Parent Training with Low-Income Families
Promoting Parental Engagement through a Collaborative Approach
CAROLYN WEBSTER-STRATTON

Children from certain types of families are at particularly high risk for developing conduct disorders (CD): namely, families characterized by factors such as low income, low educational level, high levels of stress, single-parent status, lack of support, and a history of ongoing depression, criminal activity, substance abuse, or psychiatric illness (Farrington, 1992). Children whose parents’ discipline approaches are inconsistent and erratic and who are physically abusive, highly critical, or lacking in warmth (Patterson, Capaldi, & Bank, 1991; Patterson, Stouthamer-Loeber, 1984; Reid, Taplin, & Loeber, 1981) are also at high risk for conduct disorder, as are children whose parents are disengaged from their children’s school experiences and provide little instruction for prosocial behavior (for review, see Webster-Stratton, 1990). Moreover, the risk of a child developing conduct disorders seems to increase exponentially with the child’s exposure to each additional risk factor (Cole et al., 1993; Rutter, 1980).

Head Start is a federally funded preschool program available to children whose parents are receiving welfare. This group of economically disadvantaged preschool children may be characterized as having increased risk for developing conduct disorders because so many risk factors are present at higher than average rates in this population. In a recent study of more than 500 Head Start families in the Seattle area, we found that over 74% of the sample had four or more of the risk factors noted above (Webster-Stratton, 1995). Approximately 42% of the mothers were in the high range for harsh, critical discipline as measured by independent observers.

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Consistent with what might have been predicted from these findings, 35% of the children were above the established cutoff point for conduct problems, falling in the clinical range according to the Achenbach Child Behavior Checklist (Achenbach & Edelbrock, 1991). Other larger scale investigations have also indicated that economically deprived children are at increased risk for mental health problems (Belle, 1990; Goldberg, Roghmann, McInerny, & Burke, 1984). Goldberg and colleagues (1984) demonstrated that children receiving Medicaid benefits had almost twice as many behavior problems when compared with children from more advantaged environments. Unfortunately, reports indicate that fewer than 66% of disadvantaged children who are in need ever receive services (Saxe, Cross, & Silverman, Batchelor, & Dougherty, 1987) and only 20% receive adequate treatment.

While not all the risk factors for conduct disorders are amenable to intervention (e.g., economic status or parental history of substance abuse), risk factors such as lack of parenting skills, lack of support networks, and lack of school involvement are; to reverse these risk factors is to build up protective factors which may help buffer some of the adverse effects of poverty and its accompanying stressors. The potential for addressing these factors through parent training programs suggests that parent training would be a highly useful intervention with Head Start families. However, despite Head Start’s founding philosophy of strong parent involvement (Zigler & Styfco, 1993), there have been few studies examining the benefits of adding a comprehensive parent training intervention to Head Start’s child-focused program.

INTERVENTION WITH LOW-INCOME FAMILIES

The parent training literature has suggested that parent training is less effective with disadvantaged parents—particularly low-income single mothers—who have been described by Wahler (1980) as “insular” and “multiply entrapped.” It also has been reported that recruitment rates for parent training interventions with low-income families of children with conduct problems are low, especially if there is an evaluation component (Spoth & Redmond, 1995). This population has often been reported to be the most likely to drop out of treatment (Bernal, 1984; Eyberg & Johnson, 1974), and more likely to relapse or to fail to make clinically significant improvements following treatment or to maintain treatment effects over time (Dumas & Wahler, 1983). Such families have been described as unmotivated, resistant, unreliable, disengaged, chaotic, in denial, disorganized, uncaring, dysfunctional, and unlikely candidates for this kind of treatment—in short, unreachable. However, these families might well describe traditional clinic-based programs as “unreachable.” Clinical programs may be too far away from home, too expensive, insensitive, distant, inflexible in terms of scheduling and content, foreign in terms of language (literally or figuratively), blaming or critical of their lifestyle. A cost-benefit analysis would, in all likelihood, reveal that the costs to these clients of receiving treatment far outweigh the potential benefits—even though they do genuinely want to do what is best for their children. Perhaps this population has been “unreachable” not because of their own characteristics, but because of the characteristics of the interventions they have been offered.

The paradox is that while on the one hand we decry the lack of efficacy of therapy (i.e., parent training) with economically disadvantaged families, we also
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maintain the belief that if we could just do more therapy focusing more broadly (i.e., on family dysfunction and parental psychopathology), we would be more effective. But the problem may not lie in the focus of the therapy (i.e., parenting skills vs. family dynamics), but, rather, in the therapeutic model or approach—namely, a traditional clinic-based model of parent training. Before abandoning parent training as an intervention with this population, we should examine alternative models of parenting.

PARTNERS PARENT TRAINING

Recently we conducted a randomized study wherein we examined the effectiveness of an established, theory-based parent training program (PARTNERS) as a selective prevention intervention (Medicine, 1994) with a sample of 210 Head Start parents and their 4-year-old children. The programs proven effectiveness as a clinical intervention for young children with identified conduct problems suggested its potential as a community-based, early prevention program designed to enhance family protective factors by strengthening parenting competence, fostering parents' involvement in children's Head Start preschool experiences, and promoting social support networks. Eight Head Start centers were randomly assigned to two conditions: (1) an experimental condition in which parents participated in the parent training program (PARTNERS) as well as in the Head Start program, or (2) a control condition in which parents participated only in the regular center-based Head Start program (controls). Baseline assessments for all eight centers included teacher and parent reports of child behavior as well as interviews and independent observations of parent–child interactions in the home and child behavior in the classroom. Home interviews lasted 2–3 hours and were carried out by warm, friendly women who had extensive experience working with parents. In some cases the interviewers were Head Start mothers who had shown natural leadership and caring interpersonal qualities. These interviews were followed by the home observations; observers asked parents to do what they would normally do and to try to ignore their presence. Post assessments at the end of the school year included parent and teacher reports as well as independent observations in the home. Evaluation of parental engagement included attendance, dropout rate, consumer satisfaction, and percentage improvement in observable parenting behaviors.

Approximately 65% of the total enrollees in the four Head Start centers participated in the study. Of those assigned to the PARTNERS group, 88% attended more than two-thirds of the sessions. Only 12% attended fewer than four sessions or dropped out after attending the first session. Results of home observations by independent raters indicated that PARTNERS mothers made significantly fewer critical remarks, used less physically negative discipline, and were more positive, appropriate, and consistent in their discipline style when compared with control mothers. PARTNERS mothers perceived their family service workers as more supportive than did control mothers; furthermore, teachers reported that PARTNERS mothers were more involved in their children's education than control mothers. In turn, PARTNERS children were observed at home to exhibit significantly fewer negative behaviors, less noncompliance, more positive affect, and more prosocial behaviors than control children. Consumer satisfaction with
the program was high, with 89% reporting "positive" to "very positive" overall satisfaction, 91% reporting they expected positive results, and 95% saying they would "highly recommend" the program to others. More than 85% of the parents in the intervention condition wanted the program to be longer and to continue into the kindergarten year.

