the following suggestions. First, parenting programs that can offer on-site child care while parents are in session or assist with transportation needs have had greater success in keeping parents in treatment (e.g., Horne & Patterson, 1979). Similarly, interventions need to be delivered within the communities in which families reside, and must be offered at convenient times and locations. For example, use of community centers, churches, or schools located close to a family's home as places to deliver parent training interventions may greatly improve attendance and opportunities for success.

Second, due to the negative nature of most social service contacts that families of lower income status experience, parenting interventions may be most effective when delivered by individuals and agencies trusted by parents. When this is not possible, extra care in establishing rapport prior to conducting any formal assessment or treatment is a critical first step to successful intervention.

Third, parent trainers may need to directly address the broader needs of a family by either referring them to social service agencies or including a social work component in their treatment program. Enhancement of parents' social supports, particularly those that provide parenting support, may become a critical target of intervention. For some families, treatment for child problem behavior may end up looking more like case management at first. Parents cannot fully engage in parent training until their other

basic needs have been adequately addressed; thus, working with socially isolated or highly stressed families that present for assistance in managing their children's behavior may require much more than parent training in order to be successful.

Challenge: Most parenting interventions have been developed with Caucasian families and some principles or techniques may not generalize well to families of other ethnic backgrounds. Behavioral parent training, and the conceptual models upon which is it based, was developed with mostly intact, middle-class families of European American descent. Little consideration has been formally paid to how cultural factors, including ethnicity and social class, contribute to the development of parenting and the interventions designed to improve it. Indeed, parent training, as it has been described in this article and evaluated in the empirical literature, is based on the assumption that particular parenting behaviors (e.g., positive reinforcement, non-physical punishment) are associated with optimal child and adolescent development. However, little research has been directed to testing these assumptions in diverse ethnic groups. Culture and ethnicity do play critical roles in shaping child-rearing attitudes and practices, and to conduct parenting interventions without being sensitive to the cultural context of parenting leaves clinicians vulnerable to alienating the very families who seek their help (see Forehand & Kotchick, 1996, for a review).

Little is known about the effectiveness of parent training with particular ethnic groups, or what factors best predict success in parent training with ethnically diverse populations. Without such data to guide decisions about treatment for antisocial behavior, practitioners are left with having to evaluate the "fit" between parent training principles and techniques and a particular family's ethnic or cultural approach to parenting. Certainly, the parent training interventions described are left open to some modification based on a family's needs, and practitioners are encouraged to make such modifications if cultural beliefs about parenting clash with the theoretical and practical underpinnings of the parent training programs currently available. In this spirit, we offer the following suggestions based on available literature and our own experiences with implementing parenting interventions in the increasingly culturally diverse United States.

First and foremost, practitioners must have an awareness of the cultural attitudes and practices related to parenting that a family espouses before implementing parent training. Practitioners can learn from their clients by asking questions about parenting beliefs, expectations, and practices during assessment, or by consulting the work of colleagues in other social sciences, including anthropology, sociology, and political science, who have conducted research on parenting in diverse cultures.

Second, aspects of parent training may need to be modified to match parenting beliefs and expectations. For example, in our work with African American families, we encountered substantial resistance to the notion of reinforcing or rewarding children for compliance with parental demands. Many of the African American families with whom we interacted seemed to consider compliance to be an expected behavior, and rewarding such behavior was viewed as undermining a central family theme of respecting authority. We dealt with this issue by changing our language – instead of referring to reinforcement as rewarding, we referred to the practice of overtly showing appreciation for child compliance as "showing your child that you love her" and as a step to building stronger parent-child relationships. We also de-emphasized material, and to some extent, verbal rewards and stressed the importance of non-verbal and social reinforcement (e.g., giving hugs).

