The purpose of this article was to describe the therapeutic processes involved in a parent-training program for families with conduct-disordered children. Videotaped transcriptions of over 100 hours of group discussion therapy sessions provided the data for this study. Findings indicated that the therapeutic process of helping parents learn to manage their children's behavior problems was based on a collaborative model. This model included six roles for therapists, which were labeled building a supportive relationship, empowering parents, teaching, interpreting, leading and challenging, and prophesizing. In addition, the script for parents included five recurring themes related to helping them cope more effectively. These were promoting parents' problem-solving, helping parents "come to terms" with their child, gaining empathy for their child, parents' accepting their own imperfection, and learning how to "refuel." Examples of each of these roles and themes are discussed.

“What Really Happens in Parent Training?”

CAROLYN WEBSTER-STRATTON
University of Washington

MARTIN HERBERT
University of Leicester

The need to help families with conduct-disordered children is particularly urgent, for these "aggressive" children are at increased risk for being abused by their parents (Reid, Taplin, & Loeber, 1981), as well

AUTHORS' NOTE: This article was written while the senior author was on sabbatical as a Visiting Fellow at the University of Leicester and Oxford. During that time, she had the good fortune to meet Professor Herbert and to discuss and debate therapeutic issues related to treatment of families with conduct-disordered children. They found that they had arrived independently at similar conclusions regarding the importance of certain therapeutic process variables and the partnership/collaborative model. This was of interest for the generality of their conclusions because they are both working with fairly representative samples of both American and British families with conduct-disordered children. This article was supported by the National Institutes of Health National Center for Nursing Research Grant No. 5 RO1 NR01075-07. Special thanks are given to Deborah Woolley, Ph.D., for her thoughtful comments on an earlier draft of this article. Correspondence concerning this article should be addressed to Carolyn Webster-Stratton, Department of Parent and Child Nursing, JD-03, University of Washington, Seattle, WA 98195.

BEHAVIOR MODIFICATION, Vol. 17 No. 4, October 1993 407-456
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as for school dropout, alcoholism, drug abuse, juvenile delinquency, adult crime, antisocial personality, marital disruption, interpersonal problems, and poor physical health (Kazdin, 1985; Loeber, 1985; Loeber & Dishion, 1983; Robins, 1981). Thus, in the absence of treatment, the long-term outlook for conduct-problem children is poor.

One of the major strategies that has been followed in attempting to reduce conduct disorders among children involves training parents to alter the reinforcement contingencies that support the antisocial behavior of their children. The rationale for this approach is supplied by the research indicating that parents of conduct-disordered children have an underlying deficit in certain fundamental parenting skills. For example, parents of conduct-disordered children have been reported to exhibit fewer positive behaviors, to be more violent and critical in their use of discipline, to be more permissive, to be more likely to fail to monitor their children’s behaviors, and to be more likely to reinforce inappropriate behaviors and to ignore or punish prosocial behaviors (e.g., Griest, Forehand, Wells, & McMahon, 1980; Patterson, 1982; Patterson & Stouthamer-Loeber, 1984; Webster-Stratton, 1985). Following this theory, which posits the primacy of parents in the development of conduct disorders, intervention approaches have been aimed directly at training parents.

Reviews of a variety of parent-training programs based on one-to-one therapy (e.g., Kazdin, 1985; McMahon & Forehand, 1984; Patterson, 1982) have generally supported their effectiveness. In spite of the documented effectiveness of various types of parent-training programs, the literature contains comparatively little discussion of the actual therapeutic processes used by therapists in such intervention programs. In contrast, there is a rather large body of literature describing the content of parent-training programs. For example, behavioral principles, such as time-out, beta commands, praise, differential attention, response cost, and so on, are carefully outlined in detail. Describing specific behavioral principles alone does not elucidate the mechanisms or ongoing processes of what happens when a therapist tries to change or modify a parent’s behavior, attitudes, and practices in a parent-training program. There are many questions to be answered concerning the process of parent training, such as How do therapists handle parents’ resistance to new concepts? How do they ensure that homework is carried out? What are their teaching methods and strategies? When do they use confrontation? How do they promote self-confidence and self-efficacy in parents? How do they ensure that they are culturally sensitive? Patterson and Forgatch (1985) have argued that we need to move “beyond the technology” in developing an empirical base for parent training. In fact, they reported one of the few studies to examine the process of parent training. They analyzed the impact of therapist behaviors, such as confront and teach, on parent noncompliance or resistance. Their study is important in that it analyzes client-therapist interactions on a moment-by-moment basis; however, it does not place the therapists’ responses within the larger context of the ongoing therapeutic process of change during therapy.

The purpose of this article, therefore, is to provide a qualitative description of the process of working with parents who have conduct-disordered children. The therapeutic processes we describe here are complementary to the content and methods described in the Parent and Child Video Series (Wester-Stratton, 1982, 1992), which is a series of videotapes developed for use by therapists involved in parent training. A series of prior studies (Wester-Stratton, 1981, 1984; Webster-Stratton, Kolpaoff, & Hollinsworth, 1988, 1989) has shown that therapist-led parent group discussion training based on videotape modeling (GDVM) was both cost efficient and effective in improving parenting attitudes and behaviors, as well as in reducing child conduct problems. However, showing these videotapes composes only 20% of a group or individual session (20 min); the remaining time is spent engaged in therapist-led discussion. It is our contention that a knowledge of parent-training content and a familiarity with videotapes are necessary but not sufficient for ensuring success in working with most parents of conduct-disordered children; the second requirement necessary for positive outcomes is a high degree of clinical skill in working with parents, whether individually or in groups. Because we had videotaped all our therapy sessions, we had a window into the experience of therapists, providing rich data on our intervention process. From these videotapes, we analyzed the therapists’ clinical processes.
THE COLLABORATIVE MODEL

Our theoretical approach for working with parents of conduct-disordered children falls within the cognitive social learning model, although it integrates some of the core elements of the existentian-humanistic model (e.g., Rogers, 1951; Truax & Carkhuff, 1967). We are uneasy calling our approach parent training, because this term may imply a model based on a hierarchical relationship between the therapist and parent wherein the "expert" therapist is fixing some "deficit" within the parent. We would prefer a term such as parent coaching. Regardless of what we call the intervention approach, the underlying helping process we advocate for working with parents of conduct-disordered children is based on a collaborative model. Webster’s Ninth New Collegiate Dictionary (1991) defines collaboration simply: working jointly with others. Collaboration implies a nonblaming, supportive, reciprocal relationship based on using equally the therapists' knowledge and the parents' unique strengths and perspectives. Collaboration implies respect for each person's contribution—a relationship built on trust and open communication. Collaboration implies that parents actively participate in the setting of goals and therapy agenda and take responsibility with the therapist for solving their own or their family's problems. Collaboration implies that parents provide ongoing evaluation of each therapy session, so that the therapist can use these evaluations to refine and adapt the intervention to make it sensitive to the families' needs.

In a collaborative relationship, the therapist works with the parents by actively soliciting their ideas and feelings, understanding their cultural context, and jointly involving them in the process of sharing their experiences, discussing and debating ideas, and problem solving. The therapist does not set him- or herself up as the expert dispensing advice or lectures to parents about how they should parent more effectively; rather, he or she invites parents to help write the "script" for the intervention program. The therapist's role, then, as collaborator is to understand the parents' perspectives, to clarify issues, to summarize important ideas and themes raised by the parents, to teach and interpret in a way that is culturally sensitive, and finally, to teach and suggest possible alternative approaches or choices when parents request assistance and when misunderstandings occur.