In a second analysis we sought to determine the clinical significance of the intervention (Schmaling & Jacobson, 1987) and the particular characteristics of the families from the intervention condition who did not respond to the intervention. This question was of interest not only for the sake of evaluating our intervention, but also in light of the current debate regarding this population. Results indicated that for PARTNERS mothers, 71% showed a 30% reduction in critical statements, whereas 29% were categorized as nonresponders. Of the mothers who were nonresponders, 40% reported a history of drug abuse as compared with 17% of mothers categorized as responders. There was a trend (p < .06) for mother psychiatric illness also to differentiate responders from nonresponders. Responses to the program were not affected by educational level, minority status, depression level, number of negative life events, amount of support or history of physical or sexual abuse.

In contrast to what the literature has reported about parent training programs for disadvantaged families, the short-term results of this prevention program suggest that the intervention was successful in engaging at least two-thirds of the families, as evidenced by the high level of recruitment, low parent dropout rate, high percentage of families who made clinically significant improvements, and high consumer satisfaction with training methods and content. Why did this program succeed where others have failed? Because the content of this program is similar to many others, we hypothesize that it was other aspects of the intervention—our training model, our methods, our leadership style, or specific strategies—that contributed to the high level of parental engagement. To look at it a little differently, rather than characteristics of the families being the reason for the failure of previous interventions with low-income parents, we hypothesize that interventions with this population (or any population) may fail when they lack certain critical intervention characteristics that enable a family to remain engaged in a parent training program and thereby benefit from it.

The remainder of this chapter will focus on a closer examination of what we consider to be the critical features of the PARTNERS program by which we promoted parental engagement with this intervention program for this low-income group of families. More details regarding the research results of the intervention can be found elsewhere (Webster-Stratton, 1995).

Initial Steps to Promote Parental Engagement

Involving School Personnel and Parents in Planning

In launching the program, one key to attracting parents was the participation of administrators, teachers, and Head Start staff who were committed to the program's goals and methods. Because the actual staff (teachers and family service workers) at the Head Start centers were employed by school districts (although administered by Head Start), we felt that all levels of administrative support would be essential to the ultimate success of the project.
We began by developing an advisory steering committee consisting of Head Start administrators, parent policy council representatives, teachers, family service workers, and parents. This committee’s function was to provide advice concerning recruitment of families, assessment procedures, and relevant content for the intervention. The committee also assisted in the important job of informing and soliciting input from the principals and superintendents of the five school districts where the Head Start centers were located. Shared participation in the process of designing the recruitment, training and evaluation strategies would, we believed, lead to shared ownership of the program and a commitment to its eventual success.

The advisory committee conducted a series of focus groups with the separate groups of teachers, family service workers, and parents in order to define and prioritize their needs and goals, as well as to develop a recruitment plan, select sites for the intervention, and agree upon a schedule and timeline. In the first year, we conducted a pilot parent group to evaluate the program’s relevance and acceptability to parents. This was followed by a series of workshops in which we presented the pilot group’s findings and showed how the PARTNERS program meshed with their administrative and family goals and needs. Teachers and family service workers participated in mock parent groups so as to become familiar with the program content, process, and methods. As a result, they were able to serve as knowledgeable and enthusiastic recruiters for the program among Head Start parents.

We chose to train the family service workers within the Head Start organization to be the parent group trainers because of their ongoing involvement with families in the preschool setting during the week. About 30% of them had social work degrees and the others had baccalaureate degrees in psychology or some other helping profession. Some of them had been Head Start parents themselves and had first-hand knowledge of what it is like to live on welfare. Since we felt it was important for the group trainers to be as similar as possible to the parents in their cultural and linguistic background, in the second year of the project we selected representative parents to be trained as co-trainers to work alongside the family service workers. We felt that if parents perceived the group trainers and co-leaders as similar to themselves, their engagement with the program would be enhanced.

**Encouraging Every Parent’s Participation**

The next step was to advertise the parenting program to all of the parents enrolled in the Head Start centers that had been randomly chosen for the intervention trial. We began this process in the spring when parents first indicated an interest in Head Start. The family service workers and teachers described Head Start as a program not just for children, but also for parents. The PARTNERS program was described as part of the Head Start curriculum, and flyers were handed out describing the content of PARTNERS. In the fall when families actually enrolled in Head Start, further discussion of the parenting program took place during orientation meetings. Parents who had participated in the pilot parent group attended these meetings and told parents about their positive experiences with the PARTNERS program. They also called parents who were reluctant to sign up and told them of their own initial reluctance, reiterating the program’s possible benefits.
The program was offered in the centers as a "universal" intervention (i.e., offered to all parents) because we felt that singling out parents on the basis of either their increased risk factors or their child's negative behaviors would have a stigmatizing effect and therefore result in a low turnout. Although our ultimate goal was to reduce conduct problems, we advertised the program in terms of school success, for our focus groups had indicated that the majority of parents were interested in learning ways to promote their children's academic success.

**Accessibility and Feasibility of Intervention**

Quality child care is essential in order for parents to be able to attend parent training. In this case, child care was provided during the sessions for all children of participating parents (not just the Head Start child), organized largely by Head Start teachers and parents who had been trained in our program. This was perceived as an added bonus of participating in the program because it gave parents a much-appreciated break from child care. Where needed, we also provided families with transportation to and from parent groups.

Our goal was to offer the program in highly accessible locations (i.e., as close as possible to where the parents were living and working) at convenient times. Many of the Head Start centers did not have enough space to accommodate both a parent training group and the accompanying child care for 10 to 40 children at a time. We ended up holding sessions in schools, churches, and housing units.

**Incentives**

In addition to appealing to parents' intrinsic motives, we also offered some tangible benefits for participating in the program. Because baseline assessments involved a considerable time commitment from parents—a 2- to 3-hour home interview and completion of many questionnaires—we offered a $30 payment (often in the form of a voucher at a large department store) for completion of baseline assessments. In addition, if parents completed post-assessments at the end of the year and had attended at least two-thirds of the sessions, we paid them an additional $70. For each session missed, $10 was deducted from the final amount. Initially, we used raffles and lotteries as motivators, but we stopped these when feedback from parents indicated they felt it devalued their commitment to the goals of the program. Instead, we substituted periodic surprise celebrations of parents' efforts as a group and for individuals mastering a particularly difficult skill.