Challenge: Other family processes may interfere with the delivery of parenting interventions. In addition to contextual factors outside the family, such as social class or culture, the internal family context may also affect the ability of the practitioner to effectively implement parent training. Factors that may interfere with the delivery of parent training as it has been presented in this article may include intrapersonal functioning (i.e., parental psychopathology) and interpersonal functioning (i.e., marital conflict) within the family context. In terms of parental psychopathology, the best studied construct has been parental depression or depressive symptoms. Although fathers are receiving more attention in recent research, most of the available literature focuses on maternal depressive symptoms and its relation to parenting and parent training outcomes. Maternal depressive symptoms have been found to relate to a number of disrupted parenting practices, including inconsistent or overly harsh discipline, poor responsiveness to children, and

avoidance of conflict (for reviews, see Cummings & Davies, 1994; Goodman & Gotlib, 1999). Parental depression has also been found to negatively relate to parent training outcomes; most notably parental depressive symptoms are associated with premature dropout from treatment (McMahon et al., 1981).

Marital difficulties, particularly conflict between parents, have also been extensively studied in terms of its relationship to parenting (see Emery, 1999; Fincham, 1998) and parent training effectiveness (e.g., Dadds, Schwartz, & Sanders, 1987; Forehand, Griest, Wells, & McMahon, 1982). It has been proposed that conflict between parents may operate through disrupted parenting to negatively effect children's behavior. Parents engaging in high levels of conflict may be less responsive to children's needs, less likely to attend to children's behavior or to provide positive reinforcement, or less consistent in terms of discipline (McMahon & Forehand, 2001). Research concerning the impact of marital conflict on parent training appears to support a long-term, rather than short-term effect; specifically, conflict between parents and low marital satisfaction does not seem to affect immediate outcomes and the conflict may actually show improvement over the course of parent training (Forehand et al., 1982). However, higher levels of marital conflict at the start of parent training have been shown to interfere with maintenance of treatment gains over time (Dadds et al., 1987).

Parental depressive symptoms and marital conflict were included here as examples of the types of family processes that may contribute to child antisocial behavior and to difficulties in implementing parent training successfully. Indeed, there are many other family factors to consider before beginning parent training, including other forms of parental psychopathology (e.g., anxiety disorders), parental substance abuse, parental stress and anger coping skills, and relationships among other family members. To effectively treat problem behavior in children and adolescents, clinicians must first conduct a careful assessment of the family climate. After doing so, the practitioner may decide that parent training is the treatment of choice or, alternately, that it should be deferred until after other family problems are addressed. While there are no firm algorithms to match families with specific interventions, the available literature and our own clinical experience offer the following guidelines to assist practitioners in the treatment planning process.

First, if parental depressive symptoms or marital problems are not severe and/or appear to be related to child behavior or its management, parent training itself may be an effective treatment. Indeed, marital satisfaction scores have improved after parent training, as has parental depression (see McMahon & Forehand, 2001).

Second, parent training may be enhanced to address other family problems, such as parental depressive symptoms or marital distress. Parent Enhancement Therapy was developed by Griest et al. (1982) as an adjunct to Helping the Noncompliant Child (Forehand & McMahon, 1981; McMahon & Forehand, 2001). This program includes components to enhance communication between parents, problem-solving skills, and pleasant activities shared by spouses. These components were intended to target both marital conflict and parental depressive symptoms. Similarly, parent training programs may be modified to include components to address other family problems as well.

Third, if other family problems are severe enough to warrant more immediate or intensive attention, parent training could be conducted concurrently with treatment for the other problems of concern. It is recommended that such treatment be conducted with an independent therapist so that the clinician working on parent training may remain focused on the issues around child behavior and parenting practices.

Finally, if depressive symptoms, marital conflict, or other family problems are very severe (e.g., parent is suicidal; divorce is imminent), it may be better to delay parent training until those problems have received sufficient attention. Parent training is less likely to be effective until these issues are addressed in therapy.

