CHAPTER 3

Training for Parents of Young Children with Conduct Problems: Content, Methods, and Therapeutic Processes

CAROLYN WEBSTER-STRATTON and LOIS HANCOCK

This chapter describes a comprehensive videotape-based parenting program that has been proven effective both in clinical treatment programs for young children referred for conduct problems and in community programs for families at increased risk for abuse and child conduct problems because of the risk factors associated with poverty (Webster-Stratton, 1994, 1995, in press; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989). The program was designed with the broad goals of (a) strengthening parenting competence, especially the use of nonviolent discipline approaches; (b) increasing positive family support networks and school involvement; (c) promoting child social competence; and (d) decreasing child conduct problems.

The program targets parents of young children ages 3 to 8 years. There are several reasons for targeting this age range. First, epidemiological studies have indicated that conduct problems among preschool children are more common than was once thought (Landy & Peters, 1991). In one of the first studies to examine the prevalence of behavior problems in young children, Richman and Graham (1975) found that 15% of 3- to 4-year-olds had mild behavior problems and 7% had moderate to severe behavior problems. Similarly, Earls (1980) reported significant behavior problems among 24% of the preschoolers in his sample. In another study of parents of children ages 6 weeks to 5 years, the number and intensity of parental concerns peaked when children were ages 3 to 4 years; the major complaints involved difficulties with behavior management and discipline (Jenkins, 1980). Relatively high proportions of parents of 4-year-olds complain of more general problems with noncompliance, limited self-control, and poor relations with siblings and peers (Kazdin, 1985; Ogbu, 1978). Richman, Stevenson, and Graham (1982) reported that 12.9% were described by their mothers as overactive and restless, 10.7% were seen as difficult to control, and 9.2% were seen as attention seeking. A large-scale screening study of day-care attendees (ages 2–4 years) in rural Vermont (Crowther, Bond, & Rolf, 1981) found that, according to teachers, at least 20% of the children exhibited high frequencies of aggressive and disruptive behaviors, with the most severe forms observed among preschool boys.

In our own study with 500 low-income mothers of 4-year-old children from eight Head Start centers, we found that 43.6% of mothers perceived their children as being in the clinical range (above normative cutoff point) for conduct problems on the Eyberg Child Behavior Inventory (ECBI); (Robinson, Eyberg, & Ross, 1980); 25% were in the severe range (above 15 behavior problems). According to mother reports on the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1991), 35.5% of the children were above the normal cutoff T-scores for externalizing problems (85th percentile) and 20% for internalizing problems; 15% were in the severe range for externalizing problems (i.e., a T score above 67, which reflects the 95th percentile). Moreover, independent home observations of mother–child interactions indicated that the mean base rate of total child aggressive and noncompliant behaviors during home observations was 15.2 per 30 minutes, that is, one every 2 minutes. These base rates are notably higher than previously reported epidemiological studies regarding aggression in the general population of preschoolers, suggesting that poverty places children at higher risk for early-onset conduct problems. These data are also supported by Offord, Boyle, and Szatmari (1987), who found in their epidemiological study that conduct problems among children ages 3 to 7 occurred at higher rates in low-income families on welfare than in middle- or upper-income families.

The second reason for targeting hard-to-manage young children ages 3 to 8 is that these "aggressive" children are at increased risk for rejection by their peers (Coie, 1990b) and for abuse by their parents (Reid, Taplin, & Loeb, 1981), as well as for school dropout, alcoholism, drug...
abuse, depression, juvenile delinquency, antisocial personality, interpersonal problems, poor physical health, marital disruption, and criminal activities later in life (Kazdin, 1985). Studies have shown high continuity between oppositional and externalizing problems in the early preschool years and conduct disorders in adolescence (Egeland, Kalkoske, Gottesman, & Erickson, 1990; Fisher, Rolf, Hasazi, & Cummings, 1984; Richman et al., 1982; Rose, Rose, & Feldman, 1989). Campbell's review (1991) of a series of longitudinal studies of hard-to-manage preschoolers reveals a surprising convergence of findings. At least 50% of preschool children with moderate to severe externalizing problems continued to show some degree of disturbance at school age, with boys doing more poorly than girls. Of those with continuing behavior problems, 67% met the diagnostic criteria for Attention Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (OD), or Conduct Disorder (CD) by age 9. Moreover, Eyberg (1992) points out that although this percentage is high, it may be an underestimate since many of the children from the most dysfunctional families were lost to follow-up.

Developmental theorists have suggested that there may be two developmental pathways related to conduct disorders: the "early starter" versus "late starter" pathway (Kazdin, 1985; Loeb, 1990; Patterson, Rubaryshe & Ramsey, 1989). The hypothesized "early onset" pathway begins formally with the emergence of conduct problems (e.g., noncompliance, hitting, yelling at high rates) in the early preschool period, progresses to aggressive (e.g., fighting) and nonaggressive (e.g., lying and stealing) symptoms of conduct disorders in middle childhood, and then develops into the most serious symptoms by adolescence (Lahey, Loeb, Quay, Frick, & Grimm, 1992), including interpersonal violence and property crimes. In addition, there is an expansion of settings in which the problem behaviors occur, from home to day care or preschool settings, then to school settings, and finally to the broader community. For the adolescent ("late starter") onset conduct disorders, the prognosis seems more favorable than for adolescents who have a chronic history of conduct disorders stemming from their early preschool years. Adolescents who are most likely to be chronically antisocial are those who first evidenced symptoms of aggressive behavior in the preschool years (White, Moffit, Earls, & Robins, 1990). These children with early-onset conduct problems also account for a disproportionate share of delinquent acts in adolescence. Thus early-onset conduct problems are a sensitive predictor of subsequent CD, and the primary developmental pathway for serious conduct disorders in adolescence and adulthood appears to be established in the preschool period (Campbell, 1991; Campbell & Ewing, 1990; Loeb, 1991).

Based on the evidence that a significant number of children who become chronically antisocial and delinquent first exhibit aggressive symptoms during the preschool and early school years, it is surprising that there have not been more early screening and prevention/intervention studies targeted at this age group. Intervention while these children are preschoolers is particularly strategic. Intervention programs for parents of preschool and early school-age children can help these parents teach their children to behave appropriately before aggressive behaviors result in peer rejection, well-established negative reputations, and school problems (Bierman, Miller, & Stabb, 1987; Coie, 1990a, 1990b; Dodge, Coie, Fett, & Price, 1990), not to mention academic failure. Data suggest that fewer than 10% of young children with conduct problems who need mental health services actually receive them (Hobbs, 1982).

PARENT TRAINING PROGRAM

THEORETICAL BACKGROUND

In developing this parenting program, we have been strongly influenced by the seminal theoretical work (Loeb, 1985) on conduct-disordered behaviors by G. R. Patterson (1982, 1986). His social-learning model emphasizes the importance of the family socialization processes; in his "coercion hypothesis," negative reinforcement plays an important role in developing and maintaining both the child's deviant behaviors and the parents' critical or coercive behaviors. His research demonstrates that as this coercive process continues over time, the rate and intensity of parent and child aggressive behaviors escalate. Moreover, the parents' increasingly frequent use of negative discipline provides the child the opportunity for further modeling (observational learning) of aggression (Patterson, 1982). This pioneering research indicates that harsh and inconsistent parenting skills are at least partly responsible for the development of conduct problems. Patterson's success in reducing conduct problems by training parents of preadolescents, suggested to us that we working with at-risk families to train parents in supportive, noncoercive parenting skills while their children were still very young could alter the poor long-term prognosis for these children.

SUMMARY OF PARENTING PROGRAM AND RESEARCH FINDINGS

For the past 15 years, we have conducted a program of research to develop and evaluate videotape modeling for group discussion parent training programs for families of children with conduct problems (ages 3–8 years). Our original 12-week parent program, titled BASIC (10 videotapes with more than 250 vignettes) was heavily guided by the modeling literature and focused on teaching parents interactive play skills and reinforcement skills based on the early work of Hanf (1970) and Eyberg and Matarazzo.
(1980), as well as a specific set of nonviolent discipline techniques including Time-Out and Ignore as described by Patterson (1982) and Forehand and McMahon (1981) logical and natural consequences, and problem-solving strategies (D'Zurilla & Goldfried, 1971; D'Zurilla & Nezu, 1982). In 1987, we developed a supplement to the program (ADVANCE) that addressed other family risk factors (e.g., depression, marital distress, poor coping skills, lack of support). In 1992, we revised our training videotapes to make the program more culturally sensitive, more prevention-oriented, and more usable outside the Pacific Northwest; for example, we included a higher percentage of people of color (40%). In addition, we developed a new program titled Supporting Your Child's Education to address the risk factors related to children's lack of academic readiness and weak home/school connections. All three programs involved videotapes and group discussion.

Research in a series of randomized studies with over 600 children referred for conduct problems (ages 3–7 years), the BASIC program has been shown to be effective in significantly improving parental attitudes and parent-child interactions, along with significantly reducing parents' use of violent, nonverbal discipline and reducing child conduct problems (Webster-Stratton, 1982, 1984, 1989, 1990b, 1994; Webster-Stratton et al., 1989). The ADVANCE program has been shown to be highly effective in promoting parents' use of effective problem-solving and communication skills, reducing maternal depression, and increasing children's social and problem-solving skills (Webster-Stratton, 1994). Both programs have received high consumer satisfaction and low dropout rates regardless of the family's socioeconomic status. Effects have been sustained up to 4 years' postintervention (for a complete review of the clinic-based research, see Webster-Stratton, 1996, 1997).

We also examined the effectiveness of using a shortened version of the BASIC program as a selective prevention intervention in a randomized trial with 500 Head Start families. Head Start social service staff were trained to lead the parent groups. Results indicated that mothers who attended the parenting program made significantly fewer critical remarks, made less use of physically negative discipline, and were more positive, appropriate, and consistent in their discipline style when compared with control mothers. Intervention mothers perceived their family service workers (group leaders) as more supportive than did control mothers; furthermore, teachers reported that mothers who had attended the parenting program were more involved in their children's education than control mothers. In turn, children of parents who had been trained were observed at home to exhibit significantly fewer negative behaviors, less noncompliance, more positive affect, and more prosocial behaviors than children of control parents. These data supported the hypothesis that strengthening parenting competence and increasing parental involvement in children's school-related activities in a high-risk sample of welfare mothers is a useful strategy for decreasing conduct problems (Webster-Stratton, 1995).

**Specific Content of BASIC Parenting Program**

**Play Skills**

The training begins with a focus on play. Therapists discuss with parents the importance of play and present effective ways of playing with children. The unfortunate fact is that many parents of children with conduct problems do not want to play with their children; their interactions are simply too stressful. Typically, there is negativity on both sides: These parents feel negative toward their children out of anger and frustration concerning their children's misbehavior, and their children in turn are negative toward their parents. Therefore the first step in breaking this negative cycle of behaviors and feelings is to infuse some positive feelings into the relationship through play. For parents of highly aggressive children, playtimes can be the first pleasurable times they have had with their children in months or even years.

Regular daily parent-child playtimes help build warm relationships between family members, creating a "bank" of positive feelings and experiences that can be "drawn on" in times of conflict. This is particularly important for parents of children with conduct problems who may be feeling resentful, critical, angry, distant, or hopeless about their relationships with their children. Play with parents not only helps children feel deeply loved, thereby fostering a secure base for their ongoing emotional development, but just as importantly, promotes parents' feelings of attachment and warmth toward their children.

Teaching parents how to have good playtimes with their children not only fosters warmth in the relationship but also helps children learn some other important skills such as the vocabulary they need for communicating their thoughts and feelings. It also helps them learn the social skills of turn-taking and fosters their ability to understand the feelings and perspectives of others. Through play, parents can help their children learn to solve problems, test out ideas, and use their imaginations. Moreover, play is a time when parents can respond to their children in ways that promote children's feelings of self-worth and competence. In fact, studies have shown that children tend to be more creative, to have increased self-confidence, and to have fewer behavior problems if their parents engage in regular playtimes with their children and, when doing so, give them their supportive attention. However, many parents do not play in supportive ways; they use playtime to "teach," to correct, to instruct; or they
compete with their child, criticize his or her actions, undermine, or interfere with their child’s play. Or it may be a matter of giving only divided attention. The BASIC program focuses first on teaching parents how to engage in supportive, child-directed play.