Food at group meetings was an additional incentive—and not only as refreshment or a snack. For many parents it made the difference between attending or not attending an evening group. For example, if a mother was picking up children from day care at 5 P.M., she could not feed them and herself and make it to a 6 P.M. meeting. By offering dinner at the meeting, we enabled them to come directly to the meeting. Furthermore, husbands and partners were more likely to attend when dinner was available. Thus offering dinner amounted to making the intervention more feasible for these parents. Well-balanced dinners were offered to parents as well as to their children. Parents participated in planning menus for groups and, in some groups, a different parent took responsibility each week for purchasing the food for the subsequent session (with funds provided). This rotation of re-
sponsibility resulted in a pleasant variety in the type of food provided. Afternoon sessions included substantial snacks of fruit, vegetables, and desserts.

At the end of the year we asked parents what motivated them to participate in the program in the first place. Approximately 80% of the parents said they attended because they wanted “to learn more about parenting”; 26% of these were concerned about particular behavior problems in their children and 17% said they felt “out of control as a parent.” Of the total group, 22% said they participated specifically because they wanted to make new friends with other parents. Only 8.4% said they signed up because of the financial incentive. Of the parents, 95.8% said they would have participated even if they had not been given the financial incentives.

Training Model

*Parent Training as Collaborative*

There are many competing parent intervention models, each with different sets of assumptions about the cause of family problems, the role of the therapist and the nature of the relationship between parent and therapist, and the level of responsibility assumed by the parent and the therapist. In many—perhaps most—parent training programs, the model is *hierarchical*: The trainer's role is that of an expert who is responsible for uncovering and interpreting past experiences and family dynamics to the family. In such a model the parent's role is that of a relatively passive recipient of the trainer's knowledge and advice. In other models, parents are to blame for their children's behavior; misbehavior is evidence that the parent is unable to display effective parent skills and the trainer's role is to diagnose and repair the parent's deficit.

Our training model for working with families is collaborative. In a collaborative relationship, the trainer 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 trainer's and the parent's knowledge, strengths, and perspectives. A collaborative model of parent training is non-blaming and non-hierarchical.

As professionals, we have considerable expertise in our fields. Does the collaborative trainer have to renounce this expertise? Hardly. The collaborative training model acknowledges that expertise is not the sole property of the therapist or trainer: The parents function as experts concerning their child, their particular family, and their community; and the trainer functions as expert concerning child development, family dynamics in general, behavior management principles, and so on. The collaborative trainer 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. It also implies that parents evaluate each session and the trainer is responsible for adapting the intervention so that it meets the families' needs.

Another aspect of the collaborative trainer'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. For example, a parent who lives in a one-
room trailer will not have an empty room for time-out and will have difficulty even
finding a suitable spot to put a time-out chair. A parent living in an apartment,
where walls usually are not soundproofed, will be acutely sensitive to the possible
reactions of neighbors when she or he tries to ignore the screaming child; with good
reason, that parent may resist using the ignore technique. These parents may raise
objections—apparently unrelated from the therapists' 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/trainer would try to overcome the parents' 
resistance. In contrast, the collaborative therapist/trainer 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 would involve the parents in problem solving to adapt the con-
cepts to their particular situation. To take another example, a highly active, impul-
sive child will not be able to sit quietly and play attentively with his parents for
long periods of time. Such children will also have more difficulty sitting in time-
out than will less active children. As another example, some children are not par-
particularly responsive to tangible reward programs. The trainer needs to be sensitive
to these differences in child temperament so that she or he 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 trainer
lectures, the parents listen. The noncollaborative trainer 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 par-
ticular circumstances of an 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 which may not be congruent with their goals, values, and lifestyles and
which are not adapted to the temperament of their child. This is particularly im-
portant when there are cultural or class differences between the trainer and the
group: assumptions arising from the trainer's own background or training simply
may not apply. The collaborative model implies that, insofar as possible, the
trainer 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 trainer can
then reinforce and expand on these ideas.

A collaborative style of trainership is demonstrated by open communication
patterns within the group and the trainer's attitude of acceptance toward all the
families in the program. By building a relationship based not on authority but on
rapport with the group, the trainer creates a climate of trust, making the group a
safe place for parents to reveal their problems and to risk new approaches. The
collaborative leader is a careful listener. She or he uses open-ended questions
when exploring issues, for they are more likely to generate discussion and collab-
oration, and she or he encourages debate and alternative viewpoints, treating all
viewpoints with respect. The trainer's empathic understanding is conveyed by the
extent to which she or he actively reaches out to the parents, elicits their ideas,
and attempts to understand rather than analyze (see Webster-Stratton & Herbert,
1994, for a more comprehensive discussion of collaborative model).
Parent Training as Empowerment

This partnership between parents and group trainer has the effect of giving back dignity, respect and self-control to parents who, because of their problems, including poverty, 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 trainer 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 perpetuating a sense of inadequacy and creating dependence on the therapist or trainer. There is a further reason for this model: Because we want parents to adopt a participative, collaborative, empowering approach with their own children, it is important to use this approach with the parents in the program—that is, 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) (Herbert, 1987).

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 (1980) and others to be "insular"—that is, 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 girl- or boyfriends. 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—ranking second to books in terms of effectiveness as a 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 involve 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. For instance, 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. 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 them. Frequently, fathers voiced that this was the first time they had ever talked to another father about parenting. This assignment was carried out four times during the program, with different "buddies" each time.

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) in the program with them 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, 1985c]). 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, 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 (1980) research has indicated that single mothers who have contact with other people outside the home fare much better in their parenting than do mothers without such contacts, while maternal insularity or social isolation results in the probability of intervention failure (Dumas & Wahler, 1983). In our group, sometimes parents almost seemed to have forgotten their identity as individuals other than as parents. One of the home assignments was to do some self-care activity so that parents learned how to take “caring moments” in which they do something nice for themselves. Emphasis was placed on inexpensive activities such as taking a walk or a hot bath, reading a book, listening to music, meeting a friend for coffee, and so forth. 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.

Training Content

There is a rather large body of literature describing the content of parent training programs. Commonly taught behavior management strategies such as time-out, praise, effective limit setting, differential attention, response cost, and so on, along with the behavioral principles that underlie them, have been described in detail in many parent training programs (e.g., Barkely, 1987; Forehand & McMahon, 1981; Patterson, 1982; Webster-Stratton, 1992a). The behavioral content of the PARTNERS program was presented under the following eight topics, which provided the focus for the eight weekly sessions: (1) How to Play with Your Child, (2) How to Help Your Child Learn, (3) Effective Praise and Encouragement, (4) How to Motivate Your Child, (5) Effective Limit Setting, (6) How to Follow Through with Limits and Rules, (7) Handling Common Misbehaviors, and (8) Problem Solving. These topics were selected based on information from parents and teachers as well as our own beliefs about which behavioral strategies were most important for the 4-year-old child.