Such partnership between the parents and the therapist has the effect of giving back dignity, respect, and self-control to parents who are often seeking help for their children's problems at 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 model, which gives parents responsibility for developing solutions (alongside the therapist), is more likely to increase parents' sense of confidence, self-sufficiency, and perceived self-efficacy in treatment than are other therapy models that do not hold parents responsible for solutions. Support for the value of this approach comes from the literature on self-efficacy, attribution, helplessness, and locus of control. For example, Bandura (1982, 1989) has suggested that self-efficacy is the mediating variable between knowledge and behavior. Thus parents who are self-efficacious will tend to persist at tasks until success is achieved. The literature also indicates that people who "own" outcomes are more likely to persist in the face of difficulties and less likely to show debilitating effects of stress (e.g., Bandura, 1977; Dweck, 1975; Seligman, 1975). Moreover, research (Backeland & Lundwall, 1975; Janis & Mann, 1977; Meichenbaum & Turk, 1987) suggests that this collaborative process of sharing information and thinking has the double-edged advantage of reducing attrition rates, increasing motivation and commitment, reducing resistance, increasing temporal and situational generalization, and giving both parents and the therapist a stake in the outcome of the intervention efforts. On the other hand, controlling or hierarchical modes of therapy, in which the therapist makes decisions for parents without inviting their input, may result in a low level of commitment, dependency, resentment, and resistance (Janis & Mann, 1977; Patterson & Forgatch, 1985). In fact, if parents are not given appropriate ways to participate, they may see no alternative but to drop out or resist therapy as a method of gaining control.

SETTING THE STAGE FOR COLLABORATION

The setting. It is important to consider the setting of the services. Our experience is that parents respond better to an informal office setting than to a formal one. Our offices include a large comfortable
group room with a parent lending library and a place to make coffee and tea. Many parents come to our group sessions early just to have coffee and cookies and chat informally with other parents before the group session starts. Initially, our therapists provide snacks for the midgroup break, but very soon we find that other parents offer to bring in surprises for the group, such as pizza, cakes, and so forth. This informality helps to decrease the distancing not only from the therapist but also from the other parents and promotes a comfortable environment.

The intake interview. First, a collaborative approach begins at the very first encounter with the parents—at the initial intake interview. During this interview, the therapist tries to enter into the parents’ experience and feelings; a typical question is, “What is life like at home with your child?” Parents are asked to explain the approaches they have tried—those that have worked or have not worked—as well as their theories regarding the possible causes of the child’s problems. The parents’ explanatory model and attributions for the child’s problems are elicited through questioning. They are asked to list the problems that they are concerned about and to set them in order of priority from their perspective. Ideally, parents come to feel that a genuine effort is being made to understand their internal reality.

Next, the therapist tries to elicit the parents’ hopes and goals for therapy. He or she asks questions such as “What is your greatest hope for what will happen as a result of coming to therapy?” Defining the parents’ goals at the outset helps the therapist correct any unrealistic expectations of therapy. In addition, it helps the family to focus on a more positive future at a time when they may be feeling depressed and vulnerable. During this initial session, the therapist listens carefully to the text and subtext of what the parent is saying; he or she listens with a “third ear” to the meaning of the child’s problem for the family. Throughout the interview, the therapist tries to follow the parents’ agenda, beginning where the parents want to begin and covering their points of concern. Thus the therapist has already begun during the first interview to demonstrate empathic understanding and involve parents immediately in the meaning of therapy as a collaborative enterprise.

After discussing the parents’ experiences and perceptions of their child’s problems, their explanatory model, and their hopes for therapy, we then share with them our philosophy regarding the causes of child conduct disorders. We explain our program, emphasizing its collaborative nature. This collaboration is also discussed in our clinic brochure. For example:

**Therapist:** Our job is to work with you, to support you, and to consult with you so that the interactions between you and your child are more positive and so that you can achieve your goals. The way our program works is we meet each week with a group of parents (with similar children) in order to study and discuss together some videotapes of parent-child interactions about child behavior management. We work together as a team and we expect you to be our “cotherapist” in this process. This means that as we analyze the videotapes and decide together on some strategies for you to try out at home with your child, you become the experts on what works or doesn’t work with your child. When things don’t work, you bring this information back to us and we put our heads together to come up with a better strategy for the problem. You see, we each have a contribution: What we can offer is more alternatives, information, and resources, and what you can offer is help deciding and implementing the best strategy for your situation. How does that sound to you?

We sometimes find that parents have a preexisting cognitive “set” regarding therapy, which may be quite different from our approach. For example, they may expect us to “fix” the child through child therapy or to change the child’s temperament with medication. On the other hand, because we place such a strong emphasis on parent involvement, they might incorrectly assume that we blame parents for the problems they are experiencing with their child. Although self-blame and guilt are recurring themes throughout the process of therapy, it is important for parents to hear from the onset that we take a nonblaming, nonjudgmental, and nonpatronizing stance toward the causes of the child behavior problems. We want them to know that we are interested in supporting parents and helping work to improve their situation rather than determining who is at fault. Our orientation is toward the malleable present and future, not the unalterable past. For example:

**Therapist:** We appreciate hearing your own theories regarding the reasons for your child’s problems. Our own approach when we see children misbehaving is not to assume that either the child is at fault (a
"bad egg") or the parent is inept. Rather we feel that—for whatever reason—the interaction between the parent and child has gone askew and is "out of synch." This may have occurred because the child has a more difficult temperament and is more resistant to discipline than other children, or because stresses on the family make it particularly hard to keep up the difficult work of parenting, or some combination of these factors.

The concepts of partnership, cotherapy, group discussion and support, education, and problem solving are brought up repeatedly throughout the initial therapy sessions to emphasize the collaborative nature of the intervention program and to educate parents in its elements.

**Initial group meeting.** The initial group meeting is critical in terms of setting not only the structure and ground rules for all future meetings but also the tone. First, the therapist explains the group rules in terms of starting and ending meetings on time, the value of active participation in discussions, the importance of one person talking at a time, and how digressions or disagreements will be handled by the therapist. The therapist again discusses the collaborative philosophy, objectives, and rationale for the program to the whole group, so that parents can raise any questions that may have come up since the intake interview. Next, group members are asked to share a little of their personal experiences with their children as well as their goals and hopes for participating in the program. This discussion results in the group members building rapport; they quickly realize that they are all experiencing similar difficulties and are not alone in their problems. It becomes evident that the therapist and parents are all working collaboratively toward similar goals.

The collaborative model of interacting with parent groups is demonstrated by the therapist’s open communication patterns and accepting attitudes toward all the families in the program. By building rapport with every member of the group, the therapist attempts to create a climate of trust, making the group a safe place for everyone. The therapist needs to be empathic and listen carefully to indicate that he or she appreciates and wants to understand everyone’s point of view. During this initial session (as well as later on), it is important to use open-ended questions when exploring issues, for open-ended questions are more likely to generate a lively discussion and collabora-

ration, whereas questions that can be answered with a yes or no tend to produce very little exchange of ideas. Examples of questions that we might ask are, “Why do you think your son gets so frustrated?” or “How might you feel if this were happening to you?” or “What kinds of things might a parent do in this situation?” Open-ended questions include those designed to elucidate factual information (cognitive questions) as well as feeling information (affect questions). Debate and alternative viewpoints are encouraged, so that the therapist and parent groups can begin to engage in problem solving. All viewpoints are respected, and, when possible, parents are encouraged to make their own connections and develop their own insights. The therapist’s empathic understanding will be conveyed by the extent to which he or she is actively reaching out to know the parents, to understand their perspectives, and to receive their communication and meaning.

Although the collaborative relationship is considered the underlying structure for the process of intervention, within this relationship, the therapist assumes a number of different roles, which include building a supportive relationship, empowering parents, teaching, interpreting, leading, and what we call prophesizing. Each of these roles is really a more specific expression of the collaborative relationship. In Figure 1, we have depicted the collaborative process as an evolving wheel—the therapist’s job is to keep the wheel turning—for only when all the parts of the wheel are used will the collaborative process be complete.

**THERAPIST ROLE 1: BUILDING A SUPPORTIVE RELATIONSHIP**

As was mentioned above, a collaborative approach requires that the therapist be empathic and use effective communication skills. This article will not review these counseling skills, as there is an extensive literature describing the therapeutic skills needed for effective relationship enhancement (for a review, see Brammer, 1988). Suffice it to say that empathy involves recognizing the feelings and perceptions (conscious and unconscious) that the parent has communicated. Empathy is conveyed unambiguously through the use of summaries of the parents’ statements as well as supportive and reflective statements.
In our therapy, we emphasize several relationship-building strategies in particular.