In the first three 2-hour sessions of the BASIC program, parents view and discuss more than 50 videotaped vignettes of parents and children playing together in both appropriate and inappropriate ways. Parents are asked to play with their children at home for at least 10 minutes every day, using the skills they learned in the weekly group sessions. Therapists discuss the most common pitfalls that parents encounter when playing with their children. The following principles are stressed:

**Points to Remember When Playing with Children**

- Follow the child’s lead.
- Pace at the child’s level.
- Engage in role play and make-believe with the child.
- Praise and encourage the child’s ideas and creativity.
- Use descriptive comments instead of asking questions.
- Be an attentive and appreciative audience.
- Curb the desire to give too much help; encourage the child’s problem solving.
- Don’t expect too much—give the child time to think and explore.
- Avoid too much competition with children.
- Don’t criticize.
- Reward quiet playtimes with parental attention.
- Laugh and have fun.

**Praise**

Parents of children with conduct problems often find it hard to praise their children. Perhaps believing that children should behave appropriately without adult reinforcement or that praise should be reserved for exceptionally good behavior or outstanding performance, many parents would never think of praising their children for playing quietly or for doing their chores without complaining. Although some parents believe they should not have to praise their children for everyday behaviors, many others simply do not know how or when to give praise and encouragement. They themselves may have received little praise from their own parents when they were young, not accustomed to hearing praise, the words may seem awkward or artificial. Or perhaps they are so stressed and angry with their children for misbehaviors that they cannot see any praiseworthy behavior even when it does occur.

Consequently, our therapists teach parents to identify the behaviors they want to promote, to look for those behaviors, and to praise them. Here are the major points we emphasize:

**Points to Remember about Praising Your Child**

- Don’t worry about spoiling children with praise.
- Catch the child when he or she is being good—don’t save praise or perfect behavior.
- Make praise contingent on positive behavior.
- Praise immediately.
- Give labeled and specific praise.
- Praise with smiles, eye contact, and enthusiasm.
- Give pets, hugs, and kisses along with verbal praise.
- Praise in front of other people.
- Praise wholeheartedly, without qualifiers or sarcasm.
- Increase praise for difficult children.
- Model self-praise.

Sometimes parents will say that their child is so deviant that they can find nothing to praise. Many times, these are depressed parents who cannot see the prosocial behaviors in their child. Watching the videotapes of parent-child interactions helps such parents to identify positive behaviors that they can reinforce.

Many parents who don’t praise their children don’t praise themselves, either. If they listened to their internal “self-talk,” they would find that they are rarely or never saying things like, “You’re doing a good job of disciplining Johnny,” or “You handled that conflict calmly and rationally,” or “You’ve been very patient in this situation.” Instead, they are quick to criticize themselves for every flaw or mistake. Therapists teach parents how to speak to themselves in positive statements and to create positive experiences for themselves as incentives or rewards for following through with their playtimes each week. We believe that if they can do this for themselves, they will be more likely to continue praising and playing with their children.

**Incentives**

For some oppositional and conduct-disordered children, parental praise is not sufficient reinforcement initially to turn around a difficult problem behavior. In these cases, incentives or tangible rewards can be used by parents to help motivate the child. Incentives or rewards include things the child particularly enjoys such as a special treat, additional privileges, a toy or a favorite activity, stickers, additional time with a
parent, or having a friend overnight. Incentives can be used to encourage such positive behaviors in children as using the toilet, playing cooperatively with siblings or friends, getting dressed, getting ready for school on time, completing homework, cleaning up the playroom, and so on. When teaching parents about using incentives, our therapists stress the importance of continuing to provide social rewards as well; each type of reward serves a different purpose. Social rewards such as praise and physical affection should be used to reinforce the small efforts children make to master a new skill or behavior, whereas tangible rewards can be used to reinforce the achievement of a specific goal. Once children learn the desired behavior, tangible rewards can be phased out and the social reward of parental praise will maintain the existing behavior.

The therapists teach parents two ways of using rewards. The first is for the parent to surprise the child with a reward whenever he or she behaves in some desired way, such as sharing or sitting still in the car. This approach works best if the child already exhibits the appropriate behaviors fairly regularly and the parent wants to increase the frequency with which they occur. The second approach is for the parent to plan the reward in advance with the child (or “explain to the child in advance”—as in a contract). This program is recommended when parents want to increase an infrequent behavior. For example, a parent might set up a sticker chart for two children who fight frequently. She could start by telling both children that they will receive a sticker for every half hour that they play cooperatively. Then she could discuss with them a reward they would like to work for, such as having a friend overnight, reading an extra story at bedtime, going to the park with Dad, choosing their favorite cereal at the grocery store, going to a movie, picking something from a surprise grab bag, and so forth. It is a good idea to make the reward list fairly long and include nonmaterial as well as material rewards and inexpensive items as well as more expensive items. This list can be altered over time as children come up with new suggestions. Whereas preschool children (ages 3–4 years) may be rewarded by the sticker itself without needing a backup reinforcer, 5- to 6-year-olds should be able to trade in stickers for something each day if they like, and 7- and 8-year-olds can wait a few days before getting a reward.

We give parents the following list of principles to use when starting incentive programs:

Points to Remember about Incentive Programs

- Define the desired behavior clearly.
- Choose effective rewards (i.e., rewards that the child will find sufficiently reinforcing).
- Set consistent limits concerning which behaviors will receive rewards.
- Make the program simple and fun.
- Make the steps small.
- Monitor the charts carefully.
- Follow through with the rewards immediately.
- Avoid mixing rewards with punishment.
- Gradually replace rewards with social approval.
- Revise the program as the behaviors and rewards change.

Parents are given the home assignment of identifying one or two positive behaviors they want to increase and then setting up an incentive program with their child (charts and stickers are sent home with parents). When they return the following week, they present their plans and reward charts to the group and the therapist and other parents spend time reviewing and revising the charts and troubleshooting possible pitfalls.

It usually takes six to seven group sessions to cover the topics of play, praise, and tangible rewards. The objective of this first part of the training is to foster more positive relationships between parents and children and to help parents promote more appropriate social behaviors in their children. We often see behavior problems improve in this part of the program even though we have not discussed discipline. As we move into the next phase of the parenting program, we frequently refer to the pyramid (see Figure 3.1) to remind parents of the foundation (play and positive reinforcement) and to reiterate the importance of building this positive base as we begin to focus on strategies designed to decrease inappropriate behavior.

Limit Setting

The first aspect of discipline that we discuss is the importance of clear limit setting. However, we also remind parents that all children test their parents’ rules and standards. Young children scream or throw temper tantrums when a toy is taken away. School-age children argue or protest when banned from something they want. This is a healthy expression of a child’s need for independence and autonomy. Research shows, in fact, that normal children fail to comply with their parents’ requests about one third of the time. What makes the oppositional defiant or conduct-disordered child different is that he or she is noncompliant about two thirds of the time. This means that these parents are engaged in power struggles with their child the majority of the time, making it very difficult for them to adequately socialize their child.

We teach parents that children test parents’ rules not only to assert their autonomy, but also to see whether their parents are going to be
environment and learn which behaviors are appropriate or inappropriate. Our therapists explain that consistent limit setting and predictable responses from parents help give children a sense of stability and security. They reassure parents that children who feel a sense of security regarding the limits of their environment have less need to constantly test it. While stressors such as marital discord, single parenting, poverty, unemployment, depression, and lack of support may make it difficult for parents to be consistent, strengthening parents’ sense of commitment to limit setting can help buffer the disruptive effects of these stressors on parenting. One of the ways the therapists elicit this commitment is to engage the parents in an exercise of listing the advantages as well as the possible barriers to limit setting. The subsequent discussion helps parents grasp the importance of consistent limit setting for their children’s eventual adjustment and define the reasons for their inconsistency. We highlight the following major points:

**Points to Remember about Limit Setting**
- Be realistic in your expectations and use age-appropriate commands.
- Give one command at a time.
- Use commands that clearly specify the desired behavior.
- Make commands short and to the point.
- Use “do” commands and “when-then” commands.
- Make commands positive and polite.
- Give children options whenever possible.
- Give children ample opportunity to comply.
- Praise compliance or provide consequences for noncompliance.
- Give warnings and helpful reminders.
- Don’t use “stop” or “don’t” commands.
- Don’t give unnecessary commands.
- Don’t threaten children.
- Support your partner’s commands.
- Strike a balance between parent and child control.

**Ignoring Skills**

Young children with conduct problems engage in irritating behaviors such as whining, teasing, arguing, swearing, and tantrums at rates higher than normal children. Although these inappropriate behaviors are usually not dangerous to others, they frequently lead to peer rejection and isolation, which are damaging to children’s self-esteem. Yet these misbehaviors can often be eliminated through systematic ignoring.

Ignoring is one of the most difficult approaches for parents to use; many parents argue that ignoring is not discipline at all. Thus, it is particularly important for the therapist to explain the rationale for this
approach. The rationale for ignoring is straightforward. Children’s behavior is maintained by the attention it receives. Even negative parental attention, such as nagging, yelling, and scolding, can be rewarding to children. When misbehavior is ignored, on the other hand, children receive no payoff, so that if the ignoring is consistently maintained, children will eventually stop what they are doing. And as they receive approval, attention, and incentives for appropriate behaviors, they learn that it is more beneficial to behave appropriately than inappropriately.

The following are the key principles we emphasize:

Points to Remember about Ignoring
- Limit the number of behaviors to ignore.
- Choose specific behaviors to ignore and make sure you can ignore them.
- Be consistent.
- Physically move away from the child but stay in the room if possible.
- Avoid eye contact and discussion while ignoring.
- Return attention to the child as soon as misbehavior stops.
- Be prepared for testing.

Time-Out Skills
We teach parents to use time-out for high-intensity problems, such as fighting, hitting, and destructive behavior. The therapist explains to parents that time-out is actually an extreme form of parental ignoring in which children are removed for a brief period from all sources of positive reinforcement, especially parental attention. Not only does time-out assure that the child’s misbehavior is not being reinforced by attention, but time-out models for children the parent’s use of self-control and a non-violent response to a conflict situation. Time-out gives the child (and the parents) time to cool down, get control over misbehavior, and reflect on what has happened. Because time-out forces children to reflect and calm down, they are more likely to develop appropriate guilt, and an internal sense of responsibility or conscience over time. We also help parents understand that time-out is a discipline approach that fosters a warm, respectful relationship rather than a fearful, power-based relationship (i.e., based on fear of being hit by parent); one that contributes to open communication rather than devious sneaky behavior on the part of the child who wants to avoid punishment. Here are the key principles we emphasize:

Points to Remember about Time-Out
- Monitor your own anger to avoid exploding suddenly; give warnings.
- Don’t threaten time-out unless prepared to follow through.

- Carefully limit the number of behaviors for which time-out is used.
- Use time-out consistently for chosen misbehaviors.
- Be as polite and calm as possible in sending child to time-out.
- Give 5-minute time-outs, requiring that the last 2 minutes be silent.
- Ignore child while in time-out.
- Be prepared for testing.
- Use nonviolent approaches, such as loss of privileges, as backup for not going to time-out.
- Hold children responsible for messes in time-out.
- Support a partner’s use of time-out.
- Don’t rely exclusively on time-out—combine with other techniques, such as ignoring, logical consequences, and problem solving.
- Build up “bank account” with praise, love, and support.

Parents are often quite resistant to using time-outs, for various reasons. First, it is inconvenient: It requires advance planning in terms of the procedure and the location. Second, it can be time-consuming and may require that parents keep themselves under control for long periods. Third, it can be frustrating for parents because the child’s misbehavior may get worse in time-out, since children often scream, bang on the walls, or break something. Some parents resist time-out because they don’t think it produces enough remorse and pain in children, which they think are necessary for punishment to work effectively (some children even indicate they like time-out). Still other parents resist time-out because they feel it communicates rejection to the child.

