4 WORKING WITH PARENTS WHO HAVE CHILDREN WITH CONDUCT DISORDERS: A COLLABORATIVE PROCESS*

THERE IS a rather large body of literature describing the content of parent training programs. For example, strategies such as Time Out, Beta Commands, Praise, Differential Attention, Response Cost, and so on, along with the behavioral principles that underlie them, have been carefully described in detail. But descriptions of the content of parent training do not elucidate the mechanisms or ongoing processes of parent training—that is, the processes and strategies which therapists can use to try to change or modify parents' behaviors, attitudes, and practices—and the literature contains comparatively little discussion of the actual therapeutic processes utilized by therapists in such intervention programs.

Considering the documented effectiveness of various types of parent-training programs, this is puzzling, for there are many questions to be answered concerning the therapist's role in parent training. How can therapists handle parents' resistance to new concepts? How can they ensure that homework is carried out? What are the preferred teaching methods and strategies? How do they ensure that the training is culturally sensitive? When should confrontation be used? How can therapists promote self-confidence and self-efficacy in parents?

Patterson (1985) has argued that we need to move "beyond the technology" in developing an empirical base for parent training. In that vein, Patterson and Forgatch (1985) reported on one of the most comprehensive microsocial analyses of therapist-client interchanges in the parent-training literature. They showed that directive therapist behaviors such as "teach" and "confront" increased the likelihood of parental resistance and lack of cooperation, while nondirective therapist behaviors such as "facilitate" and "support" led to reliable decreases in client noncompliance. Patterson and Chamberlain (1988) have proposed a therapy model which postulates that therapist behaviors play a secondary role to extrafamilial, interpersonal, and child factors in predicting parent response during the early stages of treatment, but play a primary role in predicting client noncompliance in the later stages of therapy. In another

* This chapter is derived by permission, from Webster-Stratton & Herbert (1993).

study, Alexander et al. (1976) examined the role of therapist characteristics in predicting outcome (as defined by completion of treatment and recidivism rate) for families that participated in functional family therapy (FFT). They found that "relationship" characteristics (affect, warmth, humor) accounted for 45% of the variance in outcome, whereas "structuring" characteristics (directiveness and self-confidence) accounted for only 15%.

These studies are important; however, they do not place the therapist's characteristics and behaviors within the larger context of the ongoing therapeutic process. The purpose of this chapter, therefore, is to provide a qualitative description of the process of working with parents who have conduct-disordered children as practiced at the University of Washington Parenting Clinic.

THERAPY MODELS

There are many competing therapeutic models, each with different sets of assumptions about the therapist's role with clients, the cause of family problems, and the level of responsibility the client or therapist assumes for resolving problems. For purposes of discussion, let us pose four hypothetical therapeutic models, each an extreme—Models A, B, C. and D. In Model A, the therapist does not hold parents responsible for their problems; the responsibility lies with past experiences or the demands of society. Neither does the therapist hold parents responsible for arriving at their own solutions to the problems which brought them into therapy or which emerge during therapy. In such a model, the therapist, who is the expert in the relationship, has the responsibility for gradually uncovering the problems hidden in the client's subconscious, in past experiences, and/or in the family dynamics, and interpreting them to the individual client—or to the entire family. In such a model the client is seen as a relatively passive recipient of the therapist's analysis, interpretations, advice, and prescriptions. The advantage of Model A therapy is that it allows parents to seek and accept help for their own or their child's problems without feeling that they are to blame for them. However, this model brings with it the disadvantages of dependency on the therapist, usually over a long period of time, and in some cases isolates parents from the child's therapy process. For example, the child may be in play therapy with a therapist to work through some prior traumatic experience, while the parent is left out of the process and unaware of how s/he can help the child.

Model B therapies appear both to blame parents for their problems and to imply they are unable to control certain aspects of their lives. For

example, how often are cases of child abuse explained in terms of the parent's attachment to the child—either absence of attachment or distorted attachment? Emotional and physical abuse have been linked causally with a failure on the part of the mother to become "bonded" to her child (Lynch & Roberts, 1977; Valman, 1980). Such assumptions may well lead to a therapeutic process that creates or reinforces a negative self-image in clients and a mistrust of self.

In hypothetical Model C, the therapist is not primarily concerned with the client's past, but rather focuses on the problem at hand. The therapist's job, according to this model, is to teach specific skills so that clients can assume the responsibility for solving their own or their family's problems. This theoretical assumption leads to relatively time-limited programs. Many parent-training programs fall within this model because in them parents learn to alter their maladaptive thoughts or learn new behavior management strategies to use with their children. After treatment, families are expected to be self-sufficient. Working from an assumption that behavior is intrinsically rather than extrinsically determined, such therapies allow parents to direct their energies toward solving their own problems and learning new skills. These newly acquired skills lead to an increase in parents' perceived self-efficacy (Bandura, 1977). Parents are given credit for their improvements; as a result, they come to feel more competent. Yet this therapeutic model has several possible disadvantages. First, it may suggest there are "quick fixes" for children's problems. Second, Model C may create feelings of failure or self-blame because of the raised expectations brought about by high levels of initial success—and the dashed expectations brought about by subsequent reversals of gains. Third, this type of therapy may be delivered in a directive or prescriptive fashion, which, like Model A, will foster parents' dependency and lack of self-reliance, and may also leave parents feeling blamed for their childrens' problems.

In contrast to Models A, B, and C, each of which assumes a deficit motivation, therapies based on hypothetical Model D assume the client has it within him/herself to find solutions and change. For example, Rogerian theory, which epitomizes the humanistic approach, is client-centered, nondirective, nonintrusive, and supportive (Rogers, 1951). The Rogerian therapist's "unconditional positive regard" for clients helps them to help themselves by searching for their own answers, moving towards self-actualization and maturity. The advantage of this therapeutic approach is that it promotes the client's positive self-esteem and self-direction; on the other hand, this type of therapy can be a lengthy process and may not be appropriate for clients who do not have solid communication and problem-solving skills.

At the Parenting Clinic, our theoretical approach for working with parents of conduct-disordered children falls within Model C, while

integrating some of the core elements of Model D. We have chosen not to call our approach "parent training" because this term implies (as in Model C) a hierarchical relationship between the therapist and parent wherein the expert therapist is fixing some "deficit" within the parent. A term such as "parent coaching" is preferable. Terminology aside, the underlying helping process we advocate for working with parents of conduct-disordered children is a collaborative model. Webster's New Collegiate Dictionary defines collaboration as simply "to labor together." Collaboration implies a reciprocal relationship based on utilizing equally the therapist's knowledge and the parents' unique strengths and perspectives. Collaboration implies respect for each person's contribution, a non-blaming relationship built on trust and open communication. Collaboration implies that parents actively participate in the setting of goals and the therapy agenda. Collaboration implies that parents provide ongoing evaluation of each therapy session so that the therapist can refine and adapt the intervention to make it responsive to the family's needs.

In a collaborative relationship, the therapist works with parents by actively soliciting their ideas and feelings, understanding their cultural context, and involving them in the therapeutic process by inviting them to share their experiences, discuss their ideas, and engage in problem-solving. The therapist does not set him/herself up as the "expert" dispensing advice or lectures to parents about how they should parent more effectively; rather, s/he invites parents to help write the "script" for the intervention program. The therapist's role as collaborator, then, 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 which is culturally sensitive, and finally, to teach and suggest possible alternative approaches or choices when parents request assistance and when misunderstandings occur.