**Use of self-disclosure.** As discussed earlier, the collaborative therapist does not present her- or himself as an expert who has worked out all the answers to the parents’ problems, an expert who is distanced and aloof from the families’ problems. Instead, the therapist is not only empathic and caring, respectful and kind, but genuine. These core conditions (as described by Rogers, 1951) need to underpin the cognitive-behavioral methodology. One way for the therapist to be genuine is to be willing to be known—to share personal experiences, problems, and feelings of his or her own. Therapists always have a rich array of stories, either from their own families or from work with other families, from which they can draw on at will. One of the authors (Webster-Stratton) once shared with a parent group her intense anger and frustration when her 4-year-old child would not go to bed during the months following the birth of her second child. Afterward, a father who had been very quiet throughout the first sessions came up to her and said with an incredulous expression, “You mean you have problems too!” This led to an important discussion between the two of them and much more active participation on his part in subsequent sessions, which, in turn, was the start of a stronger therapeutic relationship.

This use of self-disclosure concerning one’s personal issues should, however, be planned strategically. It cannot be overemphasized that the purpose of this strategy is not for families to learn all about the therapist’s feelings and problems. Rather, the purpose of such examples is to help parents learn about themselves. By sharing some personal experiences, the therapist can help families understand that, for everyone, the process of parenting involves learning to cope and profit from mistakes; it is not a process of achieving perfection. Thus the therapist’s personal example in this case served to demystify the notion that there are perfect parents. It served to normalize the parents’ reactions and to give them permission to make mistakes. This example conveyed a message something like this: “Even the therapist, in her 15 years of studying children, does not know what to do at times. She makes mistakes and gets angry too. I guess I am not so bad after all.” A coping model, in which the therapist puts herself on the same level as the parents, is more effective than a mastery model, which simply demoralizes parents further because of the perceived discrepancy between their skills and the therapist’s. Moreover, this genuineness on the part of the therapist serves to enhance the therapist’s relationship with the group members, introducing intimacy, affection, and closeeness. Such a relationship, combined with the respect that parents feel for the therapist, fuels the collaborative learning process.

**Use humor.** Our therapists also make deliberate use of humor. The use of humor is important in terms of helping parents relax and in reducing 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 therapists use humorous personal examples to interject a comic note into the discussion. Funny cartoons of parents and children, abundant in newspapers, are also helpful; parents can take them home to put on their refrigerator and laugh about later. Another strategy is to rehearse or role-play a situation in an exaggerated fashion doing everything wrong—that is, with lots of criticisms, anger, and negative self-talk. This exaggeration inevitably invokes laughter and helps build group spirit. Furthermore, when the parents actually find themselves doing some of this behavior at a future date, they are able to stand back and laugh at themselves.

Optimism. Another form of therapist support is for the therapist to establish positive expectations for change. Parents are often skeptical about their ability to change, especially if they see a family pattern as irreversibly fixed or stable. For example, one parent said, “My mother beat me—now I beat my children.” In such cases, the therapist must express his or her confidence in the parent’s ability to change and to break the family cycle. Such parents need to be reinforced through positive feedback for each small success. They can also be reinforced for having made the first steps to changing.

Therapist: It is good that you are working with your child now while he is still young. You are helping him stop his negative behaviors before they become permanent patterns.

Advocating for parents. All of the therapist approaches discussed above—self-disclosure, humor, and optimism—serve the overall purpose of building a supportive relationship. The therapist can also actively support parents by acting as an advocate for them in situations in which communication with other professionals may have become difficult or is unclear. In the role of advocate, the therapist can arrange meetings and bring relevant persons, programs, and resources to the family, or bring the family to them. For example, the therapist can organize and attend meetings between parents and teachers to help the parents clarify the child’s problems, agree upon goals, and establish behavioral management programs that are consistent from the clinic to home 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 sometimes it is handled in a noncollaborative way, resulting in the parents’ feeling dependent and uncommitted. An example of this might be the therapist who makes recommendations to a teacher, without the parent’s being present or being involved in deciding what the recommendations are. On the other hand, our collaborative advocacy approach goes as follows: In preparing to go on a school visit with a parent, we might say to the parent, “We want you to share with the teacher the strategies which are working for you at home in order to see whether the teachers might consider setting up a similar program at school.” In some cases, we help arrange the meeting with the school and talk with the teacher on the telephone. But we always suggest that the parent as “cotherapist” attend the meeting and work out the plan on his or her own. By giving the parents responsibility for their own advocacy, sharing their own solutions, and advocating with (rather than for) parents, we again emphasize the collaborative process.

THERAPIST ROLE 2: EMPOWERING PARENTS

The essential idea behind collaboration is to empower the parents by building on their strengths and experiences, 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. There are several strategies that can help to empower parents.

Reinforcing and validating parents’ insights. Through use of open-ended questions, parents are encouraged to solve problems, drawing on their ideas and prior experiences. Parents are encouraged to explore different solutions to a problem situation, rather than searching for quick remedies or pat answers from the therapist. When therapists notice and comment upon a parent’s warmth, problem-solving skills, humor, and support whenever it occurs in a group, these qualities are reinforced; parents then feel validated. This affirming process helps parents to have confidence in their own insights, in their ability to sort
out problems and to learn from their mistakes (Brown & Harris, 1978). For instance:

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 I walked outside.

Therapist: 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 another time it happens?

In this example, the therapist’s role is to reinforce the father’s insights into the situation and to draw attention to his coping skills during the conflict situation. The therapist also helps the father to learn from the experience by rehearsing how he might respond in the future.

Because in most groups, there are varying levels of educational background and communication skills, it is important that the therapist reinforce every parent for sharing his or her ideas, so that every member gradually feels comfortable participating in the discussions. As part of this process, the therapist has to make sense for the group of any confusing statements made by parents, so that they are not ridiculed, ignored, or criticized because of something they have said. We call this “finding the kernel of truth” in what a parent has said: underscoring its value by showing how it contributes to the understanding of the topic under discussion. One approach is for the therapist to keep a flip chart on which parents’ useful ideas are recorded, such as “Sally’s mealtime principle” or “John’s rule when…” The developmental literature suggests that mothers who have confidence in their child rearing and who feel they have broad community support in what they do, actually do better at parenting (Behrens, 1954; Herbert, 1980).

Modifying powerless thoughts. When parents are seeking professional help for their problems, they are usually experiencing feelings of powerlessness and mounting frustration with their children because of a history of attempts to discipline them without success. This powerlessness is often expressed in terms of feeling victimized by their children—“Why me?” The feeling of helplessness is coupled with intense anger and fear of losing control of themselves when trying to discipline their children.

Father: My wife’s been at work and comes home and asks, “How did things go tonight?” I say, “Do the words ‘living hell’ mean anything to you?” That’s our sort of little joke. I’m labeling the kids in my mind as never doing what I say and I’m very angry at them.

Parents’ anger toward their children is likely to cause them to blame themselves and to then feel depressed about these feelings. Furthermore, they feel depressed about their interactions with their children, seeing themselves as a causal factor in their child’s problems.

One approach to empowering parents is to help them learn to stop the spiraling negative self-talk and to modify their negative thoughts. For example, a parent may 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 therapist then helps the parent learn how to stop and challenge 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.” We ask parents to keep records of their thoughts in response to extremely stressful situations with their children at home. Then the group discusses these thoughts, challenging and modifying unrealistic expectations and irrational beliefs. This strategy is in accordance with the cognitive restructuring strategies described by Beck, Rush, Shaw, and Emery (1979). The process of recognizing angry, helpless, self-critical, blaming, and catastrophizing thoughts and learning to substitute more adaptive and positive thoughts empowers parents by showing them that they can cope with their thought patterns as well as their behaviors.

Mother: I just can’t get the hang of it—I know I should be less critical and yell less and be more positive, but I just blew it when he wouldn’t get dressed this morning.
Therapist: Hey, but that's the first step in behavior change—you are now aware of what you are doing. Recognizing something after you've done it is a good place to start. Analyzing that situation and thinking about what you want to do differently will help you the next time it occurs. Then you might catch yourself in the middle or even before you start to yell.