Challenge: Parental expectations of child behavior, and of the therapy process, may interfere with their ability to adhere to the treatment regimen. Engaging families in parent training requires that parents view the intervention as an appropriate and potentially useful one for dealing with their concerns (McMahon & Forehand, 2001). Often parents of noncompliant or antisocial youth arrive at the therapist's door with biased, distorted, or unrealistic expectations or attributions about their child's problem behavior, its causes, their own parenting efficacy, or the therapy process (see Prinz & Miller,

1996). Sometimes, parents have unrealistic expectations about the developmental appropriateness (or inappropriateness) of their children's behavior, or they are so focused on the negative interactions with their child that they ignore or fail to recognize the child's good qualities. In addition, exasperated parents initially may not agree with the philosophy of parent training – here they are, bringing their child to clinician to be "fixed," and they are told that they have to do all the work!

Assessing, validating, and, when necessary, correcting parents' perceptions of their children's behavior and their expectations of therapy become a critical part of the treatment process. There are several ways to accomplish this. First, ask parents to share their ideas on the nature of their child's behavior, as well as their expectations about what needs to be done to alter it. This assessment will provide important information about "where parents are coming from," and how much ground they need to cover before skills training may be initiated. Second, parents who hold inappropriate expectations regarding child behavior (e.g., temper tantrums are unacceptable after age 2; young children should be able to follow multiple directions given at one time) should be educated about appropriate developmental expectations. Third, for parents who have become overly focused on the negative aspects of their child's behavior, model recognition and acknowledgement of the child's strengths and assist parents in identifying their child's positive qualities. Fourth, offer an explanation of social learning principles behind parent training techniques—parents who have some understanding of why they are being asked to do certain things and how parent training works may not be as frustrated by the demands placed on them or by setbacks in later sessions.

Challenge: Parents may not comply with the high demands placed on them in most parenting interventions. Success in parent training relies on parents' willingness to comply with homework assignments (e.g., completing behavioral observations at home, practicing skills in between sessions, reading materials that are often lengthy or complex) and regular attendance at sessions for up to several months. Some programs also require frequent telephone contacts with therapists between sessions. Relative to other therapies, behavioral parent training places high demands on parents. The cost paid by parents, though well worth it in the long run, may seem overwhelming at the outset.

Parents' failure to comply with parent training requirements has been the subject of study by Patterson, Chamberlain, and colleagues (e.g., Chamberlain, Patterson, Reid, Kavanagh & Forgatch, 1984; Patterson & Chamberlain, 1988, 1994). Parental resistance, as it has been termed, may occur both within-session (e.g., refusing to perform tasks in session, stated inability to perform) and out-of-session (e.g., failure to complete homework assignments). Contextual variables, such as social disadvantage and parental psychopathology, are associated with initial resistance, and continue to play a role in parental investment in therapy over the long run. According to Patterson and Chamberlain's (1994) "struggle hypothesis," parental resistance is expected to increase in early sessions, but eventually decrease as parents begin to meet with success in implementing their new skills. However, initial resistance is dangerous; high levels of resistance in the first two sessions of parent training have been associated with subsequent dropout (Chamberlain et al., 1984).

The quality of the relationship between parents and the therapist has been identified as a critical factor in parental compliance or resistance. Research with a family-based intervention for adolescents with conduct problems indicate that relationship characteristics such as affect-behavior integration, warmth, and humor accounted for 45% of the variance in predicting treatment outcome (Alexander, Barton, Schiavo, & Parsons, 1976). In addition, a study by Patterson and Forgatch (1985) revealed that the directive behavior of parent trainers (e.g., teaching and confronting) actually increased parental resistance in session, whereas supportive and facilitative therapist behaviors had the opposite effect. Thus, it is clear that practitioners employing parent training must be able to successfully combine the directive, "teaching" skills intrinsic to behavioral parent training with relationship building skills, such as empathy, warmth, and humor.