Conversely, many parents prefer spanking as a discipline strategy because it is efficient and immediate, and most likely will stop the inappropriate behavior in the short-term. It can even feel good to some parents because it “even the score.” That is, parents may feel they have obtained revenge for the child’s misbehavior by inflicting pain as punishment. For some parents, the use of spanking is important because it allows them to feel dominant and maintain control of the situation. However, research has shown that spanking, lecturing, criticizing, and expressions of disapproval are ineffective methods of discipline and usually result in parents finding themselves spiraling into more and more uncontrolled spanking and yelling to get their children to respond. We help parents understand that in fact, nagging, criticizing, hitting, shouting, and even reasoning with children while they misbehave are forms of parental attention which actually reinforce the particular misbehavior; these approaches also result in children learning to nag, criticize, hit, shout, or argue in response to their parents. Spanking and yelling also teach children that it is all right for someone who loves you to hit or yell at you when displeased with your behavior. Moreover, the
violence of spanking increases children's resistance, resentment, and anger toward the parent and erodes the parent-child relationship. Consequently, rather than the child reflecting on his or her mistake and feeling guilt and remorse for it, the child externalizes the event by directing resentment and blame toward the parent for hitting him or her.

We have found it useful to bring the issue of spanking to the foreground through a values exercise wherein we brainstorm (without judgment) the advantages and disadvantages of spanking, followed by the advantages and disadvantages of time-out. This discussion usually leads most parent groups to the insight that spanking has many advantages (to the parent) in the short-term but disadvantages in the long-term (to the child). On the other hand, time-out is inconvenient (to the parent) in the short-term but has more long-term advantages for the child's social and emotional development. Helping parents to shift their perspective from their child's present misbehavior to his or her future development is a critical step, with potential to greatly empower parents; they realize that they can make a difference for their child's future by the way they parent and socialize their children.

Natural and Logical Consequences

More so than time-out or ignoring, natural and logical consequences teach children to take responsibility for their own behavior. A natural consequence is whatever would result from a child's action or inaction in the absence of adult intervention. For example, if Ryan slept in or refused to go to the school bus, the natural consequence would be that he would have to walk to school. If Caitlin did not want to wear her coat, then she would get cold. In these examples, the children experience the direct consequences of their own decisions—they are not protected from the possibility of an undesirable outcome of their behavior by their parents' commands. However when implementing consequences, assuring the safety of the child should be of primary importance. For example, the child should not be permitted to walk to school if he is very young or the neighborhood is unsafe. A logical consequence, on the other hand, is designed by parents who hold children accountable for their behavior. A logical consequence for a youngster who broke a neighbor's window would be to do chores in order to make up the cost of the replacement. A logical consequence for stealing would be to take the object back to the store, apologize to the store owner, and do an extra chore or to lose a privilege.

Natural and logical consequences are most effective for recurring misbehaviors where parents are able to decide ahead of time how they will follow through if the misbehavior recurs. For example, the parent who says, "If you aren't dressed for school by 8:00 a.m., you will have to go in your pajamas," or "If you spend all your allowance on candy, you'll have no money for that movie you want to rent," is informing the child ahead of time what will be the consequence of continuing the behavior. In effect, the child has a choice and is responsible for the outcome. On the other hand, the parent who does not specify the consequence ahead of time is not helping the child see the connection between the behavior and the negative outcome. We emphasize the following principles concerning natural and logical consequences:

Points to Remember about Consequences

- Make consequences age-appropriate.
- Be sure you can live with the consequences you have set up.
- Give the child a choice; specify consequences ahead of time.
- Involve the child whenever possible.
- Use consequences that are short and to the point.
- Make consequences immediate.
- Make consequences safe and nonpunitive.

CONTENT OF ADVANCE Parenting Program

A number of studies have indicated that a family's ability to benefit from parenting training is influenced by factors such as maternal and paternal depression (McMahon, Forehand, Griest, & Wells, 1981; Webster-Stratton & Hamond, 1990), marital conflict and hostility (Dadds, Schwartz, & Sanders, 1987; Webster-Stratton, 1994), isolation (Dumas & Wabler, 1983), negative life stressors (Dumas & Wabler, 1983; Webster-Stratton, 1985b), and socioeconomic status (Webster-Stratton, 1985b, 1990a; Webster-Stratton & Hamond, 1990). Other researchers examining parent training interventions have found similar factors to be associated with treatment relapses (Dumas & Wabler, 1983; Forehand, Furey, & McMahon, 1984; Griest et al., 1982; Patterson, 1986). These findings suggest that parenting training programs need to emphasize partner involvement, parent support, problem-solving, communication, and coping skills, and depression management. Although therapy cannot alter a family's life stressors and economic situation, it can help parents and children cope more effectively in the face of stressful situations.

As a result of these research findings, we developed the ADVANCE videotape parent program, which is offered following completion of the BASIC program in an additional 8 to 10 sessions. The focus of these sessions is on parents' communication, anger management and other coping skills, and problem solving. We help parents realize that children are constantly learning from observing their parents' interactions with each other and with others in their community, including teachers and neighbors (see Figure 3.2).
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that they may be angry at an ex-partner, a teacher, another family member, or someone in their community for the lack of support and inability to understand their difficulties raising a child single-handedly. In teaching communication skills as part of our parenting program, we hope not only to enable them to resolve current problems and avert future ones, but also to model these skills for their children.

Listening. The first skill we teach is effective listening—listening without interrupting, giving advice, criticizing, or arguing. We call this "giving the other person the floor," and for humor as well as to make the point concrete, we quite literally give them a piece of floor tile. We emphasize paraphrasing, summarizing, and validating statements as part of listening skills.

Speaking Up. Among the parents who come to us for help with their children's conduct problems, we have identified a subgroup of "conflict avoiders"; because they dislike arguments, these parents store up grievances and resentments until they finally explode in anger. Teaching parents how to bring up issues as they occur involves helping them become more comfortable with conflict. This is a long-term process, but we try to develop a higher tolerance for conflict by establishing some ground rules that parents are encouraged to adopt at home as well as in the training sessions. These include:

- Politeness. It is amazing but true that families are much more likely to say mean or insulting things to the people they know and love than to strangers. Family members frequently interrupt each other, put one another down, and hurt each other's feelings. Put-downs evoke anger, resentment, defensiveness, and guilt or depression, and they undermine effective communication and problem solving. We teach parents that politeness is extremely important in the effective resolution of a situation regardless of how their child or partner is acting, and ask parents to make a conscious decision to be polite to each other. Just because someone else is rude and childish does not make it acceptable to behave similarly. This means parents must do a bit of editing before they speak.

- Permission to Stop (Truce). We teach parents to call a "stop" or "truce," and to halt all discussion when they find themselves becoming increasingly critical or angry. The therapist helps the parents decide in advance exactly how they are going to signal the need for a "stop" or "truce." They might simply say, "I need to stop talking about this right now," or "I'm getting upset. Could we talk about this later when I calm down?" (Note the use of "I" messages.) Everyone in the family needs to agree that even if only one person gives the signal, the discussion will end temporarily. The person who calls

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**Figure 3.2 Pyramid for Building Relationships.**

**Communication Skills**

Many parents—whether or not their children have conduct problems—find themselves in disagreement over how to discipline their child. This is to be expected, given that they have had different childhood experiences of parenting. Yet all too often, these different perspectives result in anger, even open conflict, between couples over how to raise their children. In the case of conduct problems, this parental conflict only aggravates the problem. Frequent marital conflict and negative affect can lead to ineffective parenting, which contributes to child conduct problems which, in turn, contribute to further marital distress and depression. Moreover, children become increasingly aggressive with peers when they frequently observe the negative interactions between their parents. A similar pattern can occur for single parents, the only difference being
the truce is then responsible for setting another time for resuming the discussion. Cooling-off periods should be no longer than 24 hours, or the parents may avoid resolving the problem altogether.

Feeling Talk. We also teach parents the importance of speaking up about feelings—both their own and their children's. Many parents talk to their children about ideas and facts, but rarely their feelings or their children's. Research suggests that boys are likely to be criticized for crying or being emotional. Girls are more likely to be taught that direct expression of angry feelings is unfeminine. As a result, boys learn to express angry feelings, and girls learn to express feelings of depression.

Parents need to be encouraged to model feeling talk for their sons and daughters. "I enjoyed our time together today. I feel happy," "I understand you feel angry about not going to the movie," and "I feel sad that your puppy died," are all examples of effective feeling-talk that involve "I" statements and are based in the present. We warn parents that expression of feelings does not include license to "let it all hang out" in a tirade of negative feelings. In fact, we educate them about the dangers of parental hostility and open conflict for children's social and emotional development. We teach them that if they express negative feelings or have disagreements in their marital relationship, it is important to reassure their children that they are not to blame. Moreover, we teach them the importance of children observing their parents discussing differences of opinion calmly and coming up with mutually agreed-on solutions to their problems. For if children can see their parents engaged in effective problem solving, their anxiety about conflict will be greatly alleviated, whereas if they see (or sense) marital conflict but do not see any resolution, they will remain anxious and be sensitized to future conflict.

Avoiding Mixed Messages. We cover "mixed messages" in our parenting training because this type of communication, when habitual, can have such devastating psychological effects on children; even when it occurs only infrequently, it undermines the parent-child relationship. When one aspect of a parent’s communication conveys approval while another conveys criticism, a child is confused and his or her self-esteem suffers. When a parent’s words say one thing and his or her behavior another, the child does not know what to believe, what to trust, and loses confidence in his or her own perceptions.

Parents undermine themselves when they deliver mixed messages. Our therapists emphasize the importance of parents being clear and consistent, so that the content and feeling of their communication match, as should the verbal and nonverbal messages. Research indicates that when there is a discrepancy, the listener tends to weight the nonverbal or feeling messages as truer. Thus, even if the words are positive, when the affect is negative, the child or partner will hear the message as negative.

Training for Parents of Children with Conduct Problems

Making Requests. Probably the most difficult communication transaction between partners, and the most common between parent and child, is that of asking someone to do something—a request or command. In relationships where an ongoing conflict exists, these can be particularly troublesome. A direct request for a specific behavior may be perceived as authoritarian and compliance might then be felt as an acceptance of the hierarchy rather than simple cooperation. People in such relationships find themselves arguing over the specific request when the real issue is the power struggle—who is in control. We teach parents about the importance of being able to make requests in a polite way and the necessity of complying with requests in any relationship; reciprocity in the relationship is emphasized as the goal as opposed to one person dominating the other.

Managing Upsetting Thoughts

All parents have their moments of anger, depression, frustration, and guilt—sometimes all at the same time—when dealing with their children’s misbehaviors. Upsetting feelings are not only to be expected, but are beneficial in that they signal the need for change and provide motivation. Danger arises, however, when these feelings so overwhelm parents that they are immobilized or lose control. In our parenting training, then, our aim is to help parents learn to cope with their emotional responses to parenting in a manner that preserves their feelings of efficacy.

We ask parents to identify some of their common negative self-statements; and then we teach them to defuse these negative thoughts in the following four ways:

1. Use Thought Interruption. As soon as the parent is aware of having a negative thought, he or she is told to stop the thought by saying, "I am going to stop thinking about that now." Some parents wear a rubber band on their wrist and snap it every time they have a negative thought to remind them to stop it. "Stop worrying. Worrying won't help anything."

2. Reschedule Worrying or Anger Time. For parents who constantly revisit all the ways their children have made them angry or compulsively review a list of all their worries, we ask them to schedule "anger time" or "worry time" into the day. For example, they will allow themselves 30 minutes at 9:30 a.m. to be as angry as they want; during the rest of the day they will not allow these thoughts to interfere with their mood, work, or play. For some parents, we will suggest a "telephone time" when they can call the therapist and tell them their angry thoughts. The paradox of this approach is that when it comes time to "vent," the parent often doesn't feel as angry and finds it difficult to do.
3. **Objectify the Situation.** The third approach we teach for stopping negative self-talk is for parents to ask themselves during moments of conflict whether what they are thinking or doing is helping them reach their goal. Some researchers have called this the “turtle technique” because parents withdraw into a shell momentarily to assess their behavior. One father in a parent group gave us an example: He was trying to leave for work and his son wasn’t ready to go. He put him in his bedroom and the boy started screaming. The father’s anger increased until he opened the door and grabbed his son saying, “You want negative attention, you’re going to get it!” Suddenly, he thought about what he was doing and realized that this was getting him nowhere. He left the room, went outside, and a few minutes later his son joined him fully dressed. The father discussed how he was able to become more objective, to stand back and assess what was happening and realize that losing control or getting revenge would only aggravate the situation.