Discussing distressing thoughts in a group is also very reassuring for parents because it helps to "normalize" thoughts that they may have 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. It also helps if the therapist can share some examples from his or her experience in which negative cognitions made him or her respond in an inappropriate manner. In addition to worrying that their own reactions are abnormal, parents often see their child's behavior as abnormal or pathological. The therapist normalizes this behavior by saying, "Indeed things don't sound happy but all children have behavior problems from time to time and all parents lose their cool with their kids—no one is perfect."

In a sense what is happening is that the therapist helps the parents reexamine their expectations for themselves and their child, with the result of reducing their sense of blame or guilt. As these perceptions are altered, the parents feel less abnormal and thus more empowered.

Promoting self-empowerment. Another element in empowering parents is self-empowerment. We try to help them learn how to give themselves a psychological pat on the back. Parents are encouraged to look at their strengths and think about how effectively they handled a difficult situation. We ask them to express their positive feelings about their relationship with their child and remember good times before this stressful period. We teach parents to verbalize actively self-statements 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."

Bandura (1977) has called this strategy strengthening the client's efficacy expectations, that is, parents' conviction that they can successfully change their behaviors. Parents, too, need tangible rewards for their efforts, such as dinner out with a spouse or a friend, a long hot bath, or a good book; and therapists can help them to learn to set up these rewards for themselves.

Building the family and group support systems. Parents of conduct-disordered children experience a sense of being stigmatized and socially isolated from other parents, those with normal children. They also fear that if they are honest with their friends about their difficulties with their children, they will be met with rejection or indifference. The therapist's role, then, is to facilitate the parent group, so that it serves as a powerful source of support and empowerment.

During group discussions, as suggestions are shared among parents, the therapist can help parents collaborate in problem solving, express their appreciation for each other, and learn to cheer one another's successes in tackling difficult problems. The other side of the coin is that the therapist can encourage parents to share their feelings of guilt, anger, and depression, as well as experiences that involve mistakes on their part or relapses on the part of their child. (However, swapping horror stories must not go on too long, or they will engender a mood of pessimism.) These discussions serve as a powerful source of support. They decrease feelings of isolation, empowering parents through the knowledge that they are not alone in their problems. 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 that aren't judging me, that are also taking risks and saying, "Have you tried this? or have you considered you are off track?"

In addition to building the support system within the group, the therapist can also build support within the family. The parents in our program report frequent arguments and fights with partners, grandparents, and teachers over how to handle a child's problems, resulting in stressed marital relationships as well as stressed individuals. Frequently, the energy required to care for the children leaves parents feeling exhausted and too tired to make plans with adult friends. As a result, these parents may feel isolated and powerless.
Time away from the child with spouses and friends can help parents feel supported and energized. It helps them gain perspective so they are better able to cope with the child's parenting needs. Sometimes parents almost seem to have forgotten their identity as individuals rather than as parents: Time away reminds parents of this important aspect of their identity. The therapist needs to advocate strongly evenings out away from the children and holiday breaks, and parents should be encouraged to take "caring days" designed to do something nice for themselves (Stuart, 1980).

We encourage every parent to have a spouse, partner, close friend, or family member (such as grandparent) in the program with him or her to provide mutual support. During therapy sessions, the therapist helps the parents (or the parent and partner) define ways they can help support each other when feeling discouraged, tired, or unable to cope with a problem. This feeling of support and understanding from another family member or friend contributes to a sense of empowerment. Our follow-up studies have indicated that the greatest likelihood of treatment relapses occurs in families in which only one person is involved in the treatment program (Herbert, 1978; Webster-Stratton, 1985). Wahler's (1980) research has indicated that single mothers who have contact with other people outside the home fare much better in parenting than mothers without such contacts, whereas maternal insularity or social isolation results in the probability of treatment failure (Dumas & Wahler, 1983).

THERAPIST ROLE 3: TEACHING

What about the therapist's role as teacher? Because a knowledgeable teacher might also be called an expert in his or her field, there may be some question about whether our approach allows the therapist to function in this capacity. Is this role compatible with a collaborative relationship, or is there a contradiction between collaborator and expert? Does the therapist have to renounce her or his expertise?

It is our contention that a therapist's expertise is not only compatible with but essential to a collaborative therapeutic relationship. Just as the parent functions as expert concerning his or her child and has the ultimate responsibility for judging what will be workable in his or her family situation and particular community, the therapist functions as expert concerning children's developmental needs, behavior management principles, and communication skills. (The specific content of parent programs will not be discussed here, as it can be found in Webster-Stratton's [1982, 1992] training manual and videotapes.)

However, what is important about such teaching is that it be conducted in a collaborative manner. A noncollaborative teaching approach is didactic and nonparticipative—the teacher lectures, the parents listen. The noncollaborative teacher presents principles and skills to parents as absolutes or as prescriptions for successful ways of dealing with their children—homework assignments are rigid, given without regard for the particular 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 that may not be congruent with their goals, values, and lifestyle and that are not adapted to the unique temperament of the child. In contrast, a collaborative teaching model implies that, insofar as possible, the therapist stimulates the parents to generate the ideas and concepts based on their experiences and to generate appropriate solutions based on their family's particular set of circumstances. When parents develop relevant and appropriate solutions, the therapist can then reinforce and expand on these ideas. Homework assignments are adapted, so that they are perceived as useful and realistic by parents. This approach increases the chance that the content of the parent program is relevant and clearly understood and used by the parents.

The net result of collaborative teaching is to strengthen the parents' knowledge base and self-confidence rather than perpetuating passivity, inadequacy, or dependence on the teacher. Similarly, we want parents to adopt a participative, collaborative, and self-empowering model when teaching their own children. In other words, we model with parents the teaching approach that we wish them to use with their children. This inductive form of teaching leads to greater internalization of learning in children (and very likely adults) (Herbert, 1980). There are several strategies a therapist can use in his or her role as teacher.
**Persuading, explaining, suggesting, and adapting.** Therapeutic change depends on persuasion, which means giving parents the rationale for each component of the program. It is important for the therapist to voice clear explanations based upon 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 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. Rationales should be given not as absolutes or commands but, rather, in the context of thoughtful discussion. When we introduce a new principle or component of the program, we try to relate it to topics previously discussed; whenever possible, connections are made between issues and principles. For example, when providing the rationale for the child-directed play interactions, the therapist explains how this approach fosters the child’s self-esteem and social competence, 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 of the possibility that parents may not immediately see the connection between playing with their children more and helping them 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. To take another example, when explaining the ignore and time-out procedures, the therapist not only explains the conceptual basis for withdrawing parental attention from the child’s negative behaviors (namely, to avoid reinforcing the child’s misbehavior with parental attention) but also makes a connection with a previously expressed concern of this parent:

**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.

**Therapist:** It is frustrating—but you know 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 therapist identifies the parent’s frustration with his son, empathizes with it, reinforces his efforts to promote empathy in his child, and then explains some child development principles concerning moral development. By doing so, the therapist is collaborating with the parent’s goal of promoting empathy in his son and helping him gain a new perspective on how to pursue this goal.

**Adapting.** In addition to persuading and explaining, the process of collaborative teaching involves the therapist working with parents to adapt concepts and skills to the particular circumstances of the parent’s setting and to the particular temperamental nature of the child. For example, 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 soundproofed, will be acutely sensitive to the possible reactions of neighbors when he or she tries to ignore the screaming child and may resist using that approach. Collaborative teaching means that the therapist understands the living circumstances of each family and involves the families in problem-solving ways to adapt the concepts to their particular situation. To take another example, a highly active, impulsive 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. Some children are not particularly responsive to tangible reward programs and so forth. These individual child temperamental differences need to be understood by the therapist so that he or she can begin the collaborative process of discovering with parents which approach will be best for a particular child.
Giving assignments. The teaching role involves giving an assignment for every session. This usually involves asking parents to do some observing and recording of behaviors or thoughts at home and trying out a particular experiment. Assignments are critical because there is an important message value that goes with them, namely, that sitting passively in the group is not magic moondust; parents must collaborate with the therapist by working at home to make changes. The assignments and experiments help transfer what is talked about in therapy sessions to real life at home. They also serve as a powerful stimulus for discussion at the subsequent session. For example, one assignment we use for parents is to keep track of their child's or their child's thoughts in response to a conflict situation with his or her child on three occasions. Parents need to understand the purpose for the assignments, of course. 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.