The behavioral components of the program were intertwined with cognitive components, because several studies have shown that parents who learn the principles underlying the behavioral strategies are better able to generalize strategies to new situations and are more satisfied with their program (McMahon & Forehand, 1984; Glogower & Sloop, 1976). Consequently, we felt parental engagement would be enhanced by what we called principle training in which we sought to
help parents determine which principle was operative in a given situation or might be used to influence a particular child behavior. For example, the modeling principle was important for parents to grasp so that they could understand why modeling a particular behavior (e.g., respect, self-control) would have long-term benefits for them in improving their child’s behavior. Or, to take another example, a parent might come to the group with questions about her child’s refusal to get dressed in the morning; the trainer would ask the parent to think about what principle might be operating to maintain the child’s dawdling and refusal to dress (i.e., attention). In addition, parents were helped to conceptualize the strategies they had learned. For example, the trainer might say, “Now you have learned to praise your child and ignore misbehavior and you know how to do it, but what makes it hard to do at dinner time?” or “What are the times of the day or situations when you find it most difficult to stay positive?” Once these difficult situations or circumstances were identified, the group would discuss strategies the parent might use to minimize the impact of the situation on their parenting.

Group leaders also attempted to explain the rationale for particular behavioral strategies in terms of parents’ stated goals. For example, when providing the rationale for doing child-directed play, the trainer would explain how this approach fosters the child’s self-esteem, social competence, and success in school, at the same time decreasing the child’s need to obtain control over parents through negative behaviors. In this example, the rationale was important not only because parents might not immediately have seen the connection between playing with their children more and helping their child be successful in school, but also because this rationale established a strong link between this new element in the training and the parents’ original reason for agreeing to participate (i.e., to promote their child’s academic success). Without this rationale, parents might not be motivated to do the play sessions. To take another example:

**Father:** He hit her and hurt her. I have talked to him over and over about how he’s making other children feel bad. I get so frustrated with him. He doesn’t seem to have any guilt.

**Trainer:** It is frustrating. But it looks like you’re doing a nice job of beginning to help him understand the perspective of others in a situation. You know, the development of empathy in children—that is, the ability of a child to understand another person’s point of view—takes years. Not until adulthood is this aspect of development fully matured. Young children are at the very beginning steps of gaining this ability. The paradox of this is that one of the best ways you can help your son learn to be sensitive to the feelings of others is for you to model your understanding of him. Children need to feel understood and valued by their parents before they can value others.

In this example, the trainer restates or echoes the parent’s frustration with his son, shows empathy about it, reinforces the parent’s efforts to promote empathy, brings up the behavioral principle of modeling, and explains some points of child development. In doing so, the trainer is collaborating with the parent’s goal, yet suggesting a new method for pursuing this goal.

In the interest of promoting engagement (as well as for therapeutic reasons), it was also important to explore parents’ affective responses to the training in general and to particular strategies they were learning. Trainers would acknowledge
in the groups that some parents might be feeling resentful, critical, angry, and hopeless about their relationships with their children, their life situation, and their ability to alter the future. When these feelings are acknowledged, they lose some of their power to disrupt the parent's engagement with the training. The trainer was then able to help parents learn how to recognize and cope with feelings that might prevent them from engaging with their children. Discussing distressing thoughts in a parent group is also very reassuring for parents because it helps to "normalize" thoughts which they may previously have considered abnormal or crazy. As parents discover that other parents have the same kinds of "crazy" thoughts and reactions, they stop blaming themselves.

Many low-income parents experience quite understandable feelings of powerlessness, which are sometimes expressed in terms of feeling victimized by their children or by fate—"Why me?" The feeling of helplessness typically is accompanied by intense anger and a fear of losing control of themselves when trying to discipline their children. Parents' anger toward their children is likely to cause them to blame themselves and to then feel depressed in reaction to their guilt. Furthermore, they feel depressed about their interactions with their children, seeing themselves as causal factors in their children's problems. More than 50% of the parents in our Head Start study were in the clinical range for depression on the CES-D inventory (Rodloff, 1977).

As with the behavioral component, the affective dimension of parents' experience was addressed through a cognitive approach. Parents were helped to understand the factors—family dynamics, past experiences, the legacy of their families of origin, current life stressors, and so on—that might be disrupting their parenting. The parent program addressed parents' depression by focusing on helping them stop their spiraling negative self-talk and, more generally, to modify their negative thoughts. We tried to help them learn how to give themselves a psychological "pat on the back." Parents were encouraged to look at their strengths and think about how effectively they handled a difficult situation. We asked them to express their positive feelings about their relationship with their child and to remember good times before this stressful period. We taught parents to actively formulate positive statements about themselves such as, "I had a good day today with Billy; I handled that situation well," or, "I was able to stay in control; that was good." For example, a parent might say, "It's all my fault, I'm a terrible parent. This is more than I can cope with; everything's out of control." The trainer would then help the parent learn how to stop this kind of powerless, self-defeating train of thought and to substitute calmer, coping self-statements such as, "Stop worrying. These thoughts are not helping me. I'm doing the best I can. He's just testing my limits. All parents get discouraged at times. I'm going to be able to cope with this."

Parents were asked to keep records of their thoughts in response to extremely stressful situations with their children at home. We then invited them to share some of this record with the group. As the group discussed these thoughts, unrealistic expectations and irrational beliefs were challenged and became modified through discussion. These strategies are in accordance with the cognitive restructuring strategies described by Beck (1979). The process of learning to recognize angry, helpless, self-critical, blaming, catastrophizing thoughts, and to substitute more adaptive and positive thoughts, empowers parents by showing them they can cope with their thought patterns as well as their behaviors.
Training Methods

Videotape Modeling

Verbal training methods such as lectures and written handouts about parenting are inexpensive and can be widely disseminated; however, such methods have been shown to be relatively ineffective for changing actual parenting behaviors. In particular, those parents with a poor educational background show low satisfaction and poor engagement with such verbal training methods, perhaps because of associated low reading abilities or because they are not verbal learners (Chilman, 1973). Performance training approaches such as videotape feedback, role play and rehearsal, on the other hand, have been shown to be very effective for improving parenting behaviors. Our own research indicated that therapist-led group discussion based on videotape modeling was superior to therapist-led group discussion without videotapes. Even self-administered videotape modeling resulted in significant changes in parenting skills and fewer dropouts when compared to group discussion without videotape (Webster-Stratton, Kolpacoff, & Hollinsworth, 1988; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989). Regardless of educational background, families showed more significant improvements if they were trained by videotape modeling rather than methods using no videotapes (Webster-Stratton, 1984).