This partnership between clients and 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' confidence and perceived self-efficacy in treatment than are models which do not hold them 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. Therefore, parents who are self-efficacious will tend to persist at tasks until success is achieved. The literature also indicates that people who have

determined their own priorities and goals are more likely to persist in the face of difficulties and less likely to show debilitating effects of stress (e.g., Dweck, 1975; Seligman, 1975). Moreover, research (Backeland & Lundwall, 1975; Janis & Mann, 1977; Meichenbaum & Turk, 1987) suggests that this collaborative process has the multiple advantages 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 incorporating their input, may result in a low level of commitment, dependency, resentment, low self-efficacy, and increased 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 asserting their independence and their control over the process.

SETTING THE STAGE FOR COLLABORATION

The Setting

There are four main settings in which behavioral work with families of behavior-problem children takes place: the child's home, the school, the clinic, and the community center. Behavior therapy, based on the one-to-one (dyadic) or behavioral family therapy (systemic) model, tends to take place in the clinic consulting room/suite or home setting. Behavioral training based on the triadic or behavioral consultation model (using significant caregivers or teachers as mediators of change) may be located in the school. When behavioral training involves group work, the clinic or a community-based center is usually the preferred setting.

It is debatable whether there are clearly differentiated criteria for choosing the home as opposed to the clinic as the setting for training/treatment of conduct-disordered children and their families, or the related issue of choosing a group, as opposed to an individual (family) modality, for the detailed work. The issue of group work being more economical and, indeed, as or more effective than individual casework, has been thoroughly investigated. Webster-Stratton has demonstrated clear advantages for the kind of group-based work that utilizes video modeling and the collaborative process of discussion and debate (Webster-Stratton, Kolpacoff & Hollinsworth, 1989; Webster-Stratton, 1990a,b). Are there

occasions, however, when there is a case for choosing an individual family approach to treatment? Are there particular clients who require something other than, or in addition to, the clearly effective group-based method?

There is a category of parents who may respond more favorably to, and welcome, interventions in their own homes (Herbert, 1978). They and/or their children find clinic and group settings somewhat daunting—for a variety of reasons. For example:

- They tend not to be very articulate and to suffer from very low self-esteem; they find the social/verbal ethos of the group difficult to cope with.

- They do not share consensus values about life and child rearing, and sense themselves as "outsiders."

- Family life is disorganized, if not chaotic. To come out to regular appointments (the organization required, and the mobility demanded) may be beyond them.

- They are particularly *private* about their personal/familial disadvantages, tragedies, and "failings" and cannot envisage public discussion of personal issues, whatever the preliminary briefing and reassurance given.

- Child/spouse abuse in the family makes them wary of a public commitment to therapy.

- They (and this often means the child) feel safer/more comfortable working from home.

- They believe the therapist cannot really understand *their* reality unless s/he sees what actually happens in the home.

- They withhold trust, and belief, in the therapist unless they see him/her "getting stuck in" where the actions (the problematic interactions) are taking place—i.e., the "front line."

- There is a potentially subversive partner (this usually is the father) who refuses to attend a clinic; the only way to access him may be to work with *all* the family in his home.

- Both parents are poorly motivated for therapy. The only way to "engage" them in a change process is a relatively long process of

"joining" the family over many home visits (or by means of intensive *day* programs).

These observations are based upon statements gathered from parents at intake evaluation sessions. None of these factors necessarily excludes a group approach, but when several converge on one family, they may make it difficult to engage the person in a commitment to clinic-based group meetings to which they have to make a regular self-directed journey. It has to be added that group and individual interventions are not necessarily an either/or choice. They may take place in parallel or sequentially if *both* modalities are thought to be required.

If the therapy is to take place in the clinic or a room in a community setting (e.g., church or school) it is important to try to find a setting for services that is informal and accessible. Our offices at the Parenting Clinic include a large comfortable group room with a 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 mid-group break, but very soon we find other parents offering to bring in food for the group such as pizza, cakes, and so forth. This informality helps to decrease the distance not only from the therapist but also from the other parents and promotes a comfortable environment.

The Intake Interview

A collaborative approach begins at the very first encounter with the parents—-the initial intake interview. During this interview, the therapist tries to enter into the parents' experience and feelings; a typical question is, "Tell me what life is like at home with your child." Parents are asked to explain the disciplinary approaches and coping strategies they have tried—those that have worked and those that have not—as well as their theories regarding possible causes of the child's problems. Through questioning, the therapist elicits the parents' explanatory model and attributions for the child's problems. Parents are asked to list the problems they are concerned about and to prioritize them from their own perspective. Ideally, they come to feel that the therapist is making a genuine effort to understand their internal reality.

Next the therapist tries to elicit the parents' hopes and goals for therapy. S/he asks questions such as, "What is your greatest hope for what will happen as a result of coming to therapy?" Hearing the parents define their goals at the outset enables the therapist to correct any unrealistic expectations on their part. A secondary effect of goal definition is that, at a time

when parents may be feeling depressed and vulnerable, it helps them focus on a more positive future. During the intake, the therapist listens carefully to the text and to the subtext of what the parents are saying; s/he listens with a "third ear" to discover not only what the child's problem are, but what those problems have meant to 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, during the first interview the therapist has already begun to demonstrate empathic understanding and to involve parents immediately in therapy as a collaborative enterprise.

After discussing the parents' perceptions of their child's problems, their experiences attempting to deal with those 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. For example:

THERAPIST: Our job now 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 (whose children are similar to yours) 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?

This collaboration is also discussed in our clinic brochure.

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 alter the child's temperament with medication. Or, because we place such a strong emphasis on parental involvement, they may incorrectly assume that we blame parents for the problems they are experiencing with their child. While self-blame and guilt are recurring themes throughout the process of therapy, it is important for parents to hear from the outset that we take a nonblaming, nonjudgmental stance towards the causes of the child's behavior problems and to see this attitude reflected consistently in our interactions with them. We want them to realize that we are interested in supporting parents and helping work to improve their situation rather

than determining who is at fault, and that our orientation is toward the malleable present and future, not the unalterable past. The therapist might say:

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 either that the child is at fault (a "bad egg") or that 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 concerning its elements.

Initial Group Meeting

The initial group meeting is critical in terms of establishing not only the structure and ground rules for all future meetings but also in setting a tone for therapy. 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 the therapist's strategies for handling digressions or disagreements. The therapist again presents 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 that they are not alone in their problems. It becomes evident that the therapist and parents are all working collaboratively towards 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 a relationship based not on authority but on rapport with every member of the group, the therapist attempts to create a climate of trust, making the group a safe place for everyone to reveal their problems and frustrations. The therapist

needs to be empathic and listen carefully to indicate that s/he 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 lively discussion and collaboration, whereas questions that can be answered with a "yes" or "no" tend to produce very little exchange of ideas. Open-ended questions include questions designed to elucidate factual information (cognitive questions) as well as feeling information (affect questions) and ideas. For example, useful open-ended questions might include: "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?" Debate and alternative viewpoints are encouraged so that the therapist and parent groups can begin to engage in problem-solving. All viewpoints are respected; when possible, parents are encouraged to draw their own connections and develop their own insights. The therapist's empathic understanding will be conveyed by the extent to which s/he actively reaches out to the parents, attempts to understand (rather than analyze) their perspectives, and elicits their ideas.