Although establishing a collaborative, supportive therapeutic relationship will certainly go a long way in promoting parental investment in treatment, there still remain the practical costs of parent training, including the time demanded by treatment and the expense of attending sessions. Overcoming these barriers, particularly for families most likely to present for treatment (i.e., highly stressed, fewer available resources), can be difficult. However, being creative and flexible often generates potential solutions, such as the following: First, offer

incentives or rewards for progress and compliance in therapy. For example, returning portions of a refundable deposit, engaging in phone calls with clients, and actually conducting treatment sessions can be made contingent on completion of assigned tasks. Alternatively, paying parents a small "parenting salary" upon completion of assigned tasks may increase treatment compliance and reduce dropout, particularly for lower-income families (see Kazdin, 1985). Such a "salary" could involve a small reduction in the weekly therapy fees charged. Second, being flexible in terms of where and when sessions are conducted may increase parental cooperation. As stated earlier, holding sessions at a trusted, local community center or offering services such as transportation or child care may be particularly powerful incentives for parents at high risk for drop out due to the level of competing demands for their time. Finally, employing with parents some of the same techniques they are expected to use with their children (e.g., attending, positive reinforcement) not only models these skills for parents, but also may serve to increase compliance with treatment demands.

Challenge: Because severe antisocial child behavior is more common among families who face a variety of other stressors, therapists may feel incapable of effecting real and lasting change. Parent training has never been characterized as a particularly taxing form of therapy for those who practice it. Indeed, since most of the real effort is made by parents, parent training may even be considered by some to be an "easy" treatment to implement. However, for those who work with severely antisocial youth, burnout is a real issue. Often the odds are stacked against treatment success—families are overburdened or overstressed, or the child's own behavior makes parenting interventions difficult to administer (i.e., severe antisocial/delinquent behavior). In addition, true treatment success is often dependent upon the presence and strength of family and community supports, forces which are often beyond the control of the therapist.

To counter feelings of powerlessness and exhaustion, practitioners working with severely antisocial youth are encouraged to follow the lead of Linehan and her colleagues, who identified therapist support systems as being critical to success in her dialectical behavior therapy for adults with borderline personality disorder (Linehan & Kehrer, 1993). Additionally, parent trainers can work toward building a network within the community to implement multi-level interventions. For example, Prosocial Family Therapy, developed by Blechman and colleagues, specifies a close working relationship and treatment involvement among all adults who serve caretaking roles in the target child's life (e.g., at school, in the juvenile justice system, etc.; see Blechman, 1998).

THE FUTURE: DIRECTIONS IN BEHAVIORAL PARENT TRAINING

This section will serve as a forum for discussing the future directions of parent training research and dissemination. This discussion is directed toward those working in research arenas, and is based in part on the current status of behavioral parent training research and practice. With parent training emerging as one of the best studied child and family treatment approaches (Kazdin & Weisz, 1998; Lonigan, Elbert, & Bennet-Johnson, 1998), researchers now find themselves in a somewhat unique situation—an opportunity to move research objectives beyond establishing efficaciousness in clinical trials. This extension is somewhat uncommon in social and behavioral sciences; however, in other fields, establishing efficaciousness in clinical trials is only one of several steps involved in fully examining a treatment (Duan & Rotheram-Borus, 1999). In the biomedical field, for example, testing for efficaciousness comes after first establishing that programs do no harm (Phase I) and second, might have beneficial effects (Phase II). Then, efficaciousness is established in Phase III trials, after which dissemination trials (Phase IV) begin. Phase IV trials involve implementing treatment under less controlled conditions and exploring how effectively treatment can be integrated into actual treatment settings with a range of providers and with more heterogeneous populations (Duan & Rotheram-Borus, 1999). This step is crucial, as every intervention that has been supported in research has not always been supported in practice (Hughes, 2000; Kratochwill & Stoiber, 2000).