The PARTNERS program relied heavily on videotape modeling. The series of videotape programs shows parents of different sexes, ages, cultures, socioeconomic backgrounds, and temperament styles interacting with their children in natural situations—during mealtime, getting children dressed in the morning, toilet training, handling child disobedience, playing together, and so forth. The 130 vignettes include scenes in which parents are “doing it right” and “doing it wrong.” The intent in showing negative as well as positive examples was to demystify the notion that there is “perfect parenting” and to illustrate how parents can learn from their mistakes (Webster-Stratton, 1992b).

The videotapes were designed to be used in a collaborative way—as a catalyst for group discussion and problem solving, not as a device that renders the parents passive observers. After a videotape vignette was shown, the trainer would pause the tape to give parents a chance to react and discuss what they had observed. The trainer often would ask open-ended questions such as, “Do you think that was the best way to handle that situation?” or, “How would you feel if your child did that?” The goal was to have parents become actively engaged in problem solving and sharing ideas about the vignette. Trainers would also facilitate learning by asking the parents how the concepts illustrated in the vignettes applied or did not apply to their own situations. For example, a mother made 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.

TRAINER: 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?
Role-Playing and Rehearsal

Role-playing and modeling of newly acquired behaviors are one of the most common components of parent training programs; they have been shown to be quite effective in producing behavioral changes (Eisler, Hersen, & Agras, 1973; Twentyman & McFall, 1975). Role-play helps to evoke sequences in behavior, enabling parents to anticipate situations more clearly. However, some parents may feel reluctant to participate in role-playing, particularly if they feel inadequate regarding their own behavior as parents. Use of this method can lead to disengagement with therapy, and even dropout, if it is not handled well.

The PARTNERS program included two to three suggested role-plays for each session. Besides presenting a clear rationale for the role-play, the trainer would often do the first role-play in order to reduce parents' self-consciousness and anxiety. If the trainer could make the role-play humorous through exaggeration, so much the better. For example, the trainer (role-playing the parent) would go out of the room and shout from a distance (e.g., kitchen) for the child (role-played by the parent) to put away the toys. This usually raised chuckles of recognition—there is no way for the parent to know whether the child registers the command or responds in any way. We believe that the trainer should take on the roles of ineffective parent or a misbehaving child, but not a competent parent; if the trainer demonstrates a high level of skill, parents may be reluctant to volunteer for fear of not measuring up to the trainer's example.

After the trainer had done the first role-plays, we then broke the parent group into pairs to practice particular skills. Later on, as groups became comfortable with each other, parents role-played 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 played the child and another parent the child's parent. The remainder of the group would act as coaches for the parent who was in the parent role. Sometimes it is helpful to "freeze frame" the role-play and then ask the group to brainstorm, "Now what should she do?" or, "What is the child trying to communicate or achieve by behaving like that?" Reluctant role players may be cast as a coach or partner to the parent who is doing the actual role-playing so that they can offer advice is needed but are not seen as central.

The content for the role-plays came from the parents themselves. For example, if a parent came to the group after a week of trying to ignore her son's whining and said, "I can't ignore him—it's much worse than anything you showed us on videotape," the trainer might respond, "Okay, you be your whining son, and Sally, why don't you demonstrate how you would try to ignore this." This role-play has the added advantage of helping the parent experience the strategy from the child's perspective—the withdrawal of attention, the refusal to engage in a struggle—in order to experience its effectiveness.

Home Assignments and Self-Management

A home assignment was given for every weekly group session. This usually involved asking parents to do some observing and recording of behaviors or thoughts at home and/or experimenting with a particular strategy. For example,
one assignment asked parents to play one-on-one with their child each day for 15 minutes; another assignment was to record how often they praised between 5 and 6 P.M. for 2 days, and then to double their base rate for the remainder of the week. Another was for parents to keep track of their thoughts in response to a conflict situation with their child on two occasions. We regarded assignments as critical because they conveyed at least two important messages: namely, that participation in the group was not "magic moon dust" and that change was not the trainer's responsibility; parents had to collaborate with the trainer by working at home to make changes. The home assignments helped to translate theory (what is talked about in group session) into real life. They also provided a powerful stimulus for discussion at the subsequent session.

Parents will naturally resist these assignments, seeing them as one more stress in their lives, so it was essential to make a case for the usefulness of the assignments. Homework was presented to parents as an integral part of the learning process. When a parent failed to complete an assignment from the previous session, the reasons for this were explored. A collaborative approach involves 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?" "Do you think it is just as hard for your child to learn to change as it is for you to change?" "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?" Often these questions were explored as a group discussion topic.

It is important to explore reasons why some parents might be having difficulty doing their home assignments; otherwise, parents may conclude that the trainer is not really committed to the assignments, or does not really want to understand their particular situation. The process of talking about the assignments and renegotiating assignments if parents feel they are too difficult or unrealistic (without making them feel a failure) is a key to motivating parents' engagement with the program.

In order to facilitate the self-management and home activity portion of the program we gave each parent a personal folder. Each week the trainer put the new assignment in the folder and reviewed the parents' assignment from the prior week. Trainers commented in writing on these assignments in the folder, sometimes giving a sticker or prize and discussing with the group a strategy that a parent has discovered. For shy group members, these folders became a private way to communicate with the trainer; the trainer was able to give personalized feedback by writing in the folders. Often a folder resulted in the leader discovering how engaged a nonverbal parent really was. Another benefit of the folders was that they were the one place where parents could tell the trainer private comments they might not want to share with the whole group. On the inside cover of the folder was a checklist where parents were asked to check off whether or not they did the weekly assignment. When the trainer reviewed a weekly folder she or he would call parents who had missed two consecutive weekly assignments. In our Head Start final program evaluation 83% of the parents reported the home assignments to be "useful" to "very useful" and fewer than 1% reported them to be "somewhat useless" to "very useless."
Readings and Tapes

Although we have noted that verbal training methods are less effective than performance-based methods, this does not mean that we eliminated all books and written materials. In fact, since people have varied learning styles, we believe that effective programs should utilize many different learning methods. In the PART-NERS program every parent received a copy of the author's *The Incredible Years: A Trouble-Shooting Guide for Parents of Children (ages 3–8 years)* (Webster-Stratton, 1992a) (or audiotapes for nonreaders) and were given a weekly reading assignment which dovetailed with the videotapes shown that week. For many parents this was the only parenting book they had ever read, and for the first time they saw the possibility of using books as a resource for parenting. There were times when parents came to sessions having read “ahead” and having tried out strategies not yet presented in class. Final evaluations indicated that 88.9% found the book to be a “very useful” learning method.