While the collaborative relationship is the underlying structure for our process of intervention, within this relationship the therapist assumes a

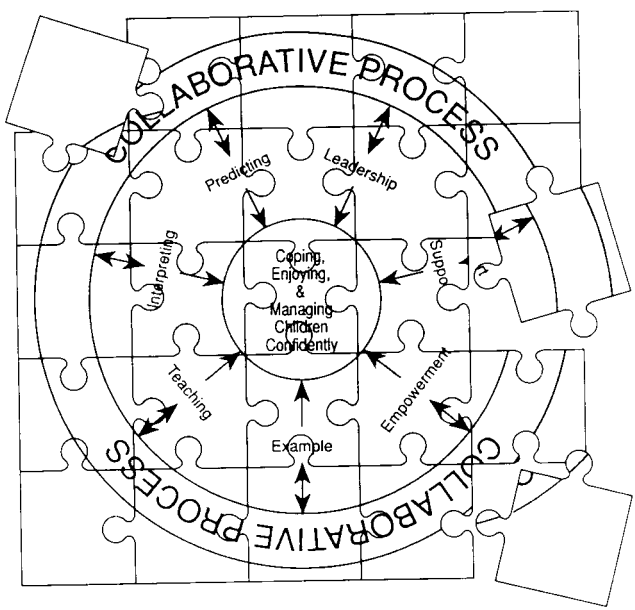


Figure 4.1 The collaborative process of working with parents

number of different roles. These include: building a supportive relationship; empowering parents; teaching; interpreting; leading; and what we call "prophesizing." Each of these roles is one specific expression of the collaborative relationship. In Figure 4.1 we have depicted the collaborative process as a jigsaw. The therapist's job is to sort out where and when to use each of the pieces of the puzzle; only when all the pieces are integrated will the collaborative process be complete.

THERAPIST ROLE No. 1: BUILDING A SUPPORTIVE RELATIONSHIP

As mentioned above, a collaborative approach requires that the therapist be empathic and use effective communication skills. This paper will not review these counseling skills, as there is an extensive literature describing the therapeutic skills needed for effective relationship enhancement (for reviews see Truax & Carkhuff, 1967; 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/himself as an "expert" who has worked out all the answers to the parents' problems, an expert who stands apart from the families' problems. Instead, the therapist is not only empathic and caring, respectful and kind, but "genuine." These core conditions (as described by Carl Rogers, 1951) are necessary underpinnings for the cognitive-behavioral methodology. One way to be "genuine" is for the therapist to be willing to be known—to share personal experiences, feelings, and problems of his/her own. Therapists always have a rich array of stories, either from their own families or from work with other families, which they can draw upon at will. The author (Webster-Stratton) once shared with a parent group her intense anger and frustration when her four-year-old child would not go to bed during the months following the birth of her second child. Afterwards, 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 laid the basis for 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 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 the process of parenting for everyone 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 was intended to demystify the therapist and to discredit the notion that there are perfect parents. It served to normalize the parents' reactions and to give them permission to make mistakes. The intended message was something like this: "Even the therapist, in her 15 years of studying children, doesn't know what to do at times. She makes mistakes and gets angry too. I guess I'm not such a bad parent 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 would simply demoralize parents further because of the perceived discrepancy between their skills and those of the therapist. Moreover, this genuineness on the part of the therapist serves to enhance the therapist's relationship with the group members, introducing intimacy, affection, and closeness. Such a relationship, combined with the respect parents feel for the therapist, fuels the collaborative process.

Use of Humor

Our therapists make deliberate use of humor to help parents relax and to reduce 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 to the discussion. Humerous cartoons of parents and children, which are found in abundance in newspapers and magazines, 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 doing everything wrong—i.e., with lots of criticisms, anger, and negative self-talk. This exaggeration inevitably evokes lots of laughter and helps build group spirit. Furthermore, when the parents find themselves engaging in some of

this behavior at a future date, they may be able to stand back and laugh at themselves.

Optimism

Another form of support is for the therapist to establish positive expectations for change. Parents are often skeptical about their ability to change, especially if they see in their behavior a family pattern, for patterns often seem fixed and irreversible. For example, one parent said, "My mother beat me, now I beat my children." In such a case, the therapist must express his/her confidence in the parent's ability to break the family cycle. The therapist can point out each small step toward change—even the step of coming to therapy in the first place—as evidence that the problem is not fixed or irreversible. These parents need to be reinforced through positive feedback for each success, however small, and for each change in their behavior, whether or not it results in improvement in their child's behavior. It can be helpful to cite examples of other parents in similar situations who have been successful in teaching their children to behave more appropriately.

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

Each of the therapist approaches discussed above—self-disclosure, humor, and optimism—serves the overall purpose of building a supportive relationship. The therapist can also actively support parents by acting as an advocate for them in situations where communication with other professionals may have become difficult. In the role of advocate, the therapist can bring relevant persons, programs, and resources to the family, or bring the family to them. For example, the therapist can organize and attend meetings between parents and teachers so as to help the parents clarify the child's problems, agree upon goals, and set up behavior management programs which 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, if it is handled in a non-collaborative way, it can result in the parents feeling dependent or even

uncommitted. An example of this might be the therapist who makes recommendations to a teacher, without the parent being present or being involved in formulating the recommendations. 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 take the initiative in working out the plan. By giving 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 No. 2: EMPOWERING PARENTS

The essential goal of our collaborative therapy is to "empower" parents by building on their strengths and experience so that they feel confident about their parenting skills and about their ability to respond to new situations that may arise when the therapist is not there to help them. Bandura (1977) has called this strategy strengthening the client's "efficacy expectations"—that is, parents' conviction that they can successfully change their behaviors. There are several strategies that can help to empower parents.

Reinforcing and Validating Parents' Insights

Through the use of open-ended questions, parents are asked to problem-solve, drawing upon their ideas and prior experiences. Parents are encouraged to explore different solutions to a problem situation, rather than settling for "quick fixes" or the first solution that comes to mind. The therapists studiously avoid giving any pat answers, keeping the focus of the discussion on the parents' insights.

When therapists notice and comment upon a parent's problem-solving skills, parents 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 out of the room.

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 if it happens again?

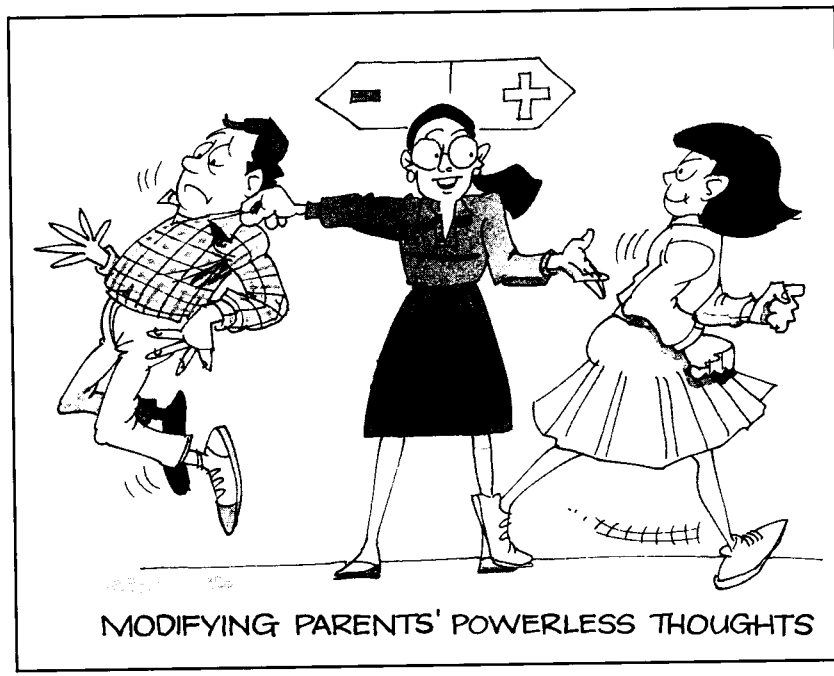
In this example, the therapist's role is to reinforce the father's insight and to draw attention to his coping skills during the conflict situation. The therapist also helps the father to learn from the experience by rehearsing how he might respond in the future.