4. **Normalize the Situation.** The fourth approach that therapists help parents learn is to objectify or normalize a situation by remembering that all relationships have conflict and all children have behavior problems. Moreover, all parents and children have feelings of guilt, depression, anger, and anxiety. The group process is very effective for helping with normalization because parents soon realize most of the parents in the group have had similar thoughts and reactions.

Once parents have learned to normalize thoughts and to stop the negative ones then they need to learn how to increase their positive thoughts, because reducing the number of negative thoughts does not automatically increase positive ones. We teach six steps to help increase positive thoughts:

1. Dispute negative self-talk; refute negative labels.
2. Substitute calming or coping thoughts for negative ones.
3. Time projection—paint a positive future.
4. Think and verbalize self-praise.
5. Use humor. Laugh.
6. Model positive, coping self-talk out loud.

Therapists help parents identify negative labels they may carry about their children’s or partner’s personalities (e.g., ‘he’s totally irresponsible’) and to refocus on positive behaviors they want to encourage. Therapists can dispute negative thinking by asking the parents, “Is that always true?” or “Is that totally accurate?” or by encouraging parents to ask themselves these questions. Most likely, the behavior is only true for the moment. When parents move from the behavior to the specific behavior that is annoying them, they may be able to come up with a coping statement. Diane’s dad might say to himself, “I seem to be labeling her. She’s not really lazy. She’s just having trouble remembering to take out the garbage. I’ll talk to her about ways to remember.” The therapists can help remind parents that all children throw tantrums, disobey, forget to do chores, and behave aggressively from time to time.

Negative labels go hand-in-hand with defeatism. A mother who has worked with her son but finds he continues to get poor grades may say to herself, “I’m tired of this. Why try at all? Nothing will work”; or “I can’t deal with this.” He’s just not capable.” The adoption of a defeatist attitude usually results in withdrawal from the problem, avoidance of discipline, and a simmering level of anxiety or anxiety. Eventually, parents will either explode with anger or become depressed. Moreover, saying that a child is not capable of changing has the possibility of becoming a self-fulfilling prophecy. We teach parents to think, “This is frustrating and I’m tired but I can cope,” or “No one can make me give up. Things will get better. It just takes time.” The important message for parents to give themselves and their children is that they can all cope with the situation. Even if things are bleak, parents can reflect a positive outlook for the future.

A related tendency is what we call “negative prophecy”—predicting a dismal future. Parents of conduct problem children often come to expect that because negative behaviors have occurred, they will continue and will determine future events: Five-year-old Connie has been stealing small things around the house, and her father thinks, “She will become a delinquent and drop out of school.” Other examples of negative foretelling are, “He’ll never stop,” “Oh no, it’s starting again. It will be just the same as last time.” This kind of gloomy prophesying causes parents to feel depressed, behave passively, and withdraw from helping their children act more appropriately. Moreover, negative predictions set up a self-fulfilling prophecy. If parents are convinced that their children will never behave any better, then they probably won’t.

Our therapists strive to help parents to think more positively so that they focus on coping and present children with more hopeful messages about their capabilities. One strategy is prediction—mentally traveling forward to a time when the stressful period will have ended and a positive outcome has been achieved. The mother of 6-year-old twins who fight constantly might say to herself, “It is hard to have two 6-year-olds. They bicker all the time. But in a few years they will probably get along well and be good friends.” Sometimes parents say to themselves, “This isn’t fair! Why do I have to have a child like this? I don’t deserve this. My child
deserves to be punished.” They feel victimized by their children and their life circumstances, and their anger serves the purpose of justifying their revenge. They may think they are in control of the situation even though their anger is out of control. Indeed, it is hard to let go of anger, especially if parents feel they are the victim of unfair treatment. Being angry can help them feel righteous, energized, and powerful. Giving it up can be difficult because it is sometimes confused with loss of power. In such situations, we find it is useful to help parents think in terms of long-term goals rather than the short-term satisfaction of revenge. Parents are encouraged to say to themselves, “In the long term, it is better for my child to see me cope by taking charge of my anger rather than to let it control me.” Another constructive self-statement would be, “The long-term cost of letting my anger explode would be far greater than the momentary satisfaction of showing my child (or partner) I won’t be pushed around.”

Some parents assume they know why their child or spouse behaved in a certain way. Often they attribute motives to misbehaviors and act on these beliefs as if they were true. We call this “mind-reading.” These assumptions can become self-fulfilling prophecies. For example, two children are bickering in the den while their mother is trying to watch the news. She mind-reads, “They are being loud on purpose. They want to make me mad!” Or a father comes home from grocery shopping and finds his wife talking on the phone while the kids mess up the living room. He mind-reads, “Nobody cares about me. If she cared about me, she would make the kids behave properly.” This kind of negative mind-reading is bound to increase resentment and anger toward his wife and children.

We help parents understand the importance of focusing on the behavior they want to change and to avoid speculating about motives. Instead of the mother thinking, “They are doing it on purpose to make me mad,” she might say to herself, “I don’t know what has upset them today. Perhaps I should ask them.” She asks them about their problem instead of making assumptions. In the second example, the father might tell himself, “I need to talk to her about helping the kids keep the living room tidy.” He avoids mind-reading and focuses on the behavior he wants to change. He has chosen to see himself as a facilitator of change rather than a victim of his family.

As parents learn to use coping, calming thoughts when confronted with a problem, we encourage them to say them out loud (see Table 3.1). While a family is seated at the dinner table, Mom might say to Dad, “Peter, I think I coped well with Alice’s problem at school. I told myself not to overreact, that all children have difficulty at school from time to time. I set up an appointment with her teacher to talk about ways we can help her learn to share better. I feel good about that.” Here Alice’s

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**Table 3.1**

<table>
<thead>
<tr>
<th>Upsetting Thoughts</th>
<th>Coping Thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>“My child is a monster. This is ridiculous.”</td>
<td>“My child is testing to see if he can get his own way. My job is to stay calm and help him learn better ways to behave.”</td>
</tr>
<tr>
<td>“I’m sick of being her maid. Things are going to change or else!”</td>
<td>“I need to talk to Bethany about her leaving her clothes around. If we discuss this calmly, we should be able to reach a good solution.”</td>
</tr>
<tr>
<td>“He’s just like his father. I can’t handle it when he’s angry.”</td>
<td>“I can handle this. I am in control. He has just learned some powerful ways to get control. I need to develop a plan to teach him more appropriate ways to behave.”</td>
</tr>
<tr>
<td>“I can’t take this. Why did I have to end up with a child like her?”</td>
<td>“She’s difficult because she’s only 5 years old. She’s learning and it will get easier.”</td>
</tr>
</tbody>
</table>

**Other Calming and Coping Thoughts**

I don’t like it when she acts like that, but I can handle that.
My job is to stay calm and help him learn better ways to ask for what he wants.
I can help her learn better ways to behave.
He is just testing the limits, I can help him with that.
This is not the end of the world. She is a bright child and I’m a caring mother. We will make it over this hump.
He really doesn’t do that much any more, and has been quite good lately. This is a temporary setback.
I shouldn’t blame my impatience on her. I’ll talk to her about it.
I am doing the best I can to help them learn more positive behaviors.
I can develop a plan to deal with it.
I have a lot of coping techniques I can call upon.
This stress I’m feeling is exactly what the therapist said I might feel, it is a reminder to use my coping exercises.
She doesn’t really understand what those swear words mean. I’m not going to let it upset me.
Don’t be so hard on myself—nobody’s perfect. One step at a time.
We’re getting through this—each day it gets a little better.
I don’t need to take care of everything right now; all I need to do is take care of today.

**Examples of Self-Praise Thoughts**

I have good self-control.
I like people.
I can cope.
No one can make me mad; it’s up to me.
I can control my thinking and my anger.
I’m a good parent.
I try hard.
mother not only is modeling how she stopped herself from overreacting, but also is modeling self-praise.

Managing Stress through Personal Time-Out

Once parents have learned to recognize upsetting thoughts and substitute coping thoughts, we move to the topic of handling stress. The first step is becoming aware of their physiological responses to stressful events and thoughts. Many people report that in stressful situations they experience levels of physical tension, rapid heartbeat, headache, hypertension, and muscle tension that interfere with their behavior and thinking processes. One of the myths about stress is that it happens only in crises or emergencies. In fact, studies show that everyday hassles may actually produce more stress. And parenting certainly can produce a lot of stress.

The daily tensions—getting everyone ready to leave for work and school, rushing around doing errands, meeting deadlines, trying to find a babysitter, not having enough money to pay for school pictures or a birthday present—take their toll. Stress results not only from major life events like divorce or moving, but also by seemingly little things, such as children misbehaving or being ill, cereal spilled on the floor, or a pile of dirty clothes. The causes of stress are highly individual. What brings one person to the verge of “losing it” may not bother another person at all. Helping parents learn to manage their stress levels is essential to helping them learn to become skillful, consistent parents.

Modifying negative self-talk and developing a repertoire of coping thoughts help parents lower their levels of stress. We also recommend to parents that they develop the habit of taking personal “time-outs” from stress to provide an opportunity for physical, mental, and emotional relaxation and recuperation. In most sports, there is provision for time-out. These breaks give the coach and team a chance to catch their breath, regroup, and then reenter the game with renewed energy. In our daily lives, however, there are very few time-outs. Even coffee breaks are usually filled with stimulation rather than relaxation. Certainly there are very few opportunities for recuperation in the average parent’s day, especially for at-home parents of young children. And yet it is the at-home parent who is particularly in need of opportunities to rest, strategize, and reenter the game of parenting with renewed energy.

The essence of parental time-out is for parents to step back from the stress of interacting with their child and refocus on what is essential. Once parents have gained perspective on the situation and calmed down their physiological reactions such as racing heart or muscle tension, they have robbed it of the power to overwhelm them. Parental time-outs may last a minute or they may last an hour—whatever is possible given the circumstances. Here are some variations on parental time-out: One to two sessions are devoted to this topic, although aspects of these themes are interwoven throughout every session:

- **Time-Out for a Breather.** This involves breathing deeply and slowly ideally in a quiet place. If possible, the parent also practices deep relaxation. Actually, the mere act of deep breathing will result in some degree of muscle relaxation.
- **Time-Out on the Go.** This technique can be used anywhere, while grocery shopping, doing the dishes, or sitting at a desk. Parents are taught to systematically tense and relax certain muscle groups and to visualize their muscles relaxing and releasing tension. For example, breathe in, tensing one arm and fist as tightly as possible. Hold for a count of four, then relax fully while breathing out. Repeat for other parts of the body.
- **Time-Out for Visualizing.** A third use of time-out is to visualize or imagine a calm scene. Parents choose their own personal visualization—a cloudless sky, an expanse of ocean, a quiet library. They can use it when they find themselves becoming tense.
- **Time-Out to Control Anger.** While some parents believe that “blowing off steam” by shouting and swearing will drain off violent energy and reduce aggression, we teach them that rather than having a cathartic or beneficial effect, outbursts of anger inflame aggression and violence. Studies have shown that couples who yell at each other do not feel less angry afterward; they feel more angry. The reason for this is that angry outbursts are self-reinforcing because they give people a false sense of power. They often feel that their anger forces others to take them seriously or results in others’ compliance. Therapists help parents to look at the long-term effects of anger on themselves and on their children. When parents are taking a time-out to control anger, we ask them to practice their deep breathing and visualization exercises and focus on coping self-statements.
- **Time-Out for Self-Talk about Stress.** Parents are taught to use their self-talk as a way to manage stress, that is, to stop stressful thoughts by refuting or disputing them, or putting the stress in perspective. For example, tell yourself, “This is normal. Stress is a reasonable and normal response to what I’m dealing with today. This is the way I usually feel when I begin a time-out.” Parents learn to use these feelings of tension as allies in coping with the situation. They serve as signals for parents to say to themselves, “Relax, take a slow breath. Take it easy.” We teach parents to expect their stress will rise at times and to remember, the objective is not to eliminate it totally but to keep it manageable. The idea is for parents to normalize stress and recognize it as a part of family life. They are helped to think
about it as temporary rather than ongoing, to focus on what is controllable instead of what is uncontrollable, to focus on coping rather than on feelings of being overwhelmed, and to define steps they can take rather than blaming others.