**Trainer's Strategies**

Many low-income parents have had primarily negative experiences with professionals (caseworkers, social service agency staff, teachers, therapists) in the past, and came to the PART-NERS program with some skepticism and even mistrust of the therapists and group leaders. Bearing this in mind, we theorized that there would be better parental engagement with the program if the trainers saw their role within the context of a “friendship relationship.” A collaborative trainer was conceptualized as the kind of friend who listens, asks for clarification, is reflective and nonjudgmental, tries to understand what the parent is saying through empathy, helps problem solve and does not command, instruct, or tell parents how to do their job.

One of the ways the PART-NERS trainers showed their commitment to the family was through follow-up calls made during the week. Trainers “checked in” with a friendly call each week, asking how things were going and whether parents were having any difficulty with the home assignments. In the final evaluations of the training, parents commented that they were genuinely touched that a trainer “just called to see how I was doing.” (These calls also aided the trainer by revealing how well parents were assimilating the material presented in group so that the trainer could attempt to clarify any misperceptions.) These calls allowed trainers and parents to get to know one another outside the group—particularly useful in the case of the quiet or reluctant parents—and promoted engagement with the program.

**Self-Disclosure**

As discussed earlier, the collaborative trainer renounces the role of an “expert” who has all the answers, an expert who stands apart from the families’ problems. The trainer must be not only empathic, respectful and kind, but also genuine. These core conditions (as described by Carl Rogers, 1951) are the necessary underpinnings for the cognitive–behavioral methodology. One expression of genuineness is the trainer’s willingness to be known—to share personal experiences, feelings
and problems of his or her own. Trainers and therapists always have a rich array of stories, either from their own families or from work with other families, which they can draw upon at will.

Self-disclosure concerning one's personal issues and experience was, however, planned strategically. It cannot be overemphasized that the purpose of self-disclosure was not for clients to learn about the trainer's feelings and problems; rather, the purpose of self-disclosure was identical to the purpose of the training: to help parents learn to function more effectively in their role as parents. By sharing some personal experiences, the trainer could help families understand that parenting is, for everyone, a process of learning to cope and to profit from mistakes; it is not a process of achieving perfection. Thus the trainer's personal examples helped discredit the notion that there are perfect parents. They also served to normalize the parents' reactions and to give them permission to make mistakes. Moreover, this genuineness on the part of the trainers was designed to enhance the trainer's relationship with the group members, introducing openness and a degree of intimacy, and fueling the collaborative process.

**Humor**

Humor has value as a coping strategy and a training strategy. Trainers made deliberate use of humor to help parents relax and to defuse anger, anxiety, and cynicism. Parents need to be able to laugh at their mistakes; this is part of the process of self-acceptance. Humor helps them gain some perspective on their stressful situation, which otherwise can become debilitating. Some of the videotape scenes in our program were actually chosen more for their humor value than for their content value. Our trainers used humorous personal examples in the discussions, distributed humorous cartoons of parents and children (which are found in abundance in newspapers and magazines), and role-played situations in which they did everything wrong—that is, with lots of criticisms directed at the child, negative self-talk, and so on. Laughter helped build group spirit, strengthening parents' engagement.

**Reframing**

Therapeutic change depends on providing explanatory “stories,” alternative explanations which help parents to reshape their perceptions of and their beliefs about the nature of their problems. Retraining by the trainer or therapist (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 view of an experience by placing the experience in another “frame” which fits the facts of the situation well, thereby altering its meaning.

One common strategy in PARTNERS groups was for the trainer to help parents see the developmental needs represented by the child's behavior. Retraining 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 the important 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 this way, parents can feel 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 being parents.

**Positive Expectations**

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 trainer 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 trainer expressed her 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.

PARTNERS trainers tried 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 (1977), efficacy expectations are thought to be the most important component. Thus, successful treatment depends on the ability of the trainer to strengthen parents' expectations of personal efficacy ("I am able to do it"). Citing examples of the success of other parents in similar situations proved to be a useful strategy.

**Positive Reinforcement**

Trainers tried to validate and reinforce parents whenever possible by noticing and commenting upon their use of effective strategies and their insights. One father reported the following incident:

**Father:** I was just so frustrated with him! He wouldn't get dressed and was dawdling—I was going to be late for work. I got angrier and angrier. Finally, I went into his bedroom and shook him by the shoulders and yelled, "You want negative attention, you're going to get negative attention!" Then suddenly I thought, What am I doing? Where is this getting me? and walked out of the room.

**Trainer:** So, you were able to stop yourself in the middle of an angry tantrum. Good for you! That's remarkable. It sounds like your ability to stand back from the situation, to be objective and think about your goals, really helped you stop what you were doing. Is that true? What do you usually find helps you keep control of your anger? How would you replay the situation if it happens again?

In this example, the trainers reinforced the father's insight and drew attention to his coping skills during the conflict situation. The trainer also helped the father learn from the experience by rehearsing how he might respond in the future. These parents need to be reinforced through positive feedback for each change in
their behavior, whether or not it results in improvement in their child's behavior. This affirming process helps parents gain confidence in their ability to sort out problems and to learn from their mistakes (Brown & Harris, 1978). The developmental literature suggests that mothers who have confidence in their child-rearing and who feel they have broad community support actually do better at parenting (Behrens, 1954; Herbert, 1987).

Because in most groups there are varying levels of educational background and communication skills, it is important for parents' engagement and for group cohesion that the trainer reinforce every parent for sharing his or her ideas regardless of the trainer's opinion of those ideas. Furthermore, PARTNERS trainers attempted to clarify for the group any unfocused or confusing statements made by parents so that they would not be ridiculed, ignored, or criticized because of something they had said. We called this “finding the kernel of truth” in what a parent has said: underscoring its value by showing how it contributes to the group's understanding of the topic under discussion. In our experience, if the trainer does not clarify and validate these statements, the parent who makes them is at risk for dropping out—and so might other parents who become disillusioned with the experience.

**Other Strategies for Promoting Engagement**

**Identifying Goals of Group**

At the initial parent group meeting, parents were asked to share some of their personal experiences with their children, as well as their goals for the training program. The goals for each parent were posted on the wall so that they could be referred to throughout the program. This initial discussion often produced immediate group rapport as parents realized they had similar difficulties and were working toward similar goals. Throughout the training, parents were given home assignments to write down the child behaviors they wanted to see increase or decrease. These targeted behaviors (e.g., go to bed at 8 p.m., not interrupt when on phone) became the focus of principle training. Several times during the program the trainer drew up a composite list of behaviors parents were working on so that group members could see the similarities among their issues. This promoted ongoing group cohesion, as well as attention to individual goals, thereby increasing parents' commitment to the program.