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, before presenting new material.

When a parent questions the usefulness or feasibility of an assignment, this should receive immediate attention, although not the kind of attention it might receive from a hierarchical teacher. Rather, the problem should be explored in a collaborative fashion. For example, a single parent with four young children says that she is unable to set aside 15 min 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 2-3 minutes throughout the day? Or, are there any times when you have only one or two children at home?

When a parent fails to complete an assignment from the previous session, this should receive immediate attention, and the reasons for this should be explored in a collaborative fashion. For example, the therapist can ask, "What makes it hard for you to do the assignment?" "How do 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?" It is important to explore reasons why some parents might be having difficulty doing their home assignments; otherwise, parents will conclude that the therapist is not really committed to their usefulness or does not really want to understand their particular situation.

Reviewing and summarizing. Another aspect of the teaching role is reviewing and summarizing for the benefit of all. The therapist can end each session with a summary of the major points of discussion from that session and a review of the handouts and assignments for the next week. Along with ensuring that everyone understands the assignment for the next week, the therapist needs to express confidence in the parents' ability to carry out the assignment. Our parents like to be given notebooks into which they can put handouts that review each session's content, as well as take notes and record their weekly assignments. We also try to provide parents with current articles that either reinforce concepts or stimulate group discussion. These, of course, will only be useful for parents with reading skills. For parents who do not read, we use cues, such as cartoons and stickers, to help remind them of essential concepts at home. For example, we use red sticker dots to remind parents to decrease their negative self-talk and green dots to increase positive self-talk. We suggest that parents put these cartoons and stickers on the refrigerator or a place where they will see them often and be reminded of the concept.
commented, “No one ever asked me if the problem was that the wax was too hard to receive the seal.”

Therapist’s interpretation. We can’t change the nature of the children’s wax, or to put it in the format of a different image, their “hard wiring,” but we can work hard to get the best imprint and channel all that energy in a productive direction.

This analogy depicts the concept that socialization takes longer with some children; conduct-disordered children do not take the imprint easily. Pointing to the wax rather than the person who uses the seal as the source of the difficulty shifts the blame away from the parents. Further, it helps them to empathize with the child’s temperamental difficulties.

Flossing analogy: Teaching children is like flossing our teeth: You have to keep doing it over and over to get long-term results.

With this analogy, we are depicting the notion that daily repetition and constant monitoring can achieve long-term results, even though it does not seem to be accomplishing much day by day.

Priming-the-pump analogy: You know the old farm pumps that had to be pumped a dozen times before water would come out? You have to “prime the pump” to build children’s self-esteem with lots of supportive input from parents. You also have to “prime your own pumps” so that you can keep on functioning as an effective parent—that is, you need to fill yourself with positive thoughts and take time to refuel your own energy.

With this analogy, we are explaining the idea that parents need to keep pumping in positive messages before they will receive positives back.

Diamond analogy: These children are like diamonds—parents need to carefully chip away the hard edges of diamonds to see their beauty. Of course, hard diamonds are very valuable.

This analogy is used to reframe the parents’ negative perceptions of their child’s temperament. Thinking of these difficult children as hard diamonds waiting to be beautiful emphasizes not only their innate value but also the parent’s socialization role.

Gas-on-the-flames analogy: Arguing and reasoning with a child when he is noncomplying and angry is like throwing gas on the flame.

This analogy is used when trying to help parents learn to ignore children’s misbehavior rather than yell and scold. It is important that they understand that such an approach actually fuels the problem rather than dampening it.

Megaphone analogy: Think about yourself using a megaphone when you praise your child—that is, do it more strongly and enthusiastically than you might otherwise be likely to do. Sometimes these children seem deaf—as if hidden in a suit of armor and a helmet—there is so much armor that it takes quite a lot of repetition to penetrate. Sometimes these children even deflect the praise because they have a hard time accepting a new—a positive—image of themselves and are more comfortable with the old image.

This analogy is used to encourage parents to use praise more frequently and more often than they otherwise would. It also helps prepare them for the occasions when children reject praise and to understand why this might be happening.

Vending machine analogy: Remember when you are first ignoring a child’s misbehavior that it will escalate before it gets better. This is like the experience that sometimes happens with vending machines. Let’s say you put in a quarter but no Coke comes out. You press the lever a few times—still no Coke. Then you start banging the machine because the machine is ignoring you. But what would happen if a Coke happened to come out as you were banging? Next time you lost a quarter and needed a drink you would start out banging.

This analogy is helpful to parents not only as a preparation for the tantrums and misbehavior that will be the child’s response to ignore and time-out procedures but also as a warning of what will happen if they give in to this misbehavior.

Radar antenna analogy: Monitoring kids means keeping your radar antenna up at all times, so that you know where your child is and what he/she is doing. That way, you can spot potential problems before they develop. Antennas are important not only so that you can assure yourself that your child is not in trouble, but also so that you can spot positive behaviors that need to be reinforced.

This analogy helps parents understand that constant monitoring on their part is required at all times. Parents sometimes have false expectations that children can be left unattended. This analogy also encourages parents’ understanding that effective parents anticipate problems
and nip them in the bud (based on an early signal on their radar) by distracting their child or by stopping the behavior early on.

Reframing. Therapeutic change depends on providing explanatory stories, alternative explanations that help parents to reshape their beliefs about the nature of their problems. Reframing by the therapist (cognitive restructuring) is a powerful interpretive tool for helping parents understand their experiences, thereby promoting change in their behaviors. It involves altering the emotional or conceptual viewpoint of the parent in relation to an experience. This is done by placing the experience in another frame that fits the facts of the situation well, thereby transforming its entire meaning. One common strategy is to take a problem that a parent has with a child and reframe it from the child’s point of view rather than from the parent’s perspective. For example:

Parent: My child has gotten incredibly worse this week—he is impossible to handle and I’ve had to use Time-Out a lot. He’s wearing me down.

Therapist: You know, I always think kids regress to test the security of the limits in their environment before they take a major new step forward in their development.

or

Parent: Now he just stands at the window screaming at other kids to come and play with him—he is so needy for friends. I don’t understand why he has to do that.

Therapist: Well, you know, these aggressive kids have frequently been rejected by other kids—so they are pretty insecure about friendships. It will take time to teach him the positive social skills so that he learns how to approach other children more appropriately. But, you know, the fact he is so interested in making friends is really a good sign—he hasn’t gotten to the point of rejecting other kids himself.

or

Mother: She yells and screams at bedtime and needs water, a cookie, a hug, and on and on.

Therapist: Yes, those bedtime rituals get to be a drag—but you know they are so important, because if they are predictable they will give the child a sense of security. And going to sleep is a time when children really need this predictability and routine, because going to sleep represents a separation from you—a loss.

In the examples above, the parents saw the children as defiant, angry, uncooperative, immature, and exhausting for the parents to cope with. The therapist reframed the incidents to help the parents see the developmental stage this behavior represented or to understand the child’s emotions in the situation. Helping parents perceive the behavior as testing the security of limits or reacting to the loss of the important parent or moving toward independence helps the parents cope better with the situation and see it as appropriate or normal, rather than becoming angry or feeling helpless. In essence, reframing involves changing a negative label for a behavior into a positive one; as we mentioned earlier, it can be an empowering process for the parent.

THERAPIST ROLE 5: LEADING AND CHALLENGING

Are there times when the therapist must take control of the group and even confront parents? If so, how does this role fit into the collaborative model? The most obvious reason for the therapist to lead the group is that otherwise it will lack focus and organization. Our evaluations have indicated that parents become frustrated if the discussion is permitted to wander or one person monopolizes the session. Parents appreciate having enough structure imposed on them to keep the discussion moving along. Another reason the therapist must exercise leadership skills is to deal with the group process issues, such as the arguments and resistance, that are an inevitable part of every group’s therapy process.