- **Time-Out for Fun.** Here parents are urged to use time-out for doing something pleasurable such as reading, going for a walk, taking a bath. We focus on pleasures involving little or no expense and that are nurturing rather than destructive to one’s health.

All the preceding uses of parental time-out can help parents release tension and anger, regain a calmer physiological state, and gain a greater sense of control over their own emotional state and their own behavior—thereby helping them be better parents. All might be termed “self-care.”

In our experience with parent training groups, we have found the notion of parental self-care to be a foreign concept—especially with low-income families, who are typically so overwhelmed with daily tasks and depressed about their life circumstances that they feel unable to focus on self-care. As we talk with them about time-outs for personal, no-cost, or inexpensive pleasures, we meet resistance: “I can’t take care of myself—I can’t afford a sitter and I can’t leave my children alone to take a walk,” or “I can’t go to a movie—I don’t have a car or any money!” or “You’ve got to be kidding—I’ve got enough to do!” Our first homework assignment on this topic is, therefore, for parents to make a list of things they could do to give themselves a pleasurable break from parenting. Another homework assignment is to list typical daily stressors and come up with a positive strategy for handling the stress. Our discussion on this topic includes an exercise where parents list all possible obstacles to following through with their plan to reduce stress and think about ways to counteract some of these obstacles. As groups hear themselves talk in terms of devaluing themselves and their needs and feeling trapped, they begin to brainstorm ways they could help each other to accomplish this goal. We teach parents several ways to take personal time-out for the release of tension and anger, and the attainment of self-control.

**Problem Solving**

Although many people might like to think that the ideal family or couple has no conflict, we know otherwise. Conflicts and disagreements are inevitable in families and couples because of competing needs, differences in individual viewpoints, developmental pressures, and so on. What marks a resilient family or couple is not the absence of disagreements and conflict, but the ability to resolve them to everyone’s satisfaction (more or less). Families and couples that can successfully negotiate their differences and can accept compromise, resolving problems collaboratively so that all the participants have and feel the resolution takes into account their position (although it may not be exactly what they want), will be better able to maintain satisfying relationships in the face of those inevitable difficult periods in their lives; families and couples who cannot do so will break apart under the strain. In the next two portions of the training program, we focus on teaching parents problem-solving skills that can help them cope with the inevitable conflicts in all relationships. Therapists explain that problem solving is not like other types of discussion. It is neither spontaneous nor natural; it is highly structured. Problem solving involves a specific set of methods designed to enhance one’s ability to think effectively about the issues and to work toward resolution of the conflict. However, being structured does not mean that it must be dull. On the contrary, many families report that the structure underlies an interesting process that brings them together by encouraging flexibility and collaboration.

Problem-solving skills incorporate the communication and cognitive skills learned in the prior sessions. It is important that these be taught first, before the problem-solving content. Anger can cause a narrowing of vision that blocks the ability to define issues and perceive options. It may also fuel the belief that other people have deliberately caused a problem and an attitude that action must be taken immediately, without time for deliberation. Depression can cause withdrawal from the process or a passive attitude toward problems. Parents must have some control over feelings of intense anger or depression before effective problem solving can begin.

We teach six steps to effective problem solving:

1. **Set Aside a Time and Place and Decide on an Agenda.** We recommend that parents not try to resolve conflicts at the time they arise. Most people are too emotionally aroused in the “heat of the battle” to go through the problem-solving process in a rational manner. Discussing a problem at a neutral time makes it much more likely that it will be resolved effectively. To prepare for problem solving, parents need to determine a specific time and place to have discussions. Many decide to meet at the same time each week. Often this will be at night after the children are in bed. We advise that they take the phone off the hook (or turn on the answering machine and turn down the volume), turn off the television, and eliminate as many other distractions as possible. We also tell them to set the agenda in advance, so that both people can be thinking about it, and to limit it to only one problem. We advise them to spend no more than 45 minutes on a problem. Few people can tolerate more than 45 minutes of problem solving without becoming exhausted.
2. **Describe and Define the Problem.** In describing the problem, each person needs to present his or her viewpoint, including:
   a. **Situation:** What is the problem?
      - Who is involved?
      - What aspect of it bothers you?
      - How frequently does it happen (per day, per week)?
      - Where and when does it happen?
      - How does it happen? What sets it off or follows its occurrence?
      - What happened last time?
      - Why do you think it is happening, or what reasons do others give?
   b. **Response:** How do you feel when the problem is occurring?
      - What do you do and say while it is occurring?
      - How do you feel afterward?
      - Why do you respond that way?

   It is important that parents have a collaborative attitude and share responsibility for problem solving. Only one problem should be dealt with at a time. If one person does sidetrack in this manner, the other can say, "I think we are supposed to be discussing when you come home, not my discipline techniques." Although one parent might feel that he or she is the victim of a situation and that the other person is the cause of the problem, these feelings need to be put aside to encourage a sense of working together. Difficult as it is, each parent must listen carefully to the other person's point of view. Even if only one person in the family considers a situation to be a problem, it is critical that the family address it as a *mutual* problem that both people (or the whole family) must help resolve. This contributes to the well-being of the entire family.

   After both have described the problem situation from their point of view, they should define the problem concisely. The definition should be oriented toward change desired in the future rather than focusing on the past.

3. **Outline Goals and Expectations.** Once the problem has been defined, the parents should again summarize the problem and then state the desired goal. For example, "I would like you to be home by 7:00 p.m.," or, "I would like him to be able to share better." The goal should then be assessed to be sure (a) it would resolve the problem, and (b) it is realistic (expecting a tax accountant to be home by 7:00 p.m. during tax season isn't realistic).

4. **Brainstorm Solutions.** We then teach parents to brainstorm—to generate possible solutions. Parents are encouraged to generate as many solutions as they can conceive, without evaluating them. No further discussion of the problem should occur. The focus here is on creativity and productivity, so any judgments about the possible solutions or assessment of their merits should be avoided at this stage. We encourage parents to suggest several humorous ideas to lighten up the discussion.

5. **Make a Plan.** The fifth step in the process is to go through the list of possible solutions one at a time, eliminating any far-fetched and impossible ones and combining any that naturally go together. Then the pros and cons of each solution should be discussed in detail, keeping in mind the following:
   - Is it realistic and practical?
   - What are the best and worst possible outcomes?
   - Are the best outcomes short- or long-term?
   - How well do the best outcomes match the goal that we defined?

   Then a plan of action should be formulated. This may combine several ideas from the list and should state clearly what each person will do and who will be responsible for what. The agreement should be written down and a follow-up meeting should be scheduled to review how the plan of action is working and determine any necessary revisions.

6. **Evaluation of Outcome.** At a follow-up meeting, the solutions should be evaluated by answering several questions. First, was the strategy carried out as planned? For example, if the plan was that Dad would be home by 7:00 p.m. 3 nights each week and spend Saturday mornings with the family, was this done consistently? If not, what prevented him from doing so? Second, if the plan was designed to improve a behavior, how was the behavior affected? If the goal was to have their child in bed by 9:00 by using stickers, then some record should be kept of the child's actual bedtimes. Finally, do the goals and observed outcomes match? Do the changes actually create the desired outcome? If not, then a new strategy may need to be developed.

   Often when parents begin to discuss a problem with their partner or children, they find themselves arguing about who caused the problem. But arguments of this sort inevitably involve blaming and accusations; as we know, they usually escalate into bickering. They are powerful methods for undermining the problem-solving process and are sometimes even used for that purpose (though usually unconsciously). Our therapists try to impress on parents the importance of an attitude of collaboration in problem solving; that is, both parents must share responsibility for
the problem. We urge upon parents the necessity of putting aside feelings of victimization or self-righteousness and substituting a commitment to problem solving. The goal is not to decide who is at fault, but to define the nature of the problem and how to solve it.

Of course, one problem-solving session is not going to resolve a problem if it is a difficult one. But even a small step in the desired direction can be a real turnaround for a couple. Our therapists reinforce this progress and urge parents to praise each other’s problem-solving efforts. Such positive feedback sets the stage for future sessions. If couples and families can learn to successfully problem-solve together, they are more likely to maintain flexible, satisfying relationships over a long period of time.

This content usually takes three to four sessions to complete. Homework assignments for the first week include practicing defining problems clearly and using the listening and speaking communication skills. The following week, the parents are asked to outline goals and brainstorm possible solutions. We have parents practice these skills with a fairly easy problem first, and then gradually move to more difficult ones.

Teaching Children to Problem-Solve

When young children react to their problems by crying, hitting, or running to their parents, these responses do little to help them resolve the problem; in fact, they create new problems. But research shows that children resort to inappropriate strategies because they do not know other ways to respond. Parents can help by teaching their children problem-solving skills.

First and foremost, parents can teach these skills by modeling them. It is a rich learning experience for children to watch parents discussing problems with other adults, negotiating and resolving conflict, and evaluating the outcome of their solutions in an appropriate, nonhostile manner. Although parents may not want their children to observe all their problem-solving meetings, many daily decisions they make provide good opportunities for them to learn. For example, children learn from noticing how their parents say “no” to a friend’s request. They watch with interest as Dad receives Mom’s suggestion to wear something different. Is Mom sarcastic, angry, or matter-of-fact in her request? Does Dad pout, get angry, cooperate, or ask for more information? Watching parents decide which movie to see on Saturday night can teach children much about compromise and negotiation. Watching them discuss financial problems teaches children how to carry on a problem-solving discussion in the face of stress and worry.

Besides modeling problem-solving skills, parents can teach these to their children directly. But many parents confuse telling their children what to do with helping them learn to problem-solve. There are many obvious problems with this approach; parents may tell their children what to do before they have found out what the actual problem is, that is, from the child’s viewpoint. Thus one of the first tasks for parents when their children are engaged in conflict is to understand the problem from the child’s point of view. Parents need to learn to ask questions like, “What happened?” “What’s the matter?” or “Can you tell me about it?” and to deliver them in a nonaccusatory tone so that the child will be more likely to talk openly about it. This questioning not only helps the child to clarify the problem in his or her own mind, but also ensures that the parent won’t jump to the wrong conclusion about what’s going on, for any solution must be relevant to the child’s perception of the situation. And when children believe that their parents understand their point of view, they are more likely to be willing to deal with the problem cooperatively. Rather than being encouraged to learn how to think, they are told what to think and the solution is imposed on them.

We teach parents to help their children learn the following five steps to problem-solve successfully:

1. What is my problem?
2. What are some plans (brainstorm solutions)?
3. What are the consequences? What is the best plan (evaluate consequences)?
4. Am I using my plan (implementation)?
5. How did I do (evaluate the outcome and reinforce efforts)?

Throughout the process, parents can encourage children to talk aloud as they think and can praise their ideas and attempts at solutions. In this way, parents reinforce the development of a style of thinking that will help them to deal with all kinds of problems.

Our therapists begin by helping parents set up hypothetical problem situations with their children. Through the use of stories or puppets, parents can create problem scenes and ask their children to come up with as many solutions as possible. We give parents a list of possible “suppose games” they can play with their children at home for problem-solving practice. For example: Suppose a child much younger than you started hitting you. What would you do? Or, Suppose a boy had been playing for a long, long time with a toy, and you wanted to play with it. What would you do?

After proposing a hypothetical problem, parents encourage their children to think about their feelings as well as those of the other person in the situation and, on that basis, to describe the problem. Parents then invite them to come up with as many solutions as they can. If children cannot think of any to begin with, parents suggest a few. The objective for parents is to make these problem-solving discussions fun by using cartoons, stories, or puppets. They might even suggest that they write a
story together. Parents are cautioned to avoid criticizing or ridiculing any of their children's ideas, no matter how silly they are. Instead, they are urged to encourage creative thinking and to model creative solutions themselves.