Parent training programs for treating child externalizing behavior are clearly "ready" for Phase IV trials, and in some cases, Phase IV trials are being conducted (e.g., Calzada, Caldwell, & Miller, 2000). In moving beyond clinical trials, it appears that parent training researchers should now focus on three areas: (1) identifying alternative methods of packaging or

delivering parent training programs to diverse families; (2) developing effective methods for training clinicians in established intervention programs; and (3) disseminating programs so that they will reach the necessary audiences.

Packaging and Delivering Interventions

A longstanding concern of both researchers and clinicians has been how to best "package" programs so that they are accessible to families who do not traditionally present for treatment in clinics and mental health centers. In research studies, treatment is typically administered either by individuals with graduate degrees in clinical psychology or by individuals who are highly trained in treatment delivery. Research is needed to determine how treatment might be implemented in settings (e.g., schools, social service agencies, housing authorities) where parents are already involved and which are administered by individuals with whom the parents are already familiar. As an example of the type of research needed, Laurie Miller and her colleagues (Calzada, Caldwell, & Miller, 2000) are currently evaluating ParentCorps, which is a parent training program administered by individuals from the communities in which the participating parents reside. Training for facilitators is time-consuming and intensive, as they have varying levels of experience in working with families and acting in leadership roles. However, these facilitators will likely have the best chance of success in engaging parents and quickly establishing rapport. The outcomes from projects such as this one will begin to provide some answers to questions about community implementation of parenting programs.

In addition, it is likely that treatment in community settings will progress quite differently from the standard 12 weekly one-hour sessions that occur in clinics. In our experience, attempting to adhere to 12 one-hour sessions can be a challenge even when working with middle-class families in the structured environment of the clinic. Research is needed to determine how both the treatment pace and didactic skill delivery may need to differ from that of the clinic when implemented in community settings. It is often unreasonable to expect that low-income families can commit to three months of weekly sessions at the same time each week due to irregularity of times when they may be working and previously mentioned challenges such as difficulty obtaining childcare and transportation. With highly-

stressed families, it may be necessary to distill the information taught in a parenting program and focus only on a few "effective ingredients." While we recognize these challenges to treatment, as scientist-practitioners we also recognize the need for systematic research that will identify those crucial skills or pieces of knowledge that parents must know to adequately modify their children's behavior.

Other potential options for the delivery of interventions include utilization of the less intensive treatment methods mentioned previously, including group interventions (e.g., Long & Forehand, 2000), books (e.g., Forehand & Long, 2002), videos (e.g., Forehand, Armistead, Neighbors, & Klein, 1994; Webster-Stratton, 1996), and computer-based programs (e.g., Kacir & Gordon, 1999), and these options are in need of further empirical validation. While traditional therapist-client interventions are quite successful, the costs of one-on-one treatment are relatively high. Alternatives deserve consideration, as they offer several benefits that may make them worthwhile if one-on-one treatment is not realistic or otherwise possible. For example, while parents in a group setting may not receive as much individual therapist attention, they may benefit significantly from interacting with other parents experiencing similar difficulties with their children. Books, as noted earlier, can be used either independently or as a supplement to traditional interventions. Computer-based programs are a more recent innovation; however, at least one such program has met with empirical support and successful outcomes. Parenting Wisely (*http://www.familyworksinc.com*), developed by Donald Gordon, is an interactive and self-administered CD-ROM program that requires no outside intervention in order to be implemented (Kacir & Gordon, 1999). Clearly, more research attention is needed to evaluate programs such as these, both as stand-alone interventions and as a way to augment more traditional parenting interventions.

Training Clinicians.

In order for programs to be implemented smoothly by practitioners, they need to be packaged in a way that allows for thorough assimilation of the skills by the therapist. However, determining the most thorough method of instruction must also be balanced by considerations regarding monetary costs and the time required to learn the programs. Treatment manuals, which most programs provide, are quite thorough and low-cost but may involve

time-intensive self-study and do not provide opportunities to have questions answered or to obtain supervision and feedback on implementation. Workshops, which some programs offer, provide intensive training on the material covered in the treatment manuals and typically offer opportunities to role play skills and even obtain feedback on skill use, but are usually costly and may require travel. One option that complements the training manuals involves videos of therapists conducting each of the parent training sessions with a family (e.g., Forehand et al., 1996). These videos are useful both for clinicians and for parents as both can see how treatment will likely progress. Further efforts could be made toward developing more interactive strategies for training clinicians in behavioral parent training programs.