But there is an apparent tension between this role and the collaborative model, because, in collaborative therapy, power is shared and parents are recognized as experts on their situations (not novices). There are several strategies that we use to preserve the collaborative spirit while allowing the therapist to function as leader. For one thing, the therapist can allow parents a role in determining the agenda for each session. Our sessions always begin with parents and the therapist
together setting the agenda and goals for the current session, debrid- ing the assignment for the previous week, evaluating progress, and discussing how things currently are going at home. We start with questions such as “Have you had any further thoughts about what we talked about last time?” or “What difficulties did you find with the assignment?” The therapist’s job then is to connect parents’ input— their questions, concerns, reactions to the assignments, and experiences at home—into the overall framework and new topics for that particular session. The trick is keeping a good balance between the parent’s individual needs, the group’s needs, and the therapist’s need to provide new knowledge and teaching. The sessions always conclude with assigning the tasks to be completed before the next session. The following are some other strategies that we find helpful in leading the sessions.

Setting limits. The therapist must impose sufficient structure to facilitate the group process. One of the most important aspects of the therapist’s role is to prevent the group process from becoming disrupted. We have found it necessary to establish some rules to keep things running smoothly. One rule that is helpful, for example, is that only one person may talk at a time. If someone breaks the rule, we simply say, “One person at a time please.” Sometimes there is a parent in a group who is critical and verbally aggressive toward either his or her spouse or another parent in the group. In such instances, we intervene quickly to stop the bullying pattern; otherwise, the other parent will withdraw. For example, the therapist may say in a supportive but firm manner, “I need to interrupt you right there.” Then the therapist can explain why he or she is cutting off the speaker. For groups that are very verbal and that tend to digress or get sidetracked, it can be helpful at the beginning of each session to select a parent participant to act as coleader. The job of this coleader is to be a timekeeper, to help identify parents who are sidetracking the discussion, and to keep the group focused on the main topics for the session. If a different participant is invited to act as coleader for each session, the task of monitoring the group discussion becomes everyone’s responsibility, and there is collaborative leadership.

In addition to keeping the group discussions orderly, the therapist enforces the time schedule. Meetings have a tendency to start later and later unless a definite starting time is established. Meetings should begin on time even if only two people are present. Similarly, the therapist needs to end the meetings on time. This may be difficult when groups are in the middle of an enthusiastic discussion; however, this is actually a good time to end a meeting, because everyone will leave feeling stimulated and excited about their involvement in the program.

Pacing the group. Another important aspect of leading a group is to pace the group so that everyone understands the concepts and is ready to move on to the next component. Some parents assimilate the concepts easily, whereas others have more difficulty. However, the skilled therapist will take advantage of the parent in the group who seems to have a good grasp of a particular concept and will solicit help in explaining things to other members. For example, the therapist might ask one member of the group to summarize for the group the previous week’s discussions. This strategy emphasizes the collaborative process. Throughout each session, the therapist’s leadership skills will involve paraphrasing and summarizing parents’ viewpoints. This process helps uncover misunderstandings; it also helps parents review the material. Further, it demonstrates that the therapist is listening to their points of view.

Dealing with resistance. Resistance is a necessary part of the therapy process; the therapist needs to be prepared for it. In fact, Patterson’s (1982) research indicates that considerable resistance will peak midway through the treatment process. Resistance may occur in a variety of ways, such as failure to do homework, arriving late for group sessions, blaming the leader, blaming the child or life circumstances, negatively evaluating the sessions, or challenging the material presented. Resistance may occur for many reasons—sometimes it has to do with the therapy change process (as Patterson’s research suggests). For example, perhaps it is part of the parent’s efforts to maintain self-efficacy and self-control in the face of family dynamics that are changing too quickly—in effect, the parent is putting on the brakes.
Or perhaps the parent does not adequately understand the concept that the therapist has explained. Perhaps the parent is resisting because he or she feels his or her stressful life circumstances make it difficult to find the time to do the assignments. Or perhaps parents have unrealistic expectations for behavioral change and are not prepared for the long, hard work involved. Such resistance may pertain more directly to some quality of the therapist. For example, the parent may not feel understood by the therapist—she or he may perceive the therapist as patronizing or think the therapist is presenting pat answers and solutions without really understanding his or her situation. On the other hand, resistance may stem from external factors. For example, perhaps the parent has had a previous learning experience that has led him or her to believe in a different explanatory model. Or perhaps the parent feels the child should change before he or she should change. Whatever the reason, the first task for the therapist is to put aside any notion that the parent’s resistance is a sign of failure on the part of the therapist or a sign that the parent is noncompliant or unmotivated—a “difficult person.” Instead, the therapist needs to recognize that the resistance is an important marker in the therapy process—a developmental step for the parent.

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 any time.
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.

When the therapist knows that the parent is resisting a basic concept or doing something different and that it is counterproductive to the goals of the therapy program, should the therapist confront and challenge the parent regarding this or just let it go in the interest of fostering collaboration and offering support? How might therapist confrontation jeopardize the goals of collaboration? Although it is tempting for some therapists to avoid conflicts with parents, this failure to address the issue really constitutes a kind of collusion with the parents in regard to their parenting practices. Consequently, how this resistance is handled by the therapist is crucial to the therapeutic relationship.

Once the resistance is identified, it should not be directly confronted, for this is likely to increase the parent’s defensiveness (Birchler, 1988). Furthermore, it devalues the parent in front of the rest of the parent group. 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. It is our contention that, instead of directly confronting the issue raised by the resistant parent, the therapist needs to approach the resistance itself gently by asking about it in a nondefensive and nonconfrontive manner. In other words, the therapist needs to collaborate with the parent in understanding the resistance.

First mother: I just don’t have the time to play—there always seems to be so much to do.
Therapist: What seems to get in the way of doing the play assignment?
First mother: I’m just so stressed out about everything in my life.
Therapist: So am I right in understanding that doing the play assignment is pretty stressful?
First mother: Yeah, well, he’s just so abusive to me—he’s so violent. It’s hard to keep the play positive.
Therapist: Yeah, it’s pretty hard to want to praise and play with a defiant child who has made your life so miserable. That seems like a logical reason for feeling resistance to doing the assignment.
First father: For me it’s not so much that the child is stressful, but it’s me that’s so stressed out!
Second mother: I find it hard because my older daughter keeps complaining she wants the playtime too. So now I’ve got one more person making demands on me for time.
Second father: Well, in our case we’ve got twins and each child had a major tantrum when I played with the other child and then tantrummed again when I ended the play.
Therapist: You probably wonder if it’s worth it! You can see from just this play exercise how families will resist change. Well, you know to second father] one good sign in your situation is the fact the children didn’t want the play with you to end. That’s an important signal that the play was very reinforcing to them. Clearly time with you is really important to them!
Third father: Well, you know in my situation I didn’t want to do the play assignment. I felt stressed out and the kids were really on my nerves but I made myself do it. And do you know, it really helped. I was so surprised that I was actually calmer afterwards!
Therapist: That's great. Many of you will find the same thing happens to you after a while. But how did you get yourself mobilized to do the play when you really didn't want to?

Third father: I just told myself I had nothing to lose by trying it once.

Therapist: Good for you! Well for those of you who didn't do the play this week let's put our heads together and brainstorm about some ways it might be possible to try an experiment this week.

Other questions the therapist might ask to explore parents' resistance to the home assignments are, "What thoughts come to mind when you think about this assignment?" "What makes it hard to do?" "Does this seem relevant to your life?" "How could we make this more helpful?" "Can anyone in the group think of a way that might help her try the assignment?"

A common area of resistance is parents' reluctance to use 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.

Therapist: 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.

Therapist: Tell me how spanking works for you and when you would be most likely to use it.

In a collaborative relationship, the therapist starts trying to understand the resistance with the premise of respecting the parent's preference for spanking as legitimate. He or she would then explore the reasons for the 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 its advantages?" "Are there any disadvantages?" "How did it affect your relationship with your parent when you were spanked as a child?" Similar questions might be then asked about the alternative approach, 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?" Notice the questions are in the form of "What do you mean?" or "How do you feel?" or "What do you think?" rather than "Why not?" These questions serve to clarify the parents' feelings, thoughts, and experiences surrounding the resistance and to facilitate problem solving and collaboration.