After generating possible solutions, the next step is to help children look at what would happen if each solution were carried out. Parents help their children imagine the possible consequences. Often, children are surprised or upset when things don't go as envisioned. This reaction can partially be avoided if they stop and predict several outcomes that might result from their behavior. A child might say that tricking or hitting a friend to get a toy is a solution. The parent would then help the child to consider the possible outcomes, such as losing a friend, getting into trouble, or getting the toy. The consequences of asking the friend for the toy might include being turned down or ignored—or it might get the child the toy. After reviewing possible outcomes, parents help their children decide which one or two might be the best. For children between the ages of 3 and 8, the second step of generating possible solutions is the key skill to learn. While implementation and evaluation are more easily done by older children, youngsters first need to consider possible solutions and to understand that some solutions are better than others.

The fourth step is for parents to help children actually implement a solution (if the problem is a real-life problem). Real-life problem solving is, of course, much harder than problem solving in a hypothetical or neutral situation. In conflict situations, children may be so angry and upset that they cannot think clearly. Parents will need to be able to calm them through discussion, so they can come up with some solutions. Sometimes children may be so emotional that they need to go for a brief time-out until they cool off. Occasionally, a problem is so distressing that it is best discussed later when both parents and their children have had time to calm down and gain some perspective. We teach parents to guide their children into thinking about what may have caused the problem in the first place and to invite them to come up with a possible solution. If parents want to help their children develop a habit of solving their own problems, they need to be encouraged to think for themselves. Parents can teach their children how to think about a problem but should not teach them what to think about it. The only time parents need to offer solutions is when their children don't have any ideas, but this should not be confused with teaching problem solving.

The opposite occurs when parents think they are helping their children learn problem solving by telling them to work it out for themselves. This presumes that their children already have good problem-solving skills; but for most young children, this approach will not work. If two children are in conflict over a toy, parental ignoring will probably result in continued arguing and the more aggressive child getting the toy. The more aggressive child will be reinforced for inappropriate behavior (because he got what he wanted) and the other is reinforced for giving in (because the fighting ceased when he backed down). The children learn from this situation, but it is not a lesson we would want them to learn.

**PARENT TRAINING METHODS**

**Videotape Modeling**

Because the extent of conduct problems has created a need for service that far exceeds available personnel and resources, we were convinced of the need to develop an intervention that would be cost-effective, widely applicable, and sustaining. Videotape modeling promised to be both effective and cost-efficient. Bandura's (1977) modeling theory of learning suggests that parents could improve their parenting skills by watching videotaped examples of parents interacting with their children in ways that promote prosocial behaviors and decreased inappropriate behaviors. Moreover, this method of training would be more accessible, especially to less verbally oriented parents, than other methods (e.g., didactic instruction, written handouts, group discussion) and could promote better generalization (and therefore long-term maintenance) by portraying many models in a wide variety of situations. Furthermore, videotape modeling has a low individual training cost when used in groups, and lends itself to mass dissemination.

Thus, we developed a program that relies heavily on videotape modeling as a therapeutic method. Therapists present 16 videotape programs composed of more than 250 brief vignettes showing parents and children of different sexes, ages, cultures, socioeconomic backgrounds, and temperamental styles. Parents are shown interacting with their children in natural situations, such as during mealtimes, getting children dressed, toilet training, handling disobedience, and playing together. Scenes depict parents "doing it right" and "doing it wrong." The intent in showing negative as well as positive examples is to demystify the notion of "perfect parenting" and to illustrate how parents can learn from their mistakes. The videotapes are used as a catalyst to stimulate group discussion and problem solving, with the therapist ensuring that the discussion addresses the intended topic and is understood by the parents. As noted earlier, our research has indicated that therapist-led group discussion utilizing videotape modeling is superior to therapist-led group discussion without videotapes, as well as to videotape alone (Webster-Stratton, 1990b; Webster-Stratton et al., 1989; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). When showing a videotape vignette, the therapist pauses the tape to give parents a chance to discuss and react to what they
have observed. Sometimes group members are uncertain about whether the kinds of parenting they have just observed are appropriate or not. Thus, the therapist asks open-ended questions such as, “What do you think about this parent’s approach to the situation?” or “How would you feel if your child did that?” (Suggested questions and discussion topics are included in therapist manual.) If participants are unclear about specific aspects of the parent-child interaction, or if they have missed a critical feature of the vignette, the therapist rewinds the tape and has the group watch the scene again. The goal is not only to have parents grasp the intended concept, but also to have parents become actively involved in problem solving and sharing ideas about the vignette. The therapist can facilitate integration of the concepts by asking how the concepts illustrated in the vignettes apply or don’t apply to parents’ own situations. For example, a mother makes the following comment after watching a few of the play vignettes:

**MOTHER:** I don’t have any toys at home. I can’t afford toys like those shown on the tapes—I’m living on a welfare check.

**THERAPIST:** You know, even if you had the money it is not important to have fancy toys. In fact, some of the best toys for children are things like pots and pans, empty cereal boxes, dry macaroni, and string—why don’t we brainstorm some ideas for inexpensive things you could use to play with your child at home?

This interaction between the therapist and mother illustrates the importance of collaborating with parents to be sure the concepts shown on the videotapes are relevant for their particular cultural and socioeconomic situation.

**Therapists’ Do’s and Don’ts of Using Videotapes**

1. Pace vignettes throughout the entire session. Avoid waiting until the last half of the program to show the majority of vignettes.
2. Allow for discussion following every vignette. If you are short of time, you may verbally highlight key points in the vignette. Do not run vignettes together without dialogue.
3. Allow for parents’ first impressions (insights) to be expressed before you offer analysis and interpretation.
4. If parents’ reactions are critical of the behavior shown in a vignette, balance their perspective by noting some positive features of the parents’ behaviors. (If you allow a group to go too negative, parents may feel you could be just as critical of their mistakes.)
5. Remember to model a realistic perspective of parenting.

**ROLE PLAY AND REHEARSAL**

Role playing or rehearsal of unfamiliar or newly acquired behaviors is one of the most common components of parent training programs and has been shown to be quite effective in producing behavioral changes (Eisler, Hersen, & Agars, 1973; Twengman & McFall, 1975). Role plays help parents anticipate situations more clearly, dramatizing possible sequences of behavior. We recommend doing three to four brief role plays during each session.

Many parents, however, feel inadequate regarding their parenting behavior, and therefore may be reluctant to undertake role playing. Besides presenting a clear rationale for conducting the role play, we have found that it is often best for the therapist to do the first role play to reduce parents’ self-consciousness and anxiety. It also helps to make the role play humorous through exaggeration. For example, the therapist role-playing the parent may go out of the room and shout from a distance (e.g., kitchen) for the child (role-played by parent) to put away the toys. This usually raises chuckles of recognition, for there is no way for the parent to know whether the child is complying or not, or whether the child has even registered the command.

After the therapist has done the first role play, we then break the parent group into pairs to practice particular skills such as play, praise, time-out, or problem solving. We often find it is a good idea to first instruct parents to “do it the worst way possible,” and then follow this with, “Now use as many of the positive strategies we talked about as possible.” The contrast helps reduce performance anxiety over projected demands for perfection. Later on, as parents become more comfortable, they can role-play a situation in front of the whole group; for example, role playing the use of time-out with a “difficult child.” In this case, one parent plays the child and another the child’s parent. The rest of the group act as coaches for the “parent.” It is often helpful to “freeze-frame” the role play and ask the group questions such as, “Now what should she do?” or “What is the child trying to say by behaving like that?”

Role playing can also be useful in the case of the long-winded parent who wants to describe in detail some situation at home. We can shortcut the discussion and clarify the problem by asking, “Why don’t you be the child or parent and show us exactly what happens?” This allows us to role play alternative responses for the parent to try at home.

Our weekly evaluations indicate that parents find the role plays extremely useful. Usually it is the therapist who is most resistant to the idea of doing role plays, for effective role playing requires that the therapist allow him- or herself to take risks, to be playful, to be vulnerable, and to relinquish control.
Weekly Home Assignments

As we have seen from the description of the program content, for every session there is a home assignment. Parents need to understand the purpose for the assignments. They should be presented as an integral part of the learning process.

Therapist: You can’t learn to drive a car or play the piano without practicing, and this is also the case with the parenting skills you are learning here—the more effort you put into the assignments, the more success you will have with the program.

The assignments help transfer what is talked about in group sessions to real life at home. They also serve as a powerful stimulus for discussion at the subsequent session. Moreover, assignments convey the critical message that sitting passively in the group is not “magic moon dust”; parents must collaborate with the therapist by working at home to make changes.

Parents are provided with the book, *The Incredible Years*, as part of the training materials (Webster-Stratton, 1992). Each week they are asked to read a chapter to prepare for the subsequent session. For those parents who cannot read, audiotapes of the chapter are provided. Along with the reading assignment, homework usually involves asking parents to do some observing of behavior or recording of thoughts at home and trying out a particular parenting strategy. At the start of every group session, the therapist asks parents to share their experience with the home assignment and reading for the week. This enables the therapist to see how well the parents are integrating the material into their daily lives. Parents are more likely to take the assignments seriously if they know the therapist is going to begin each session by reviewing the assignment from the previous week.

When a parent questions the usefulness or feasibility of an assignment, this should be explored immediately, in a collaborative spirit. For example, a single parent with four young children says she is unable to do 15 minutes of playtime each day with an individual child. The therapist responds:

Therapist: I imagine you barely have 2 minutes to yourself all day—let alone 15 minutes with an individual child. Let’s talk about ways to practice the play skills with several children at the same time. Or, would it be possible to play in brief bursts of 2 or 3 minutes throughout the day? Or, are there any times when you have only one or two children at home?

Training for Parents of Children with Conduct Problems

If the therapist does not pursue the issue, parents may conclude that the therapist is not really committed to the assignments or does not really want to understand parents’ particular circumstances. Similarly, when a parent fails to complete an assignment from the previous session, the therapist should explore the problem with questions such as, “What made it hard for you to do the assignment?” “How have you overcome this problem in the past?” “What advice would you give to someone else who has this problem?” “What can you do to make it easier for you to complete the assignment this week?” “Do you think there is another assignment that might be more useful for you?” Therapists review assignments each week and give parents personal written feedback as well as surprise stickers, chocolate, cartoons, or cards in their folder to applaud a particular parent’s achievement. Each week when the parent arrives at group, they put in their individual folder the week’s assignment, check off whether or not they were able to do the assignment, and they pick up the therapists’ comments on the prior week’s assignment. The individual folders offer quiet group members another channel for communication with the therapist. They are also a private place for communicating questions and comments that the parent does not want to share with the entire group. The checklists encourage parents to self-monitor; we frequently find parents asking us if they can still get credit for the homework assignment if they do it the following week.

Weekly Evaluations

Each group session is evaluated by having parents complete a brief Weekly Evaluation Form. This gives the therapists immediate feedback about how each parent is responding to the therapist’s style, the group discussions, and the content presented in the session. When a parent is dissatisfied or is having trouble with a concept, the therapist may want to call that parent to resolve the issue, or if the difficulty is shared by others, bring it up in a subsequent session.

Phone Calls and Make Up Sessions

Therapists “check in” with parents every couple of weeks with a telephone call, asking how things are going and whether parents are having any difficulty with the home assignments. These calls allow therapists and parents to get to know one another outside the group—particularly useful in the case of quiet or reluctant parents—and promote engagement with the program, as well as revealing how well parents are assimilating the material presented in group. We recommend an individual call to any
Parent who has two neutral or negative weekly evaluations in a row regarding any aspect of the program (therapist, group discussion, or content), to let the parent know the therapist is concerned about the issues raised in the evaluations and will try to meet that parent’s learning needs.

When a parent misses a session, therapists call them right away to let the parent know the therapist is concerned about his or her participation and takes absences seriously. It also gives the therapist an opportunity to help the parent make up the session and do the assignment before the next session.

PARENT TRAINING PROCESS

Parent Training as Collaboration

There are many competing parent intervention programs, each with different sets of assumptions about the causes of family problems; the role of the therapist; the nature of the relationship between parent and therapist, and the level of responsibility assumed by the parent and the therapist. What they have in common is that in most parent training, the model is hierarchical: The therapist’s role is that of an expert who is responsible for uncovering and interpreting past experiences and family dynamics to the family; and the parent’s role is that of a relatively passive recipient of the therapist’s knowledge and advice. The child’s misbehavior is evidence that the parent is unable to effectively parent, and the therapist’s role is to diagnose and repair the deficit within the parent.