Disseminating Programs.

As in most fields, becoming highly skilled in treatment outcome research requires a high level of devotion and commitment to that one area. Unfortunately, the skill set for conducting research does not translate well into the field of marketing: those who do an excellent job of developing and testing treatments typically do a poor job of promoting them outside of the traditional academic outlets. In fact, the skills required for effective marketing can almost be considered contradictory to the skill set typically held by researchers. Research findings about empirically supported programs need to be translated into succinct, easily readable, and engaging summaries that do not resemble results sections of research papers. Programs need recognizable logos, descriptive names, and attractive brochures and handouts. Furthermore, either the researcher, or someone knowledgeable about the program, needs to focus on attending conferences for practitioners and obtaining interviews on talk shows and in magazines that will reach the target audience of program consumers (e.g., practitioners, parents).

For empirically supported programs to be implemented by practitioners, they have to be readily available and accessible. Even when a particular program's efficaciousness is presented in a scientific journal, information is rarely included regarding how the program manual might be obtained. Including this information would be a relatively easy step for researchers. In addition, more efforts need to be made to use web resources, practitioner-focused

conferences, mailings, and state and local psychology associations to disseminate programs.

In addition to the need for clinical researchers to better promote and disseminate their programs, there clearly is a need for a more open avenue through which clinicians implementing parent training programs in the "real world" can communicate with researchers any difficulties they encounter. As the individuals most familiar with the treatment, they can then partner with researchers in developing solutions similar to those presented in the challenges section of this chapter. However, it would also be beneficial for clinicians to be more involved in the research process so that these parent training programs can be better fitted to real-world practice. One potential path for this involvement is for clinicians using empirically supported parent training programs to submit case studies of treatment implementation in journals that specialize in issues related to clinical treatment, such as Cognitive and Behavioral Practice or Clinical Case Studies.

As this discussion suggests, much is left to be done in the field of parent training research. If empirically validated programs are going to be implemented in "real world" practice, researchers must find ways to accomplish the goals of improved dissemination and marketing of their products. One potential avenue involves researchers themselves developing skills in dissemination and marketing. However, this investment may be prohibitive, both in terms of financial cost and time. A second avenue involves partnering with a company or organization that specializes in marketing and dissemination, or hiring a consultant who is more expert in marketing.

CONCLUDING COMMENTS

Clearly, parent training has a long history which establishes it as one of the best studied and most effective interventions for childhood and adolescent problem behavior (Alvarado et al., 2000; Brestan & Eyberg, 1998; Kazdin & Weisz, 1998). The basic model of parent training provides a format for intervening with mild to severe behavior problems, and has proven to be flexible and adaptable in a wide range of clinical settings (e.g., Calzada, Caldwell, & Miller, 2000; Griest et al., 1982) and to a wide variety of child difficulties beyond acting-out behaviors (see Wells, 2001, for a review). While its core principles and methods have been supported as both efficacious and modifiable, several challenges

remain to be conquered. As we have discussed, clinicians and researchers face important tasks in furthering the development of parent training. Specifically, clinicians and researchers must find avenues through which they may collaborate more easily to remedy and refine aspects of implementation beyond laboratory walls. Researchers are charged with identifying viable and efficacious alternatives for delivery, including the exploration of the potential offered by the internet and other computer-based intervention modalities. Further research is sorely needed to identify the best options for dissemination, marketing, and training of practitioners so that empirically validated parent training approaches are utilized with those families who need them. Parent training may be in the enviable position of being a well-established and widely utilized program, but, in the ever-evolving social and political climate of modern society, there is always more work to be done.

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