**Ensuring Group Safety and Sufficient Structure**

One of the most difficult aspects of the trainer's role is to prevent the group experience from becoming negative. If this should happen, dropout is a certainty. Therefore, during the first meeting we asked group members to generate rules that would help them feel safe, comfortable, and accepted in the group. These rules were kept posted on the wall to be added to or referred to if necessary during weekly sessions. Examples included (1) only one person may talk at a time, (2) everyone's ideas are respected, (3) anyone has a right to pass, (4) no "put downs" are allowed, and (5) confidentiality within the room.

For groups that were very verbal and tended to get sidetracked, it was helpful at the beginning of each session to select a parent to act as a co-trainer. The job of this parent co-trainer was to be a timekeeper, to make sure all vignettes were covered, to
help identify participants who were sidetracking the discussion, and to keep the group focused on the main topics for the session. Our evaluations indicated that parents became frustrated and disengaged if the discussion wandered, and they appreciated having enough structure imposed to keep the discussion moving along. By rotating the job of co-trainer, the task of monitoring the group discussion became everyone's responsibility; everyone was committed to the group's functioning well.

The group process can also be disrupted by a participant who challenges the trainer's knowledge or advocates inappropriate child-rearing practices. It is important that the trainer 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 trainer looked for the relevant points in what the person had said and reinforced them for the group. By conveying acceptance and warmth, even toward a parent who is an obviously difficult group member, trainers modeled acceptance and helped group members see that the goal was to understand and respect everyone.

Weekly Evaluations

Each week the parents were asked to evaluate the group session. This immediate feedback about how each parent was responding to the trainer's style, the group discussions, and the content presented in the session brought to light any engagement problems as the program was in progress—the parent who was dissatisfied with the group, the parent who was resisting a concept, the parent who did not see the relevance of a particular concept to his or her own situation, the parent who wanted more or less group discussion. Between sessions, trainers would call any parent who indicated a neutral to negative weekly evaluation on more than one occasion to discuss their concerns about the program. Sometimes the trainer would meet with parents individually to resolve these issues. If several participants were having difficulty understanding a particular concept, the trainer would bring it up in a subsequent session with the whole group. By responding to parents' evaluations with actions, trainers validated the collaborative nature of the program and fostered parental engagement. After the last session, the entire program was evaluated. This information was useful not only in planning future parent groups, but also in identifying parents who needed further help.

Managing Disengagement and Resistance

When a parent is resisting a basic concept or disengaging from the program, the trainer faces a dilemma. Should the trainer confront and challenge the parent regarding this, or just let it go in the interest of fostering collaboration and offering support? The trainer may be worried that confrontation will jeopardize the collaborative relationship. Yet this failure to address the issue really constitutes a kind of collusion with parents regarding their parenting practices. Therefore, how this resistance is handled by the trainer is crucial not only to the parents' level of engagement with the program, but also to the effectiveness of the training.

Resistance takes a variety of forms—failure to do homework, arriving late for group sessions, blaming the trainer, blaming the child or life circumstances, negatively evaluating the sessions, or challenging the material presented. Clients say such things as:
MOTHER: I feel I just can't absorb it all and I'm getting behind at home. I just can't do all this play stuff, there isn't anytime.
FATHER: Yeah, I go out of this group charged up, but when I get home I lose it. I don't start thinking about applying all this stuff until right before our group is to meet again.

To some extent, resistance is a necessary part of the change process for which trainers (and clients) need to be prepared. Patterson and Forgatch (1985) indicate that considerable resistance will peak midway through the intervention process. Resistance may be part of the parent's efforts to maintain self-efficacy and self-control in the face of changing family dynamics—in effect, the parent is "putting on the brakes." Or parents may resist out of discouragement—unrealistic expectations for change and lack of preparation for the long, hard work involved.

But in other cases, resistance is the client's legitimate and understandable response to aspects of the intervention or the trainership that are inappropriate, ill-conceived, or ineffective. Too often we refuse to entertain the possibility that client resistance or disengagement are evidence of flaws in our approach. Freudian tradition, of course, discourages us from doing so, viewing resistance as an element in the therapeutic relationship. Certainly this view of resistance has supported the prevalent skepticism about working with disadvantaged clients, the tendency to see them as unreachable due to their own circumstances rather than due to aspects of the training model, the training format, the trainer's role, and so on. Whatever the source of the resistance, the first task for the trainer is to put aside any notion that the resistance is a sign that the parent is noncompliant or unmotivated—a "difficult person." Perhaps the parent is resisting because his or her stressful life circumstances make it difficult to find the time to do the assignments. Perhaps the parent is disengaged because he or she perceives the trainer as patronizing or thinks the trainer is presenting "pat" answers and solutions without really understanding his or her situation. Or perhaps the trainer shows no sensitivity to the parents' culture, is using unfair language or foreign examples, or uses humor that makes the parent uncomfortable.

One aspect of PARTNERS that frequently inspired resistance was the use of time-out as an alternative to spanking.

FATHER: Well, all this time-out stuff is well and good, but in the final analysis I think spanking is what you really need to do. Especially when something bad happens, like a broken window.

TRAINER: So you really see spanking as the final "big gun"?
FATHER: I do. You know, I was spanked by my father and it didn't do me any psychological harm.

A collaborative trainer deals with resistance by starting from the premise that the parent's views are legitimate—in this case, respecting the parent's preference for spanking as legitimate. She then would explore this viewpoint with nonjudgmental questions such as, "Tell me how spanking works for you. How often do you use it?" "How do you feel afterwards?" "How does your child feel about it?" "How does it affect your relationship?" "Do you ever feel you lose control when you spank?" "What do you see as the advantages of spanking?" "Are there any disadvantages?" "How did it affect your relationship with your parent when you..."
were spanked as a child?” Similar questions might then be asked about time-out. “Let’s look at an alternative approach. What are the difficulties with time-out?” “What don’t you like about it?” “What are its disadvantages?” “Are there any advantages?”

In our parent groups this kind of discussion between the trainer and a resistant parent tended to draw group members into the discussion, whereas a judgmental or authoritarian response would tend to result in silence. Direct confrontation is likely to increase the parent’s defensiveness (Birchler, 1988). Furthermore, it devalues the parent in front of the other group members. In fact, in one of the few studies to do a microanalytic analysis of therapist–client interactions, Patterson and Forgatch (1985) found that resistance met by direct confrontation or teaching on the part of the therapist actually increased parents’ noncompliance.