In contrast, our training model for working with families is active and collaborative. In a collaborative relationship, the therapist does not set him- or herself up as an expert dispensing advice to parents about how they should parent more effectively. With a root meaning of “to labor together,” collaboration implies a reciprocal relationship based on utilizing equally the therapist’s and the parents’ knowledge, strengths, and perspectives. A collaborative model of parent training is nonblaming and nonhierarchical. This approach to parent training has been described in detail in a recently published book (Webster-Stratton & Herbert, 1994).

As professionals, we have considerable expertise in our fields. Does the collaborative therapist have to renounce this expertise? Not at all. Yet the collaborative training model acknowledges that expertise is not the sole property of the therapist: The parents function as experts concerning their child, their particular family, and their community, and the therapist functions as expert concerning child development, family dynamics in general, behavior management principles, and so on. The collaborative therapist labors with parents by actively soliciting their ideas and feelings, understanding their cultural context, and involving them in the therapeutic process by inviting them to share their experiences, discuss their ideas, and engage in problem solving. Collaboration implies that parents actively participate in setting goals and the intervention agenda. Collaboration also implies that parents evaluate each session, and the therapist is responsible for adapting the intervention in response to their evaluations.

Another aspect of the collaborative therapist’s labor is working with parents to adapt concepts and skills to the particular circumstances of those parents and the particular temperament of their child. A parent who lives in a one-room trailer is unlikely to have an empty room for time-out and will even have difficulty finding a suitable spot to put a time-out chair. A parent living in an apartment where walls are not soundproof will be acutely sensitive to the possible reactions of neighbors when he or she tries to ignore the screaming child; with good reason, that parent may resist using the ignore technique. These parents may raise objections—possibly unrelated from the therapist’s point of view—to the use of time-out or ignoring. In traditional (hierarchical) therapy, these would be seen as instances of resistance, and the therapist would labor to overcome the parents’ resistance. In contrast, the collaborative therapist would operate from the assumption that the parent had legitimate grounds for resisting this aspect of the training, would attempt to understand the living situation and other circumstances of each family and involve the parents in problem solving to adapt the concepts to their particular situation. Highly active, impulsive children will not be able to sit quietly and play attentively with their parents for long periods. Such children will also have more difficulty sitting in time-out than less active children. Other children are not particularly responsive to Tangible Reward programs. Therapists need to be sensitive to these differences in child temperament so that they can begin to collaborate with parents in defining the approaches that will work for them and their child.

A noncollaborative approach is didactic and nonparticipative—the therapist lectures, the parents listen. The noncollaborative therapist presents principles and skills to parents in terms of “prescriptions” for successful ways of dealing with their children. Homework assignments are rigid, given without regard for the particular circumstances of the individual family. We reject this approach because, for one thing, it is unsuccessful: It is likely to lead to higher attrition rates and poor long-term maintenance. Furthermore, it is ethically dubious to impose goals on parents that may not be congruent with their goals, values, and lifestyles and that may not suit the temperament of their child. This is particularly important when there are cultural or class differences between the therapist and the group, where assumptions arising from the therapist’s own
background or training may simply not apply. The collaborative model implies that, insofar as possible, the therapist stimulates the parents to generate solutions based on their experience with their child, and based on their family's cultural, class, and individual background. When parents come up with solutions they view as appropriate, the therapist can then reinforce and expand on these ideas.

A collaborative style of leadership is demonstrated by open communication patterns within the group and the therapist's attitude of acceptance toward all families in the program. By building a relationship based not on authority but on rapport with the group, the therapist creates a climate of trust, making the group a safe place for parents to reveal their problems and to risk new approaches. The collaborative therapist is a careful listener who uses open-ended questions when exploring issues, for they are more likely to generate discussion and collaboration. He or she encourages debate and alternative viewpoints, treating all viewpoints with respect. The therapist's empathic understanding is conveyed by actively reaching out to the parents, eliciting their ideas, and attempting to understand rather than analyze.

Parent Training as Empowerment

This partnership between parents and group therapist has the effect of giving back dignity, respect, and self-control to parents who, because of their particular situation, may be in a vulnerable time of low self-confidence and intense feelings of guilt and self-blame (Spitzer, Webster-Stratton, & Hollinsworth, 1991). It is our hypothesis that a collaborative approach is more likely to increase parents' confidence and perceived self-efficacy than all other therapeutic approaches. The essential goal of collaborative intervention is to "empower" parents so that they feel confident about their parenting skills and about their ability to respond to new situations that may arise when the therapist is not there to help them. Bandura (1977) has called this strategy strengthening the client's "efficacy expectations," that is, parents' conviction that they can successfully change their own and their child's behaviors. Bandura (1982, 1989) has suggested that self-efficacy is the mediating variable between knowledge and behavior. Therefore, parents with high "self-efficacy" will tend to persist at tasks until they succeed. The literature also indicates that people who have determined their own priorities and goals are more likely to persist in the face of difficulties and less likely to show debilitating effects of stress (e.g., Dweck, 1975; Seligman, 1975).

Moreover, this model is likely to increase parents' engagement in the intervention. Research (Backeland & Lundwall, 1975; Janis & Mann, 1977; Meichenbaum & Turk, 1987) suggests that the collaborative process has the multiple advantages of reducing attrition rates, increasing motivation and commitment, reducing resistance, increasing temporal and situational generalization, and giving parents and the therapist a joint stake in the outcome of the intervention. On the other hand, controlling or hierarchical modes of therapy, in which the therapist analyzes, interprets, and makes decisions for parents without incorporating their input, may result in a low level of commitment, dependency, low self-efficacy, and increased resistance (Janis & Mann, 1977; Patterson & Forgatch, 1985), as well as resentment of professionals. In fact, if parents are not given appropriate ways to participate, they may see no alternative but to drop out or resist the intervention as a means of asserting their control over the therapeutic process.

In short, the net result of collaborative parent training is to empower parents by strengthening their knowledge and skill base, their self-confidence, and their autonomy, instead of creating dependence on the therapist and inadvertently perpetuating a sense of inadequacy or helplessness. There is a further reason for this model: Since we want parents to adopt a participative, collaborative, empowering approach with their children, it is important to use this approach with them in the parent program (i.e., to model with them the relationship style we wish them to use with their children). This form of training leads to greater internalization of learning in children (and very likely adults).

Parent Training Groups as Support Systems

It is debatable whether there are clearly differentiated criteria for choosing between one-on-one intervention and group training. Our own research with clinic families has shown that group training utilizing videotape modeling is at least as therapeutically effective as one-on-one intervention and certainly more cost-effective (Webster-Stratton, 1984, 1985b). But aside from the obvious economic benefits, there is another benefit to the group format: greater parental engagement with the program, a particularly compelling benefit in the case of low-income single mothers, who have been reported by Wahler (Wahler & Afton, 1980) and others to be "insular"—socially isolated, with little support and few friendships. Insular parents frequently report feeling criticized and otherwise rejected in their relationships with relatives, professionals, case workers, spouses, and friends. Parent groups can become an empowering environment for these parents, decreasing their insularity and giving them new sources of support.

Many of the parents in our studies initially were reluctant to participate in groups, preferring the privacy of individual counseling. However, after completion of the training, 87.7% reported that group discussion
was a very useful training method. After having had a successful group experience, many parents were for the first time willing to consider serving on PTA boards or participating in other school and community-related group functions.

In the parent group, parents learned how to collaborate in problem solving, how to express their appreciation for each other, and how to cheer each other’s successes in tackling difficult problems. They also learned to share their feelings of guilt, anger, and depression, as well as experiences that involved mistakes on their part or misbehaviors from their children. These discussions served as a powerful source of support. Through this sharing of feelings and experiences, commonality was discovered. Feelings of isolation decreased, and parents were empowered by the knowledge that they are not alone in their problems and that many of their problems are normal. And this sense of group support and kinship increased parents’ engagement with the program. The following comments were made in one of our groups:

**Father:** You know when this program is finished, I will always think about this group in spirit.

**Mother:** This group is all sharing—it’s people who aren’t judging me, who are also taking risks and saying, “Have you tried this? or have you considered you might be off track?”

One of the ways we helped our groups become support systems was by assigning everyone a parent “buddy” in the second session. Buddies were asked to call each other during the week to share how the homework assignment (e.g., praising, limit setting) was going. New “buddies” were assigned every few weeks throughout the program. Parents were initially hesitant about making these calls, but as they experienced the sense of support they received from these phone conversations, they expressed a desire to continue these calls. Many fathers voiced that this was the first time they had ever talked to another father about parenting. If a parent missed a session, the buddy would call right away to tell the parent he or she was missed and to fill the person in on the week’s material.

**Building Parent Support outside the Group**

Parents often reported conflicts with partners and grandparents over how to handle the child’s problems, resulting in stressed relationships and stressed individuals. Therefore, in addition to building the support system within the parent group, the program also emphasized building support within the family and home life. The program encouraged every parent to have a spouse, partner, close friend, or family member (such as a grandparent) participate in the program to provide mutual support. (Our own follow-up studies as well as others’ have indicated that the greatest likelihood of relapse occurs in families in which only one person was involved in the intervention (Herbert, 1987; Webster-Stratton, 1985a). During parent groups, partners were helped to define ways they could support each other when one was feeling discouraged, tired, or unable to cope.

Frequently, the energy required to care for children, coupled with financial constraints, leaves parents feeling exhausted and too tired to make plans to spend time with each other or with adult friends, let alone interact with them. Yet time away from the child with a partner or a friend can help parents feel supported and energized. It helps them gain perspective so they are better able to cope with parenting. Wahler’s (Wahler & Afton, 1980) research has indicated that single mothers who have contact with other people outside the home fare much better in their parenting than mothers without such contacts, whereas maternal insularity or social isolation results in the probability of intervention failure (Dumas & Wahler, 1983). In our group, sometimes parents seemed almost to have forgotten their identity as individuals. Thus, one of the home assignments was to do some “self-care” activity in which parents did something nice for themselves. Paradoxically, the result of spending some time away in “self-care” activities was often a feeling of support and understanding from one’s partner or the other adult who made it possible.

**THERAPIST STRATEGIES**

**Therapist Qualifications**

Therapists in our programs have represented several disciplines including nursing, social work, education, psychology, and psychiatry. These individual qualities may help the leader in our program, but the personality is determined not by their educational or professional background but by their degree of comfort with a collaborative process and their ability to promote intimacy and assume a friendship role with families—that is, the kind of friend who listens, asks for clarification, is reflective and nonjudgmental, tries to understand what the parent is saying through empathy, and helps problem-solve and does not command, instruct, or tell the parent how to parent. At the same time, the therapist must also be able to lead and teach—to explain behavioral principles and provide a clear rationale for them, to challenge families to see new perspectives, to elicit the strengths of the parent group, and to provide guidance and support within the group when necessary.
Advocacy

Therapist approaches such as self-disclosure, humor, and positive reinforcement serve the overall purpose of building a supportive relationship. The therapist can also actively support parents by acting as advocates for them, particularly in situations where communication with other professionals may have become difficult. In the role of advocate, the therapist can bring relevant persons, programs, and resources to the family, or bring the family to them. For example, the therapist can arrange and attend meetings between parents and teachers so as to help the parents clarify the child’s problems, agree on goals, and set up behavior management programs that are consistent from the clinic to home and to school.

It must be emphasized that the ultimate goal of this advocacy role is to strengthen the parents’ ability to advocate for themselves and for their children. The danger of advocacy is that it can become a “rescue” or an “expert” role; and as a result, the parents may feel dependent or uncommitted. An example of this might be the therapist who makes recommendations to a child’s teacher, without the parent being involved. Our approach to advocacy in this situation would be to say to the parent, “We want you to share with the teacher the strategies that you are trying to use at home to see whether the teachers might consider setting up a similar program at school.” We accompany the parent and try to provide support. By giving parents the responsibility for their own advocacy, sharing their own solutions, and advocating with (rather than for) parents, we again emphasize the collaborative process.