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/her ideas so that every member gradually feels comfortable participating in the discussions. As part of this process, the therapist has to clarify for the group any unfocused or 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 for what they do, actually do better at parenting (Behrens, 1954; Herbert, 1980).

Modifying Powerless Thoughts

When parents seek professional help for their problems, they usually have experienced or are experiencing feelings of powerlessness and mounting frustration with their children due to a history of unsuccessful attempts to discipline them. This powerlessness is often expressed in terms of feeling victimized by their children—"Why me?" The feeling of helplessness typically is accompanied by intense anger and a fear of losing control of themselves when trying to discipline their children.

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.

Because none of us feel good about ourselves when we become angry at our children, parents' anger towards their children is likely to cause them to blame themselves and to then feel depressed in reaction to their guilt. Furthermore, they feel depressed about their interactions with their children, seeing themselves as a causal factor in their child's problems.

Therefore, a powerful and necessary aspect of empowering parents is to help them learn to stop the spiraling negative self-talk and, more generally, 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 this kind of powerless, self-defeating train of thought and to challenge it by substituting 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. I can manage." We ask parents to keep records of their thoughts in response to extremely stressful situations with their children at home. We then invite them to share some of this record with

the group. As the group discusses these thoughts, unrealistic expectations and irrational beliefs are challenged and become modified through discussion. This strategy is in accordance with the cognitive restructuring strategies described by Beck and his colleagues (1979). The process of recognizing angry, helpless, self-critical, blaming, catastrophizing thoughts, and learning to substitute more adaptive and positive thoughts empowers parents by showing them 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.

It is often necessary to counter the myths and attributions that get in the way of therapeutic change. Below are some typical examples of some myths and unhelpful attributions.

Sole ownership

- It's my child's problem; s/he's the one who has to change.
- It's me who's to blame.

If it doesn't hurt it doesn't work

- A good belting is all he needs.
- Kindness doesn't work with her/him! All s/he understands is a good hiding.

Narrow limit-setting

- Give her/him an inch and s/he takes a mile.

Broad limits

- S/he won't love me if I insist.
- I feel so guilty if I say no.

Gender issues

- Only fathers can set firm limits.
- It's a mother's job—the discipline side of things.

Scapegoating

- It's the father's bad blood coming out in her/him.

Attributions

- There's a demon in her/him.
- I don't trust her/him; s/he has her/his father in her/him.

Catastrophizing

- I'm a complete failure as a parent.
- I can't forgive myself for the mistakes I've made.

Intergenerational ideas

- The hidings I had from my father did me no harm, so they won't do her/him any harm.

Unrealistic assumptions

- Other parents all seem to cope.

- Children should change overnight.
- Why should s/he be praised for doing what s/he should be doing anyway?

Discussing distressing thoughts in a parent group is also very reassuring for parents because it helps to "normalize" thoughts which they may previously have considered abnormal or crazy. As parents discover that other parents have the same kinds of "crazy" thoughts and reactions, they stop blaming themselves. It also helps if the therapist can share some examples from his or her experience in which negative cognitions led him/her to respond inappropriately. 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 it' with their kids—no one is perfect." Thus the therapist helps the parents reexamine their expectations for themselves and their child, with the result of reducing their self-blame and anger. As these perceptions are altered, the parent feels less abnormal and 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 to remember good times before this stressful period. We teach parents actively to formulate positive statements about themselves such as, "I had a good day today with Billy, I handled that situation well," or "I was able to stay in control, that was good." 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 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 misunderstanding, indifference, or outright rejection. The therapist's role, then, is to facilitate the parent group so that it serves as a powerful source of support, an empowering environment.

During group discussions, the therapist can help parents collaborate in problem-solving, express their appreciation for each other, and learn to cheer each other'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 their 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 the 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, too tired to make plans to spend time with adult friends, let alone interact with them. Yet, 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 strongly to advocate evenings out and other breaks away from the children, and parents should be encouraged to take "caring days" on which they 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 them to provide mutual support. 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 had contact with other people outside the home fare much better in their parenting than mothers without such contacts, while maternal insularity or social isolation results in the probability of treatment failure (Dumas & Wahler, 1983). During therapy sessions, the therapist helps the parents (or the parent and partner) define ways they can 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.

THERAPIST ROLE No. 3: TEACHING

What about the therapist's role as teacher? Since a knowledgeable teacher might also be called an "expert" in his/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 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 parents function as experts concerning their child and have the ultimate responsibility for judging what will be workable in their particular family and 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 training manual and videotapes, and is alluded to in Chapter 7.)

However, teaching can be collaborative or noncollaborative. A noncollaborative teaching approach is didactic and nonparticipative—the teacher lectures, the parents listen. The noncollaborative teacher presents principles and skills to parents in terms of absolutes and "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 which may not be congruent with their goals, values, and lifestyle and which are not adapted to the unique temperament of the child. In contrast, a collaborative teaching model implies that, as far as possible, the therapist stimulates the parents to generate ideas and insights based on

their experiences, and to generate appropriate solutions based on their family's particular set of circumstances. When parents come up with appropriate solutions, the therapist can then reinforce and expand on these ideas. Homework assignments are adapted so that they are perceived as useful by parents. This approach increases the chance that the content of the parent program is relevant, clearly understood, and utilized by the parents.

The net result of collaborative teaching is to strengthen the parents' knowledge base and their self-confidence, instead of perpetuating a sense of inadequacy and creating dependence on the teacher. Since we want parents to adopt a participative, collaborative, empowering approach when teaching their own children, it is important to use this approach with them in therapy—to model with them the teaching approach 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/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. The treatment principles, objectives, and methods should not be shrouded in mystery. 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. Research has indicated that parents' understanding of the social learning principles underlying the parent-training program leads to enhanced generalization or maintenance of treatment effects (McMahon & Forehand, 1984).

However, it is also important that these rationales and theories be presented in such a way that the parent can see the connection with his/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 with issues previously raised by the parents. 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, while at the same time decreasing his/her need to obtain control over parents by negative behaviors. In this example, supplying the rationale is important not only because parents may not immediately see the connection between playing with their children more and helping their child be

less aggressive, but also because of the connection made between this new aspect of the program and the parents' original reason for seeking help (their child's aggressiveness). If they do not understand the rationale for the play sessions, they may not be motivated to do them at home. 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 child 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 it looks like you're doing a nice of 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. In 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 parents 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 sound-proofed, will be acutely sensitive to the possible reactions of neighbors when s/he tries to ignore the screaming child; that parent may resist using that approach. Collaborative teaching means that the therapist attempts to understand the

living circumstances of each family and involves the families in problem-solving 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 less active children. Some children are not particularly responsive to Tangible Reward programs. The therapist needs to be sensitive to these individual differences in child temperament so that s/he can begin the collaborative process of defining with parents which approach will be best for a particular child.