In a parent group, this discussion between a therapist and a resistant parent would quickly draw everyone into the debate. We find it helpful when this occurs to organize the discussion by listing the advantages and disadvantages, the short-term and long-term consequences for the child and for the parent on a blackboard. At the end of this discussion, the therapist summarizes all the ideas that have been generated, clarifies misperceptions, and adds his or her own interpretations if they have not already been covered. This process of collaborative problem solving in the group serves to move people away from absolutist (i.e., in terms of right and wrong attitudes) and opens people up to new ideas that they may not have considered previously, thus reducing resistance. On the other hand, a noncollaborative approach in which the therapist directly confronts the parents' ideas creates a boxing match in which both the therapist and the parent have to defend their own position to protect their integrity. Once the reasons for the resistance are understood by both the parents and the therapist and problem solving has occurred, the therapist then is ready to invite the parent to consider a short experimental period.

Therapist: 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 the example above, the therapist is not hitting the resistance directly with a confrontation or repetition of the rationale for why she or he thinks time-out is right (and why the parent is wrong to use spanking).
Rather, the therapist is engaged in a process of gentle persuasion through open, honest communication. This process of exploring the reasons for the resistance, followed by the exercise of looking at the advantages and disadvantages of spanking versus time-out is a kind of values clarification and problem-solving exercise that helps clarify feelings and experiences surrounding the issue. This joining strategy is more likely to result in a gradual change in parents’ perceptions and behaviors, especially if conducted in the context of a supportive relationship.

Reframing is also a helpful strategy when responding to resistance. Once the therapist has collaborated to understand the reason for the resistance, then he or she can then reframe the treatment objectives in such a way that parents can cooperate and carry out the experiment. 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 important, the child would feel abandoned. Further exploration by the therapist uncovered the fact that this parent had been locked for hours in her bedroom by her own parents! As a result of this discussion, the therapist and parent set up a time-out mechanism based on a chair in the corner of the living room rather than the bedroom. Over future sessions, the therapist reframed the situation to help the parent understand that short time-outs with the parent in 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 initially joining with the parent and then reframing the situation so that the parent perceived the objective as promoting security (rather than as abandonment), the therapist enabled the parent to accept the strategy for herself and her child. This is the essence of collaborative therapy.

THERAPIST ROLE 6: PROPHESIZING

Children’s behavior improve slowly and regression in their misbehavior is inevitable, despite parents’ hard work. When some families encounter these setbacks, they react with disbelief, depression, and anger. They may even decide to drop out of the program at this point.

The therapist’s role as prophesizer, then, is important in terms of preparing families for future relapses not only in their children’s behaviors but also in their own behaviors. The therapist’s role as prophesizer also includes predicting resistance to change as well as forecasting positive expectations for improvement.

Anticipating problems and setbacks. One helpful strategy to prevent disillusionment for parents is for the therapist to predict setbacks in children’s behaviors, thus anticipating potential problems and regression with parents before they occur. Then the therapist can engage in a hypothetical problem-solving discussion of how parents will handle particular problems if they should occur. For example, the therapist could rehearse and prepare families for children’s negative reactions to changed circumstances, such as a child’s possible reactions after coming home from a week’s visit with his or her dad or a boy’s jealous reactions when his stepbrothers or stepsisters come home for summer vacation or a prolonged illness. Or after a particularly bad experience in the grocery store, the therapist could collaborate with parents to prepare a plan for a more successful experience. Similarly, the therapist could help parents develop a strategy for having a more successful visit with their in-laws. By mentally rehearsing how they will handle the worst possible scenario, parents’ anxiety is reduced because they feel prepared to cope effectively with a conflict situation. Moreover, if the worst fails to occur, they are pleasantly pleased with their progress.

The therapist also needs to prepare parents for the fact that there will be relapses in their own parenting skills after the program has ended. The therapist should reassure parents that relapses are normal parts of the learning process. Relapses should be construed as a signal that some strategy needs to be implemented; parents can be encouraged to see them as an opportunity to practice or review. It is a good idea to rehearse what they might do when a relapse occurs. For example, they might call a group member, contact the therapist, practice program exercises again, review strategies and videotapes, arrange for time away to refuel energy, or focus on positive alternatives. Below is an example of what the therapist might do to prepare parents for relapses by reframing their interpretations.
Therapist: Expect and be prepared for relapses. They are part of your own and your child’s learning process. The child needs to relapse and test the security of his environment every now and again to see if the rules still hold. Then once he knows his base is secure, he can tackle a new challenge. You know, it’s a bit like the old adage: “two steps forward, one step back.”

Predicting parent resistance to change. It helps to predict in advance that parents will resist some strategies and assignments and to offer some reasons for this opposition. Otherwise, if the difficulty of making behavioral change is not acknowledged by the therapist, the parent may feel that he or she is inept and incapable of change. Some parents may even become angry at the therapist for asking them to do assignments that are so hard for them to do and not part of their personality makeup. These feelings will lead to increased resistance. When parents are prepared for these reactions in advance, they are not surprised or anxious when they occur and perceive them as a necessary part of the behavioral change process.

Therapist: 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 back to the old way of doing things.

or

Therapist: 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 phoney. So don’t wait for yourself to feel warmth towards 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.

In addition, it is important also to tell parents to call in if they are having difficulties with any of the assignments.

Predicting positive change and success: It helps to build parents’ expectations for positive change in behavior if they do persist with the assignments and implement the program. It is also important for the therapist to express confidence and optimism in the parents’ ability to carry out successfully the behavior required to produce positive changes in the child’s behaviors. According to Bandura (1977), 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. Successful treatment will depend on the ability of the therapist to strengthen the parents’ expectations of personal efficacy (“I am able to do it”).

Therapist: We have found that after parents do the daily play sessions for several weeks and increase their praise statements, their children’s behavior improves substantially. We have also found that when parents give their children attention for positive behaviors, they actually have more time for themselves in the long run because their children stop behaving inappropriately to get their attention.

It is also important to predict how other family members can benefit from the program, even if they do not attend the session. For, indeed, research (Patterson, 1982) has suggested that all members of the aggressive child’s family are victims and experience the pain of the family interactions. If nonparticipating members of the family are not helped by the participating member to see some possibility of payoff for themselves, they may actively sabotage the participating member’s efforts to change. The therapist should therefore work with the participating member to see how the program can be extended in a non-intrusive way to other family members. For example, the therapist may predict that the siblings who previously have been good children may regress in an effort to gain attention and to compete for play sessions or a sticker chart like the one that has been started with the target child. This reaction should be predicted by the therapist and presented as a positive outcome for all the children, although more demanding for the parent. Predictions should also be made about the nonparticipating fathers who may initially be suspicious of the program. However, if mothers continue competently to praise and use time-out, they will soon find fathers following suit.

The role of the therapist as prophesizer is consistent with a collaborative model because the therapist brings his or her expertise and
knowledge of possible family reactions to bear on the parents' unique situations and experiences—the single parent who is coparenting, the family with several children of differing ages, the mother with a noninvolved father, or the parent with a background of alcohol and spouse abuse. The parents collaborate by bringing their feelings and anxieties to the therapist. The therapist can effectively prophesize only if he or she has collaborated with the parents to understand their situation. Moreover, by anticipating problems beyond the most immediate child problems, the concept of working together is enriched.

THE SCRIPT FOR PARENTS:
LEARNING TO COPE MORE EFFECTIVELY

The therapeutic process that we have been describing is one of the therapist collaborating with parents in multiple roles so that these parents can gradually gain knowledge, control, and competence to cope effectively with the stresses of having a conduct-disordered child. The script for the therapy evolves around collaborating with parents to help them learn more effective coping strategies and parenting skills, so that ultimately child behavior problems are reduced and social competence is strengthened. Several themes emerge throughout the therapy process as part of this coping model.

Theme 1: Promoting parent's problem solving. By now, it should be clear that problem solving and collaboration between the therapist and parent go hand in hand throughout the sessions. Often we find that parents have initially come to us with beliefs that there is a single cause for the child’s misbehaviors and, consequently, a single solution for the problem. By the end of the program, the goal is for parents to realize that there is no single magical solution or recipe for parenting. Rather, parents have become confident in their own ability to think sequentially and analyze parent-child interactions, to search for external causes of misbehavior (as opposed to blaming badness within the child) and to generate a rich smorgasbord of possible solutions. They then have the problem-solving strategies necessary to sort out which solutions they will try and to evaluate whether or not these solutions are working. In essence, by the end of the therapy, the parents have become their own therapists.