Identifying Goals of Group

At the initial parent group, parents are asked to share some of their personal experiences with their children, as well as their goals for the training program. These goals for each parent are posted on the wall so that they can be referred to throughout the program. This initial discussion often produces immediate group rapport as parents realize they have similar difficulties and are working toward similar goals. Throughout the training, parents are given home assignments to write down the child behaviors they want to see increase or decrease. These targeted behaviors (e.g., go to bed at 8:00 P.M.; not interrupt when someone is on phone) become the focus of group discussion and brainstorming. Several times during the program, the therapist draws up a composite list of behaviors parents are working on so that group members can see the similarities in their issues. This promotes ongoing group cohesion, as well as attention to individual goals, thereby increasing parents’ commitment to the program.

Training for Parents of Children with Conduct Problems

Ensuring Group Safety and Sufficient Structure

One of the most difficult aspects of the therapist’s role is to prevent the group experience from becoming negative. If this should happen, dropout is a certainty. Consequently, during the first meeting, we ask group members to generate rules that would help them feel safe, comfortable, and accepted in the group. These rules are kept posted on the wall to be added to or referred to if necessary during weekly sessions. Examples include (a) only one person may talk at a time, (b) everyone’s ideas are respected, (c) anyone has a right to pass, (d) no “put downs” are allowed, and (e) confidentiality within the room. After identifying the rules, we ask the group to discuss why they think these rules are important.

For groups that are very verbal and tend to get sidetracked or to digress, it is helpful at the beginning of each session to select a parent to act as a cotherapist. The job of this parent cotherapist is to be a timekeeper, to make sure all vignettes are covered, to help identify participants who are sidetracking the discussion, and to keep the group focused on the main topics for the session. Our evaluations indicate that parents become frustrated and disengaged if the discussion wanders, and they appreciate having enough structure imposed to keep the discussion moving along. By rotating the job of cotherapist, the task of monitoring the group discussion becomes everyone’s responsibility; everyone is committed to the group’s functioning well.

The group process can also be disrupted by a participant who challenges the therapist’s knowledge or advocates inappropriate child-rearing practices. It is important that the therapist not seem critical or frustrated with this person’s comments, for this is the “coercion trap” many parents have experienced in the past. Instead, the therapist looks for the relevant points in what the person has said and reinforces them for the group. By conveying acceptance and warmth, even toward a parent who is an obviously difficult group member, the therapist models acceptance and helps group members see that the goal is to understand and respect everyone.

Explanation as Persuasion

Therapeutic change depends on persuasion. This implies that parents must be given the rationale for each component of the program. It is important for the therapist to voice clear explanations based on valid information and knowledge of the developmental literature as well as hard-earned practical wisdom and experience. The treatment principles, objectives, and methods should not be shrouded in mystery. Research has indicated that parents’ understanding of the social learning principles underlying the parent training program leads to enhanced generalization or maintenance of treatment effects (McMahon & Forehand, 1984).
However, it is also important that these rationales and theories be presented in such a way that the parent can see the connection with his or her stated goals. For example, when providing the rationale for child-directed play interactions, the therapist explains how this approach fosters the child’s self-esteem, social competence, and eventual success in school, while at the same time decreasing his or her need to obtain control over parents by negative behaviors. In this example, supplying the rationale is important not only because parents may not immediately see the connection between playing with their children more and helping their child be less aggressive, but also because of the connection made between this new aspect of the program, and the parents’ original reason for seeking help (their child’s aggressiveness). If they do not understand the rationale for the play sessions, they may not be motivated to do them at home.

Reframing

Therapeutic change depends on providing explanatory “stories,” alternative explanations that help parents to reshape their perceptions of and their beliefs about the nature of their problems. Reframing by the therapist or cognitive restructuring is a powerful interpretive tool for helping parents understand their experiences, thereby promoting change in their behaviors. It involves altering the parent’s emotional and/or conceptual viewpoint of an experience by placing the experience in another “frame” that fits the facts of the situation well, thereby altering its meaning.

One type of reframing that we frequently use is to take a problem a parent is having with a child and reframe it in terms of child development. Reframing a difficult child’s behavior in terms of a psychological or emotional drive such as testing the security of limits, or reacting to the loss of a parent, or moving toward independence, helps the parents see the behavior as appropriate or normal—in some cases even positive. Seen in this light, problematic behaviors are the expression of normal emotions and developmental stages. Viewing situations in this light, parents can see that they are participating in a process of growth for the child. This attitude enhances coping and decreases feelings of anger and helplessness. Understood in terms of children’s needs to test the security of their environment or to test the love of their parents, parent-child conflicts become less overwhelming and parents are more able to remain committed to the hard work of parenting.

Generational Issues

Another strategy that increases parents’ commitment, promoting empathy and bonding between parent and child, is to help the parents see the connections between their own childhood experiences and those of their child. When parents acknowledge similarities between their personality and their child’s, the therapist can help parents see how these similarities may result in conflicting reactions for them as a parent, yet give the parents intuitive insight into what parenting strategies might be most useful with their child.

The therapist can also help parents see how their reactions and responses as parents are based on their own experiences as a child (either imitating or reacting to the parenting they experienced) and how these influences may create resistance to alternative parenting styles. There is therefore a place in the collaborative model for brief consideration of the child’s and parents’ past. These stories are often negative, filled with pain, anger, self-deprecation, bitterness, and regret. It may be necessary for the therapist to help parents “lay the ghosts” to rest before they can apply themselves wholeheartedly and with optimism to problems in the here-and-now.

Reframing the Future

Parents are often skeptical about their ability to change, especially if they see in their behavior a family pattern, for patterns often seem fixed and irreversible. Thus another function of the therapist is to counter that skepticism with positive expectations for change. For example, one parent said, “My mother beat me, now I beat my children.” In response, the therapist expressed confidence in the parent’s ability to break the family cycle. Each small step toward change—even the step of coming to a parent training program in the first place—can be pointed to as evidence that the problem is not fixed or irreversible.

Therapists strive to convey optimism about the parents’ ability to successfully carry out the strategies required to produce positive changes in the child’s behaviors. According to Bandura (1989), all psychological procedures are mediated through a system of beliefs about the level of skill required to bring about an outcome and the likely end result of a course of action. Efficacy expectations are thought to be the most important component. Thus, successful treatment depends on the ability of the therapist to strengthen parents’ expectations of personal efficacy (“I am able to do it”).

Generalization and Contextualizing

Generalization—the ability to apply specific skills learned in the training to one’s own situation, and also the ability to extrapolate from current concerns to future parenting dilemmas—is enhanced by participation where group members are exposed to many family life situations and
approaches to solving problems. Another means of enhancing generalization is by group problem solving. The therapist compiles a list of behaviors that parents want to encourage or discourage and asks the group to come up with as many ideas as possible for dealing with those behaviors. Generalization is also enhanced by what we call “principles training”—pointing out or having a group member state the basic principle that can be applied across multiple situations. These principles can be listed on a poster and brought to each session to facilitate continued applications of the principle. Each principle could be identified by the group member’s name who first stated that principle (i.e., Jim’s principle: Behaviors that receive attention occur more often).

We also engage the families in a process we call “contextualizing”—asking parents to identify the particular circumstances in which they find it difficult or impossible to apply what they have been learning in the training. Often parents will identify high stress times of the day, such as the first 30 minutes when they get home at night from work, or are late for an appointment, or have relatives visiting. We encourage parents to identify these vulnerable periods and to strategically plan ways to deal with them. When parents have been successful in maintaining control during a stressful situation, we encourage them to reflect on this and to share their strategies by asking such questions as, “What made it possible for you to maintain control in such a stressful situation? What were you thinking to yourself at the time? How did you do that?” Here the therapist aims to help the parents recognize their positive coping skills.

Preparing for Termination and Predicting Relapses

Preparing for the end of the parenting program is critical. Usually we find parents beginning to raise the issue 4 to 6 weeks before the end of the training, as they begin to worry about what they will do when they are without the support of the group and the therapist. Therapists prepare parents for the inevitable relapses in their parenting skills and children’s misbehavior both during the training program and after the program has ended, brainstorming and helping parents rehearse what they will do when there is a relapse. Parents have suggested calling another parent in the group for advice and support, contacting the group therapist, practicing the program exercises in the workbook again beginning with praises and play periods, identifying the problem behaviors and reviewing the techniques presented in the course for dealing with them, arranging for some time away from the children to refuse and energize, and focusing on positive alternatives rather than becoming immersed in feelings of failure or frustration. Therapists reassure parents that mistakes and relapses are “normal” and to be expected, stressing that the important point is to develop strategies to counteract relapses so that family life doesn’t become too disrupted.

Preparing for the Long Term

We also brainstorm with parents how they can continue to feel supported after the program ends. The following are some of the ideas our groups have discussed:

**How to Continue to Feel Supported as a Parent**

- Continue to meet as a group to support each other once a month. Study some of the other videotape learning modules together.
- Identify two parents from the group who are willing to act as “touch points”—who will keep a set of the tapes and provide a place to meet to discuss parenting issues that arise.
- Put notes on the refrigerator, telephone, or steering wheel to remind yourself to use specific concepts such as praising good behavior, ignoring inappropriate behavior, and so on.
- Review the notes and handouts with a partner or a friend once every 2 weeks. Reread or listen to audiotape portions of the book.
- Reward yourself once a week for working on parenting skills by going out for coffee or to a movie with a partner or a friend.
- Plan discussions of parenting issues with a partner or friend once every 2 weeks.
- Tell yourself you are doing a good job!
- Set aside some time to relax and refuel your energy on a daily basis.
- Recognize that it is okay for parents and children to make mistakes.

An ongoing theme reiterated by the therapist throughout the training program is that it is not easy to be a parent. It is a difficult challenge that very few of us are adequately prepared for. One of the most common mistakes that adults make in relating to children is to go for the short-term payoffs (e.g., give in to a child’s tantrum to stop the unpleasant behavior) at the expenses of the long-term consequences (the child learns to have tantrums to get what he or she wants). We emphasize that although the parenting skills presented in this program need to be repeated hundreds of times and take a lot of work, the long-term benefits make it worth the effort—helping a child to become a self-confident, creative, nonviolent, and happy individual. As one of our parents so aptly put it, “You mean there is no magic moondust?” No, we have no magic moondust to sprinkle here; rather, our objective is to encourage parents to be patient with themselves and to be committed to their growth as parents as well as their children’s growth and development.
CONCLUSIONS

This chapter has provided a description of a research-based parent training program designed to prevent and treat conduct problems in young children. Research studies have given us clear guidelines about some of the critical elements of successful parenting programs. The content of parenting programs needs to be broadly based, focusing on contextual and family interpersonal issues as well as specific parenting skills. It needs to include cognitive, affective, and behavioral components. The methods need to be performance-based, including creative use of role plays, videotape modeling, direct feedback, and home practice assignments. Another essential ingredient in successful parenting training is the elusive, difficult-to-define therapeutic mix of applied science, creativity, and caring. We believe that it is the creative art of collaboration with parents that is key to the success of parenting programs. The therapist must be extraordinarily skilled in collaborating with families in ways that promote parents’ self-management, sense of competency, empowerment, and hope for themselves and their children. Additionally, by promoting collaboration not just between the therapist and parent, but also among groups of parents and with teachers and other community members, we aim to strengthen parents’ awareness of the tremendous and largely untapped support that can be developed within their families and in their communities. If we can achieve these aims, we have a structure that has a possibility of strengthening families and communities over time.

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CHAPTER 4

Parent Training Interventions for Sibling Conflict

CHARLOTTE JOHNSTON and WENDY FREEMAN

From the biblical story of Cain and Abel to television’s depictions of Bart and Lisa Simpson, conflicts in sibling relationships have fueled numerous works of both fiction and biography, and have undoubtedly been the topic of many hours of psychotherapy. Relationships with siblings are a major aspect of most people’s lives. Sibling relationships are often the only intimate, daily relationships with peers that individuals experience prior to adulthood, and bonds with siblings often last longer than any other relationship in a person’s life. During childhood, sibling relationships also provide a unique training ground for the acquisition and practice of social and life skills. Given the prevalence, importance, strength, and duration of sibling relationships, one might expect them to have been the subject of great psychological scrutiny. In fact, sibling relationships have not been extensively studied. In particular, clinical psychology, perhaps because of its tendency to focus on individual differences and diagnoses, has paid little attention to problems in sibling relationships.

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