One technique we used for handling resistance to a behavioral strategy was to list the advantages and disadvantages, short-term and long-term consequences for the child and for the parent, on a blackboard. At the end of this discussion, the trainer summarized the ideas that were generated, clarified concepts, and added his or her own ideas if they had not already been raised. This group problem solving served to move people away from “absolutist” positions, opening them up to new ideas which they might not have considered previously, thus reducing resistance. This process of exploring the reasons behind (and not the psychological reasons for) the resistance, followed by the exercise of looking at the advantages and disadvantages of particular parenting strategies, is a kind of values clarification and problem-solving exercise which helped clarify feelings and experiences surrounding the issue. This strategy serves to join people rather than alienate them. It is more likely than direct confrontation to result in a gradual change in parents’ perceptions and behaviors, especially if conducted in the context of a supportive relationship. On the other hand, a noncollaborative approach, in which the trainer directly confronted the parents’ ideas, would create a conflict wherein trainer and parent each have to defend their own position in order to protect their integrity.

Another strategy for moving the parent from resistance to engagement is to invite the parent to consider a short experimental period.

**Trainer:** I understand your viewpoint regarding time-out and that you think children should be spanked for misbehaving. At the same time, Timmy seems to have been having more and more problems with being aggressive with his peers and at school and I know you are eager to help him with this problem. I’d like to suggest that we do an experiment. I’d like you to give it a try and act as if it will work. I’d like you to try doing time-out for a month and keep records, and then at the end of a month let’s evaluate how it looks. You see, if it doesn’t work, you can always go back to the way you have been doing things and won’t have lost anything. What do you think about that?

In this example, the trainer does not attack the resistance by confronting it directly or repeating the reasons she or he thinks time-out is right (and why the parent is wrong to use spanking). Rather, the trainer engages in a process of gentle persuasion. Although she does not confront the resistance itself directly, she confronts the difference of opinion directly.
A collaborative response to resistance can reveal instances where the intervention needs to be adapted to the client. Once the trainer understands the reason for the resistance, then she or he can then modify the approach as necessary so that the treatment objectives are still foremost and the parent can cooperate with the intervention. For example, one parent said she could not put the child in a time-out room because she felt it would create bad feelings about the child’s room and, more importantly, the child would feel abandoned. Further exploration by the trainer uncovered the fact that as a child this parent had been locked for hours in her bedroom by her own parents! As a result of this discussion, the trainer and parent devised a “calm-down” strategy using a chair in the corner of the living room rather than the bedroom. Over the course of future sessions, the trainer helped the parent understand that short time-outs, in which the parent reestablishes control, help children to feel more secure in their relationships with their parents, and that children whose behavior is not controlled by their parents actually may come to feel psychologically abandoned. By accepting the parent’s objection, joining with her in coming up with an appropriate strategy, and then re-framing the concept so that the parent perceived time-outs as a way of promoting security (rather than as abandonment), the trainer enabled the parent ultimately to accept the strategy for herself and her child.

Predicting resistance early in the training may also be helpful.

TRAINER: Be prepared to feel awkward when you do this kind of play. Be prepared for yourself to resist wanting to do it because it does feel awkward. And be prepared for your child not to like it at first. Whenever someone learns a new behavior, there is a natural tendency for family members to resist this new behavior and to revert back to the status quo. In fact, some family members might actually try to pressure you to return to the old way of doing things.

OR,

You will probably feel awkward praising at first, especially if you haven’t done much of this in the past. You may even feel your praise sounds phony. So don’t wait for yourself to feel warmth toward your child in order to praise. Just get the words out, even if they are kind of flat. The feelings and genuineness will come later. The more you practice, the more natural it will become.

OR,

Lots of parents don’t like time-out at first. Compared to spanking it’s more time-consuming, it is harder to keep the self-control you need (especially if you want “revenge” with your child), and it feels awkward. But with practice it will become automatic and your child will learn exactly what to do. You will feel good because you are teaching your child a nonviolent approach to dealing with conflict.

When parents are prepared for resistance in advance, they are more able to remain engaged with the intervention, for they can reframe their reactions as part of the change process.

FATHER: My wife made me come. The first night I couldn’t wait for it to be over. I was real skeptical of 90% of the things they said in the class at first. I had never even heard of time-out. Before taking this class my idea of discipline was to spank and yell a lot—you know—hit first and ask later. I con-
centrated on the negative and that was the way I was brought up. Then about halfway through the classes I did a 360 degree turnabout—now I feel more in control, more confident, much happier as a parent now than I did before. I used to come home and think, God, what kind of trouble did they get into today? or What am I going to have to punish them for tonight? Now I appreciate them a lot more and can stand back and think, Well, jeez, they are pretty good kids. I like myself better now than I did before.

CONCLUSION

It has been stated that because low-income parents are "multiply entrapped" they will be unlikely to show up for parent groups, will most likely drop out of parent training programs, and/or will fail to show significant improvements in their parenting. In this chapter, we presented the notion that it is the characteristics of the intervention, not of the client, that determine the success of parent training with this population. We believe that successful parent training programs need to be community-based and to involve parents in planning, recruitment, co-leading groups, and setting priorities for program content. At the end of the school year we again asked the parents if they were interested in any other kinds of programs in the future. More than 70% said they wanted to continue the parent program throughout the kindergarten year. Forty percent wanted additional social skills training for their children during the summer months; 45% wanted training in anger management; 35% training in enhancing partner relationships; and 35%, in controlling depression. Thus it would seem that, having had a successful experience with a parent program, these parents are ready for and interested in broadening the focus to other family issues that they see as needs for themselves.

Successful programs need not only to involve parents in determining priorities for the content but also need to be accessible and realistic given the practical constraints of parents living on welfare or the "working poor"—that means providing child care, transportation, food, and evening groups as well as daytime groups. The training program needs to be delivered in a collaborative way so that parents are given responsibility for developing solutions alongside the trained trainer. The training methods need to be responsive to a variety of learning styles and to utilize performance-based training methods such as videotape modeling, role-playing, and home assignments. Program content needs to be relevant and sensitive to individual parent needs and family circumstances. The group format not only is more cost-effective, but enhances support networks both within the family and within the community, ultimately leading to greater parent empowerment. We believe that these elements of an intervention lead to a higher level of parental engagement, and this involvement will result in parents gaining the knowledge, control, and competence they need to effectively cope with the stresses of parenting under conditions of poverty.

FATHER: Like I said, I was spanked as a child and I felt pretty worthless but still I yelled and hit my own kids a lot. There was no communication other than yelling. Now I see my children differently—as human beings you know not just kids. I see them as having their own personality traits and their own sense of who they are and what they want to do—rather than just kids who must do what I want them to do. I see them differently.
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REFERENCES