Theme 2: Parents coming to terms. The therapist gradually helps parents come to terms with the realistic facts concerning the temperamental nature of their child. This involves helping parents manage their anger and grief related to their hoped-for ideal child and learning to accept their child's difficulties and extra needs for committed parenting. Because many of these children's problems are to some degree chronic, characterized by unpredictable relapses, constant vulnerability to changes in routine, and the emergence of new problems whenever the child faces new settings or schedules, this means helping parents face the fact that they must invest a great deal of time and energy in the hard work of anticipating, monitoring, and solving problems for many years to come.

The therapist can prepare parents for this partly by helping them focus on long-term rather than short-term goals. For example, one common mistake is for parents to go for short-term payoffs (i.e., giving into a child's tantrum to stop unpleasant behaviors) at the expense of long-term consequences (child learns to have tantrums to get what he or she wants). Parents need to be reminded of their long-term goals. For example, the therapist may point out that, in the short term, spanking or yelling may serve to stop the child's misbehavior, but in the long term may teach a child to hit or yell when frustrated, thereby fostering more aggression. Our therapists emphasize that the strategies taught in our program, such play, praise, and patient problem solving, need to be repeated hundreds of times for them to be effective.

Therapist: Your child needs to have hundreds of chances to try to learn from his mistakes. His learning more appropriate social skills is just like when he was a baby and was learning how to walk. Do you remember how often he tried to get up and fell down? How long he went holding on to something before he could take off on his own? Well, this is just the same. It takes lots of small steps and experiments for a child to learn appropriate social skills. And just as you must constantly support the baby who is stumbling (so that he does not injure himself), so must you the child who is developing his social skills.

Moreover, the therapist may even depict the environment provided by parents for these children as a sort of prosthetic environment of parent reinforcement, attention, discipline, and monitoring for a chronic problem. And, as with the diabetic child, if parents withdraw treat-
ment, the child is likely to relapse. Words such as "repeated learning trials" and "opportunities to make mistakes" and "developmental struggles" help prepare parents for this long-term coping process. As one of our parents so aptly put it, "You mean there is no magic moon dust?"

**Theme 3: Parents gaining empathy for the child.** In addition to helping parents come to terms with the hard work of parenting, it is also important to help them gain understanding, empathy, and acceptance of their child’s unique personality as well as sensitivity to the child’s particular developmental struggles. It is especially hard for parents of difficult and demanding children to remain patient, to be constantly on guard for monitoring, and set limits consistently. Parents can do this more easily and can be more supportive if the therapist has helped them to understand that some of the child’s oppositional behaviors are really needs for independence or needs to test the security of his or her environment. Parents can also learn to reduce some of their unnecessary commands and criticisms if they have been helped to understand that children need the opportunity to learn from their own mistakes. Empathy for the child will foster a warm relationship, involving increased tolerance of mistakes and more appropriate discipline.

**Theme 4: Parents are not perfect.** Coping effectively implies that parents must come to accept and understand not only their child’s strengths and difficulties but also their own imperfections as parents. The therapist helps parents learn to stop belittling and berating themselves for their angry or frustrated reactions and depressive or anxious thoughts. They come to understand that these reactions to their child are normal.

**Theme 5: Refueling the parent to ensure maintenance.** Along with parents becoming more confident and knowledgeable in their parenting skills and ability to cope with the child’s problems, parents need to recognize the importance of refueling themselves as individuals and couples. The therapist can assist this by asking parents such questions as “How are you going to keep going when the program is finished?” and “How do you keep yourself reinforced for the work of parenting?”

The therapist can encourage the parent support groups to continue meeting after the formal program has ended and urge parents to babysit for each other, so they can get time away from the children. Monthly “booster shots” for the groups with the therapists can also be scheduled routinely, so that there is a structure of ongoing support.

**EPILOGUE: SUPPORT FOR THE THERAPIST**

The therapist’s conscious use of a variety of roles such as collaborator, empowerer, supporter, teacher, interpreter, leader, and prophe- sizer helps to change parents’ behaviors and attitudes, to alter attributions about past and present behaviors, and, most important, to increase their perceived self-efficacy and persistence of effective coping skills. In a sense, the therapist’s role with parents is a model for the kind of relationship that we are encouraging parents to develop with their children. Moreover, just as parents get tired of the hard work of parenting, the therapist may tire of the hard work of filling these roles. The implementation of these roles with a group of parents, especially in the face of parent confrontations and resistance, can at times be a formidable task and requires a considerable degree of clinical skill. It is important that the therapist also have a support system in which he or she can analyze a difficult situation or group problem with other colleagues and rehearse the most effective use of a role. By discussing the situation with another therapist, it is possible to brainstorm and decide how to reframe it, interpret it, or explain it in a different way, so it makes sense to the parent. The added support and objectivity of another person can help immensely for the therapist to renew enthusiasm and keep trying in the face of highly resistant families. In sum, it is important for the therapist also to view him- or herself in a coping model—capable of making mistakes with parents, learning from the mistakes, being realistic about treatment goals, not expecting magical solutions, and feeling refueled from each family’s gradual successes. One important advantage of the collaborative group therapy model, from the therapist’s point of view, is that this process itself creates a feeling of support for the therapist because of the joint ownership of solutions and outcome. Besides reducing the dependency of families
on the therapist, collaboration is reinforcing for the therapist, in that it is gratifying to see parents coping independently. Finally, the collaborative process constantly provides new learning for the therapist.

**SUMMARY**

In summary, parent-training programs have offered great promise for helping families manage their conduct-disordered children. Although the specific behavioral techniques and content of these programs have been described extensively, the therapy process skills have been less well explicated in the parent-training literature. In this article, we have described the processes involved in our parent-training programs, which are based on a collaborative model. Undoubtedly, other therapists may be using similar processes—whether they are working with individual families or groups. We believe that it is important to detail these processes to ensure that novice therapists do not think that learning behavioral techniques is all there is to a successful parent-training program. Moreover, more sharing of the precise processes used in different parent-training programs could highlight differences or similarities among programs and reveal new avenues for research regarding family change processes. For indeed, many of the process variables that we advocate here represent our own viewpoints rather than strategies that can be conclusively supported with research.

**APPENDIX**

**CHECKLIST FOR EVALUATING THE COLLABORATIVE PROCESS**

**Leader Collaborative Skills**
- Builds rapport with each member of the group
- Encourages everyone to participate
- Models open-ended questions to facilitate discussion
- Reinforces parents’ ideas and fosters parents’ self-learning
- Encourages parents to solve problems when possible
- Fosters idea that parents will learn from one another’s experiences
- Helps parents learn how to support and reinforce one another
- Views every member of group as equally important and valued
- Identifies each family’s strengths
- Creates a feeling of safety among group members
- Creates an atmosphere in which parents feel they are decision makers and discussion and debate are paramount

**Leader Leadership Skills**
- Establishes ground rules for group
- Starts and ends meetings on time
- Explains agenda for each session
- Emphasizes the importance of homework
- Reviews homework from previous session
- Summarizes and restates important points
- Focuses group on key points presented
- Imposes sufficient structure to facilitate group process
- Prevents sidetracking by participants
- Knows when to be flexible and allow a digression for an important issue and knows how to tie it into session’s content
- Anticipates potential difficulties
- Predicts behaviors and feelings
- Encourages generalization of concepts to different settings and situations
- Encourages parents to work for long-term goals as opposed to “quick fix”
- Helps group focus on positive
- Balances group discussion on affective and cognitive domain
- Predicts relapses
- Reviews handouts and homework for next week
- Evaluates each session

(continued)


Carolyn Webster-Stratton, Ph.D., is a Professor of Nursing and Director of the Parenting Clinic in the Department of Parent and Child Nursing, University of Washington, Seattle. Her research interests focus on developing and evaluating different types of treatment programs for parents and for children with conduct disorders.

Martin Herbert, Ph.D., is a Professor of Clinical Psychology and Director of the Plymouth Health Authority, Eastern Sector, Child and Family Consultation Centre, Erme House Mount Gould Hospital, Plymouth. His research and clinical interests focus on helping families with problematic children or with children who are developmentally at risk.