Giving Assignments

The teacher 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/or experimenting with a particular strategy. Assignments are critical because there is an important message value that goes with them: namely, that participation in group therapy 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 play one-on-one with their child each day for 15 minutes; another assignment is to record how often they praise between 5 and 6 p.m. for two days, and then to double their base rate for the remainder of the week. A third example of an assignment is for parents to keep track of their thoughts in response to a conflict situation with their child on three occasions.

Parents need to understand the purpose of the assignments in general, as well as particular assignments. "Homework" 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, though 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 she is unable to do 15 minutes of play time each day with an individual child. The therapist responds:

THERAPIST: I imagine you barely have two 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 two to three 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, the reasons for this should be explored in a collaborative fashion. For example, the therapist can ask, "What made it hard for you to do the assignment?" "How have you overcome this problem in the past?" "What advice would you give to someone else who has this problem?" "Do you think it is just as hard for your child to learn to change as it is for you to change?" "What can you do to make it easier for you to complete the assignment this week?" "Do you think there is another assignment that might be more useful for you?" These questions could be explored as a group discussion topic. It is important to explore reasons why some parents might be having difficulty doing their home assignments; otherwise, parents may conclude that the therapist is not really committed to the assignments, or does not really want to understand their particular situation. It can be helpful to ask parents to set their own goals for assignments for the following week—these goals should be manageable and realistic, optimizing the chance of success. We often give parent personal mottos to use when trying to accomplish a goal:

- *Challenge but don't overwhelm yourself.* In the same way as if you were learning to drive: you wouldn't immediately venture out into the motorway.

- *Get better before you feel better.* Engaging in difficult homework tasks may make you feel worse, but you are learning to cope better. This is true of recovery from various conditions such as a broken limb or an operation.

Reviewing and Summarizing

Another aspect of the teacher 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. 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. Along with ensuring that everyone understands the assignment for the next week, the therapist needs to express confidence in the parents' ability to carry it out. 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 illiterate parents, 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.

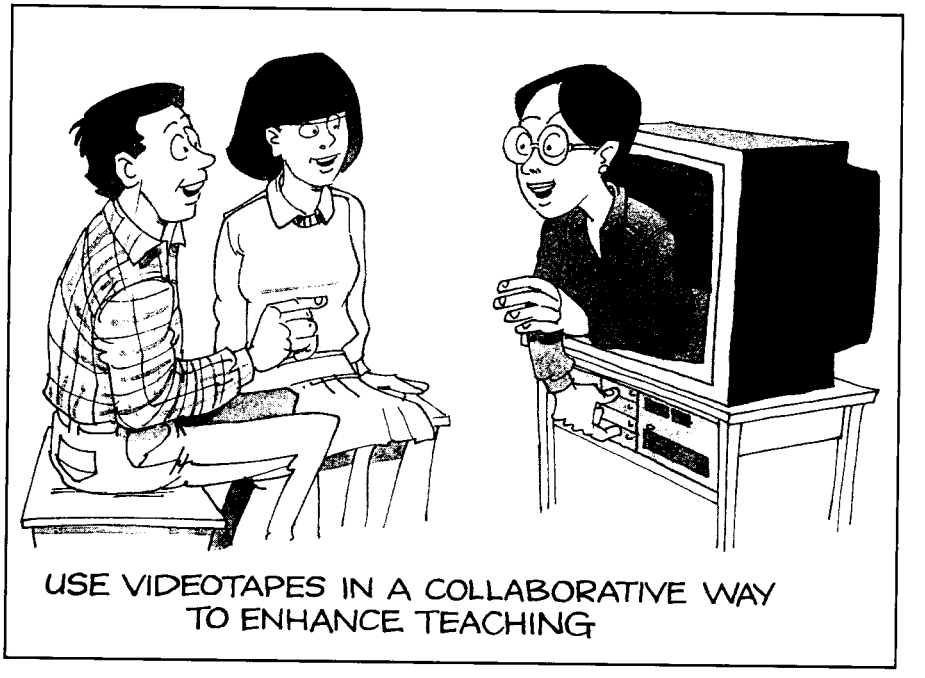
Ensuring Generalization

Generalization means teaching parents how to apply the specific skills being taught in the program to their own situation. It also means teaching them how to apply the same skills in other settings or to new types of misbehavior that may occur in the future. For instance, some parents learn how to manage their children effectively at home, but have great difficulty knowing how to handle misbehavior when it occurs in public. They have difficulty seeing how principles such as Ignore, Time Out, and Logical Consequences can be applied at the grocery store, cinema, park, or school. Other parents have difficulty knowing how to use the approaches with siblings who are exhibiting somewhat different behaviors. To counter this inability to generalize, the therapist can periodically interject a few different types of problems and situations (not raised by the group) and ask the group to problem-solve strategies to deal with them. After working on a problem area the therapist should regularly ask, "For what other child problems could you apply this strategy?" or "Are there situations where this strategy wouldn't work?" Videotapes are another powerful means of enhancing generalization, since they can depict a variety of problems in different situations and settings. (The use of videos is discussed below.) Finally, the group discussion format itself is another means of promoting generalization, in that it exposes group members to a variety of different family situations; it provides opportunities to hear other parents applying the principles to a variety of behavior problems involving children of different ages and temperamental styles.

Using Videotape Modeling Examples

There are also a number of props that can be helpful in the therapist's teaching role. The Webster-Stratton's program relies heavily on videotape modeling as a therapeutic method. We developed a series of 16 videotape programs (over 300 vignettes) showing parents and children of different sexes, ages, cultures, socioeconomic backgrounds, and temperamental styles. Parents are shown in natural situations interacting with their children: during mealtimes, getting children dressed in the morning, toilet training, handling child disobedience, playing together, and so forth. Scenes depict parents "doing it right" and "doing it wrong." The intent in showing negative as well as positive examples is to demystify the notion that there is "perfect parenting" and to illustrate how parents can learn from their mistakes. Our research has indicated that therapist-led group discussion based on videotape modeling is superior to therapist-led group discussion without videotapes, as well as to videotape alone (Webster-Stratton, 1984; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988; 1989).

However, it is important to emphasize that the videotapes are used in a collaborative way—as a catalyst to stimulate group discussion and



problem-solving, not as a device which renders the parents passive observers. When we show a videotape vignette, we pause the tape to give parents a chance to discuss and react to what they have observed. Sometimes after watching a vignette, group members are uncertain about whether the kinds of responses shown in the scenes are appropriate. If this is the case, the therapist may then ask open-ended questions such as, "Do you think that was the best way to handle that situation?" or "How would you feel if your child did that?" (Suggested questions and discussion topics are included in the therapist's manual.) The vignettes have been designed to illustrate specific concepts, it is up to the therapist to make sure the ensuing discussion addresses the intended topic and is understood by the parents. If participants are unclear about specific aspects of the parent/child interaction, or if they have missed a critical feature of the vignette, the therapist rewinds the tape and has the group watch the scene again. The goal is to have parents become actively involved in problem-solving and sharing ideas about the vignette. It would be inappropriate (and noncollaborative) to show the tapes without pausing or inviting extensive discussion and debate. The therapist can also facilitate learning by asking the parents how the concepts illustrated in the vignettes do or do not apply to their own situations. For example, a mother may make the following comment after watching a few of the play vignettes:

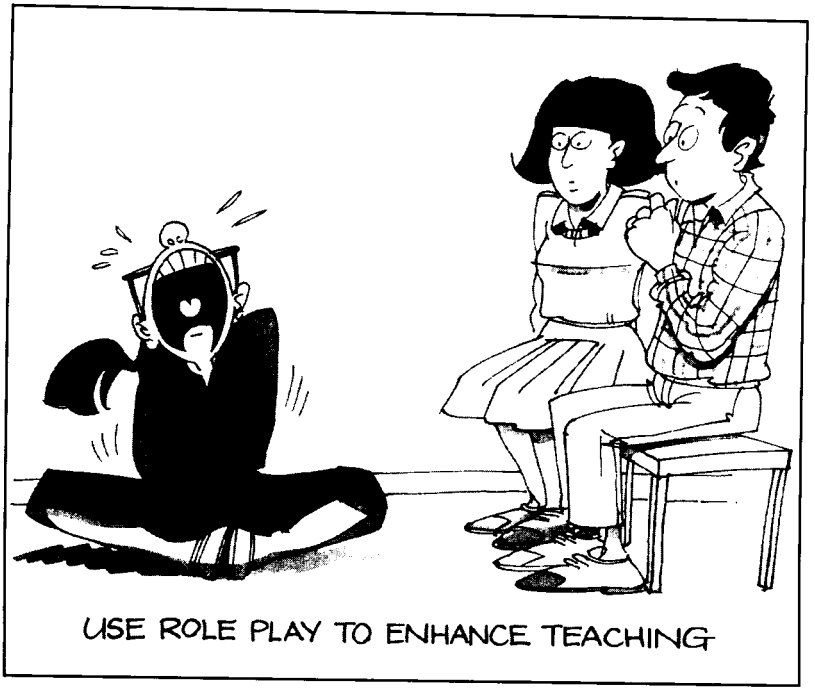
MOTHER: I don't have any toys at home. I can't afford toys like those shown on the tapes—I'm living on a welfare check.

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

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

Role-play and Rehearsal

Role-playing—modeling and rehearsing newly acquired behaviors—is one of the most common components of parent training programs; it has been shown to be quite effective in producing behavioral changes (Eisler, Hersen & Agras, 1973; Twentyman & McFall, 1975). Role-play helps to tease out sequences in behavior, enabling parents to anticipate situations more clearly.



It is helpful to do at least one role-play for each content area, but because many parents feel inadequate regarding their parenting behavior, they may feel reluctant to undertake role-playing. Besides presenting a clear rationale for conducting the role-play, we have found that it is often best for the therapist to do the first role-play in order to reduce parents' self-consciousness and anxiety. If the therapist can make the role-play humorous by exaggerating roles, so much the better. For example, the therapist who is role-playing the parent may go out of the room and shout from a distance (e.g., kitchen) for the child (role-played by parent) to put away the toys. This usually raises chuckles of recognition, for there is no way for the parent to know whether the child registers the command, takes any notice of it, complies, or not. This role-play is an effective introduction to the session and the videotape concerning commands.

After the therapist has done the first role-plays, we then break the parent group into pairs to practice particular skills. Later on, as groups become comfortable with each other, parents role-play a situation in front of the whole group—for example, role-playing the use of Time Out with a "difficult child." In this case, one parent plays the child and another parent the child's parent. The rest of the parent group act as coaches for the parent who is in the parent role. Sometimes it is helpful to "freeze

frame" the role play and then ask the group to brainstorm, "Now what should she do?" or "What is the child trying to communicate or achieve by behaving like that?"

Evaluating

Part of the teacher role is to ensure that each session is evaluated by the parents. This gives the therapist immediate feedback about how each parent is responding to the therapist's style, the quality of the group discussions, and the information presented in the session. The evaluations bring problems to light—the parent who is dissatisfied with the group, the parent who is resisting a concept, the parent who fails to see the relevance of a particular concept to his/her own situation, the parent who wants more group discussion. The therapist may want to meet with parents individually to resolve these issues. If several participants are having difficulty understanding a particular concept, the therapist will want to bring it up in a subsequent session with the whole group. This ongoing process, where the therapist responds to parents' evaluations by taking action, emphasizes the collaborative nature of the therapy process. At the end of the program, the entire treatment program should be evaluated. This information is useful not only in planning future parent groups, but also in identifying parents who may need further help.

THERAPIST ROLE No. 4: INTERPRETING

The therapist role of teacher is closely allied to another role, that of interpreter. As an interpreter, the therapist "translates" the language of cognitive, behavioral, and developmental concepts into words and behaviors that the parents can apply. But the interpreter role is more than this: the therapist must also interpret the language and culture of the family in order to help that family. The latter can occur only if there is collaboration. It is here that therapy shows itself as a craft—an amalgam of applied science and art. No matter how good the science (the theoretical framework and empirical findings), without the creative element of translating abstract and complex ideas into concrete, interesting applications which are relevant to the family's circumstances, the science is not likely to achieve much.

Use of Analogies and Metaphors

The therapist can be a more effective interpreter by using images and analogies to explain theories and concepts. S/he needs to be creative in thinking up vivid mental pictures to convey important concepts. Ideally, these analogies should be developed out of themes which are unique to a particular community or cultural group. Here are a few that we have either invented or borrowed from discussions with other therapists.

- *Hard wax/seal analogy*: Socrates used to send out letters to his friends and seal the letters with wax and his seal. His friends would complain when they received the letter that they couldn't make out the imprint of the seal and would ask him, "Why don't you get a new seal?" Socrates 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 our children's "wax," but we can work hard to get the best imprint possible.

This analogy depicts the concept that socialization takes longer with some children; conduct-disordered children do not "take the imprint" easily. By pointing to the wax rather than the seal—or the person who tries to use it—as the source of the difficulty, this analogy shifts the blame away from the parents. Further, it helps them to make allowances for the child's temperament.

- *Diamond analogy*: These children are like diamonds—parents need to chip away carefully at the hard edges of the 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 made beautiful emphasizes not only their innate value, but also the parent's socialization role.

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

With this analogy we hope to convey the notion that daily repetition and constant monitoring can achieve long-term results, even though it seems that not much is accomplished day by day.

- *Bank account analogy*: Think of praising and playing with children as building up your bank account. You have to keep putting something in all the time—only then

will you have something to draw on when you need it. Time Out and other forms of discipline will not work unless there is a "bank account" of positive resources to draw from. In fact, Time Out from an aversive relationship may actually be reinforcing.

With this analogy we are emphasizing the need for positive interaction with the child as a foundation for discipline.

- *Priming the pump analogy*: You know the old farm pumps that had to be pumped a dozen times before water would come out? Parents have to "prime the pump" with lots of supportive input to build children's self-esteem. 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 positive behavior in return.

- *Gas on the flames analogy*: Arguing and reasoning with a child when he is noncompliant 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 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 praise their children more frequently and more often than they otherwise would. It also helps prepare them for the occasions where children reject praise and suggests why this may happen.

- *Vending machine analogy*: Remember, when you first ignore a child's misbehavior, it will escalate before the behavior improves. For the child, the experience of being ignored is a little like the experience that sometimes happens with vending machines. Let's say you put in a dollar 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 dollar and needed a drink you would start out banging!

This analogy is helpful to parents in preparing them not only for the tantrums and misbehavior that will be the child's response to Ignore and Time Out procedures, but also as a warning to parents of what will happen if they give in to this misbehavior.

- *Choose your battles analogy*: Your military resources, to use an image, are not unlimited. Think about choosing those battles that are really important to you and save your energy for those. For example, wearing seatbelts, not hitting, and getting to bed on time may be more important than clean plates, wearing a different shirt, or picking up toys. In that case, it's not worth expending your resources in battle for those causes.

This analogy helps parents prioritize which household rules they are prepared to enforce and which ones they can let slide for the time being.

- *Radar antennae analogy*: Monitoring kids means keeping your radar antennae up at all times, so that you know where your child is and what he or she is doing. That way, you can spot potential problems before they develop. Antennae 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.

Parents sometimes have false expectations that children can be left unattended. This analogy helps parents understand that constant monitoring on their part is required at all times. 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.

- *Tug-of-war analogy*: Arguing with children is like parents and children playing "tug of war," both pulling the rope at opposite ends. When you find yourself in such a struggle, say to yourself that you're going to drop the rope.

This analogy helps parents understand that constant arguing only perpetuates the struggle, whereas withdrawing from the tug-of-war ends it.

- *Children are wearing L plates*: In England, when one is learning to drive, an L plate—for "Learner"—is put on the car. Imagine that your child also has an L plate on his or her back. This will remind you to be patient and tolerant when your child makes a mistake. Children are, after all, learners in life.

This analogy helps remind parents of children's developmental processes. They are still learning and, like the person who is learning to drive, will behave unpredictably and make mistakes.

Reframing

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

In our program, one common strategy is for the therapist to take a problem a parent is having with a child and reframe it from the child's point of view rather than the parent's perspective. For example:

FATHER: He's so defiant! He should be able to be toilet trained by now—he's three and a half years old! He's doing it on purpose! He even tells us right after he has had a poop in his pants. I get so angry with him!

THERAPIST: Hey, but you know what? That's a great sign—the fact he's telling you after he poops means he's getting ready to be trained. Remember how we said we recognize something after we've done it and change it the next time, whereas children tell us afterwards? But with your support he will soon learn to recognize the sensations before he goes. You know, the fact he is telling you he has done it in his pants is also a very good sign—it's much harder when children fear their parents' anger and learn to hide their underpants in closets.

FATHER: But it feels so deliberate to me—he's so advanced in other areas of his development, such as his manipulation skills with my tools and so forth. He should be toilet trained by now.

THERAPIST: Ah, this is often the case with development: As one area is maturing and developing, another area may lag behind. Think about babies. When they are learning to walk, they often slow down in their language. And for others it is the reverse—while their language is developing, they are not walking. All these areas of development—verbal, intellectual, social, moral, physical, language—develop at different rates, as does control of bowel movements.

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.

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

PARENT: My son has these incredibly long, angry outbursts when he is in Time Out. He's really out to make it difficult for me.

THERAPIST: Do you suppose he might be really testing the strength of your limit setting to see if he can get you to "lose it" or back down?

OR

PARENT: My child has gotten incredibly worse this week—she is impossible to handle and I've had to use Time Out a lot. She's wearing me down.

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

OR

THERAPIST: Rather than thinking of your child as having a problem or being a problem, it may help to think of her/him as trying to solve a problem. That behavior you don't like may be her/his way of trying to deal (not very successfully; but after all he/she's a learner) with one of life's difficulties. Let us try to see what s/he is trying to achieve; what are the developmental tasks s/he has to solve at this stage of life?

In all of the examples above, the parent saw the child as defiant, angry, uncooperative, immature, and was exhausted by the effort of trying to cope with the behavior. The therapists reframed the situations to help the parents see the developmental stage the behavior represents 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 towards independence helps the parents see the behavior as appropriate or normal—in some cases even positive. Seen in this light, the situations are part of the normal developmental process. With this view of the situations, parents can feel that they are participating in a process of growth for the child, rather than becoming angry or feeling helpless. This attitude enables them to cope. In essence, reframing involves changing a negative label for a behavior into a positive one; as we mentioned earlier, it can be a tool of empowerment for the parent.

Making Connections

Another way to interpret the language and culture of the family is to help the parents see the connections between their own childhood experiences and those of their child. This is a powerful way of promoting empathy and bonding between the parent and his/her child.

THERAPIST: As you talk about your child's impatience, high energy level, and difficulty conforming in the classroom, do you see any similarities to yourself or your experiences as a child

How do these similarities between you both affect your reactions to your child? Having been a high energy and independent child yourself, what do you think helped you the most? or the least?

In the case where the parent does acknowledge similarities between his/her personality and his/her child's, the therapist's role is to help the parent see how similar personalities may create possible conflict in their reactions as a parent and to move the parent on to seeing how this similarity makes him/her uniquely suited to judging what parenting strategies might be most useful with his/her child.

The therapist can also help parents see how their reactions and responses as parents are based on their own parents' parenting skills (either in imitation or in reaction) and how these experiences may be causing them to resist learning alternative approaches.

FATHER: When my son gets angry and defiant like that—I think to myself—my father would never have put up with any of this shit! He would have smacked me hard.

THERAPIST: How do those thoughts about your father influence your ability to stay calm? What do you tell yourself when you hear your father's voice in your head? How do you counter them?

Here the therapist's role is to help the parent see the connection between what the father learned from his own father regarding parenting, how this influences him (e.g., escalates his anger level toward his son) and what he would like to do differently or the same with his son.

A third way to help parents reframe their conflicts between their own childhoods (and parents) and their current experiences is to talk about "laying ghosts to rest."

THERAPIST: You may be finding it difficult to put all your thought and energy into the present difficulty. Perhaps there are some "ghosts" from the past (things you blame yourself for needlessly in your child rearing) that still haunt you. Let us try to put them to rest by talking about them; then you may feel more confident about facing the future.

It is one of the strengths of behavioral work that treatment and the choice of methods do not depend necessarily upon the discovery and understanding of the historical causes of behavior problems. The identification of the current problem and its contemporary antecedents and consequences is the main agenda in treatment. Very rarely can current problems be traced to specific past experiences with any degree of confidence. Nevertheless, many of the therapeutic methods in traditional psychotherapy are formulated as a response to an historical analysis of the parent's life. Such a retrospective look at past events is often of interest (and potentially of use), but essentially an exclusive or predominant preoccupation in assessment with the past history has the effect of "distancing" the problem, keeping it vague because it remains at arm's length. It certainly tends to alienate parents who are struggling with *current* problems in the child. Nevertheless, there *is* a place in the collaborative model of treatment for a brief consideration of the child's and parents' past. The stories people tell themselves about themselves and their offspring (schema) are important because they influence their actions. These stories, particularly of a mother or father who struggled to rear a difficult infant, are often negative, self-deprecatory ones. Thus it may be necessary for the therapist to help parents "lay the ghosts" of the past that still haunt them before s/he can apply him or herself

wholeheartedly (i.e., without debilitating regret and guilt) to problems in the here-and-now.

THERAPIST ROLE No. 5: LEADING AND CHALLENGING

Are there times when the therapist must take control of the group, 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 the group will lack focus and organization. Our evaluations have indicated that parents become frustrated if the discussion is permitted to wander or if one person is allowed to monopolize the session. Parents appreciate having enough structure imposed to keep the discussion focused and moving along. Another reason the therapist must exercise leadership skills is to deal with the group process issues, such as the arguments and resistance, which are an inevitable part of every group's therapy process.

But there is an apparent tension between this role and the collaborative model, since in collaborative therapy power is shared. There are several strategies which 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.

THERAPIST: Before we start, I would like us to set today's agenda. We will do this at the beginning of each session. I will have a major topic for each week and then you can add topics you want to be sure we cover. The idea is to make sure that we cover what seems important to each of us. So today's first major topic is effective play skills with children and how we can foster children's self-esteem and promote their positive behaviors. What topics would anyone like to add?

Our sessions always begin with parents and the therapist together setting the agenda and goals for the session, debriefing the assignment for the previous week, evaluating progress, and discussing how things are currently going at home. 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 parents' individual needs and the group's needs for leadership. The sessions always conclude with assigning the tasks to be completed before the next session. The following are some other strategies which we find helpful in leading the sessions.

Setting Limits

One of the most important aspects of the therapist's leadership role is to prevent the group process from becoming disrupted. The therapist must impose sufficient structure to facilitate the group process. We have found it necessary to establish some rules to keep things running smoothly—for example, only one person may talk at a time. If someone breaks this 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 their 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." The therapist then explains why s/he is cutting off the speaker. For groups that are very verbal and that tend to digress or get sidetracked, it can be helpful to select a parent participant to act as co-leader at the beginning of each session. The job of this co-leader is to be a timekeeper, to help identify parents who are sidetracking the discussion, and keep the group focused on the main topics for the session. If a different participant is invited to act as co-leader 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, since everyone will leave feeling stimulated and excited about their involvement in the program.

Pacing the Group

Another important aspect of leading a group is pacing. Some parents pick up the concepts easily, while others need more time. The therapist must pace the group so that everyone understands the concepts and is ready to move on to the next component. This may mean that some group members become impatient, ready to move on. However, the skilled therapist will take advantage of the parents in the group who seem to have a good grasp of a particular concept by soliciting their 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, or ask another to come up with an application of a particular concept. These

strategies emphasize 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 and the therapist needs to be prepared for it. In fact, Patterson's (1985) research indicates that resistance will reach a considerable 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, some having to do with the therapy change process (as Patterson's research suggests). For example, the resistance may be part of the parent's efforts to maintain self-efficacy and self-control in the face of family dynamics which are changing too quickly—in effect, the parent is "putting on the brakes." Perhaps the parent fails adequately to understand the concept which the therapist has explained. Perhaps the parent is resisting because he/she feels his/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. The resistance may pertain more directly to some quality of the therapist. For example, the parent may not feel understood by the therapist—s/he may perceive the therapist as patronizing or think the therapist is presenting "pat" answers and solutions without really understanding his/her situation. On the other hand, resistance may stem from external factors. For example, perhaps the parent has had a previous learning experience which has given him/her a different explanatory model. Or perhaps the parent feels the child's behavior should change first, before any change in parental behavior.

Whatever the reason, the first task for the therapist is to put aside any notion that the parent's resistance is either 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 the resistance as 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 the parent is resisting a basic concept or doing something that 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? The therapist may be worried that confrontation will jeopardize the goals of collaboration. Some therapists may be tempted to avoid conflicts with parents. Yet this failure to address the issue really constitutes a kind of collusion with 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 other group members. In fact, in one of the few studies to do a microanalytic analysis of therapist–client interactions, Patterson and Forgatch (1985) found that resistance met by direct confrontation or teaching on the part of the therapist actually increased parents' noncompliance. It is our contention that instead of confronting the issue raised by the resistant parent, the therapist needs to confront the resistance itself—gently, by asking about it in a nondefensive and nonconfrontational 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 play time 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 other child and then tantrumed 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 it next 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 deals with resistance by starting from the premise of respect for the legitimacy of the client's views—in this case, respecting the parent's preference for spanking as legitimate. She would then explore 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 then be 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 that the questions are in the form of "What do you mean?" or "How do you feel?" or "What do you think?" rather than "Why?" or "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 kind of discussion between the therapist and a resistant parent would quickly draw everyone into the debate, whereas a judgmental or authoritarian response from a therapist would tend to result in group members becoming silent. When resistance to a concept occurs, we find it helpful to organize the discussion by listing the advantages and disadvantages, short-term and long-term consequences for the child and for the parent on a blackboard. At the end of this discussion, the therapist summarizes the ideas that have been generated, clarifies misperceptions, and adds his/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" positions (i.e., seeing the situation in terms of right and wrong) and opens people up to new ideas which they may not have considered previously, thus reducing resistance. On the other

hand, a noncollaborative approach where the therapist directly confronts the parents' ideas creates a boxing match where the therapist and parent each have to defend their own position in order 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 is then 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 does not attack the resistance by confronting it directly or repeating the rationale for why s/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. Although she does not confront the resistance directly, she confronts the difference of opinion with 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 which helps clarify feelings and experiences surrounding the issue. This strategy serves to join people rather than alienate them. It is more likely than direct confrontation to result in a gradual change in parents' perceptions and behaviors, especially if conducted in the context of a supportive relationship.

We have also used Gottman and Leiblum's (1974) "force field analysis" as a method of approaching resistance. In this context, force field analysis is a problem-solving approach which assumes that things become "stuck" when there is an equilibrium between the forces facilitating change and those that are opposing and restraining. When dealing with resistance to change, the therapist can get the parent group to:

(1) List facilitative or helping forces for change (e.g., a new untried tactic, a renewal of confidence and determination to succeed);

(2) List restraining or hindering forces for change (e.g., exhaustion, no breaks from the children to get out of the house);

(3) List alternative intervention strategies for:

(a) strengthening existing facilitative forces (e.g., encouraging a mother to be more consistent by getting her to reward herself with something special when she is successful);

(b) adding new facilitative forces (e.g., an offer by a member of the group to babysit so as to give a mother a break; convincing a previously reluctant father to involve himself in the program);

(c) weakening or removing restraining forces (e.g., debating away a member's inhibitions about being firm and decisive with her child);

(4) List the advantages and disadvantages of each intervention.

Reframing is also a helpful strategy when responding to resistance. Once the therapist has collaborated to understand the reason for the resistance, then s/he 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 importantly, 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 strategy 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 may actually come to feel psychologically abandoned. By joining with the parent and then reframing the situation so that the parent perceived the objective as promoting security (rather than abandonment), the therapist enabled the parent to accept the strategy for herself and her child. This is the essence of collaborative therapy.

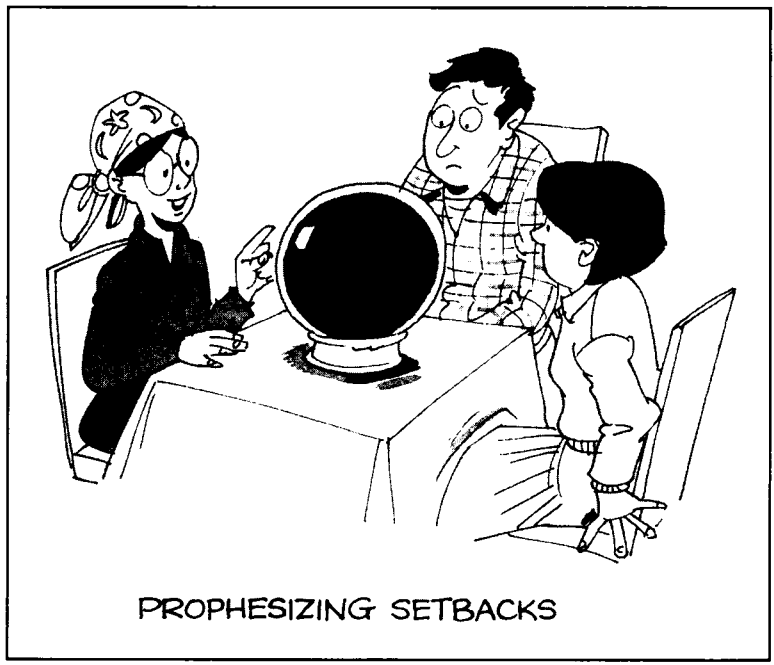
THERAPIST ROLE No. 6: PROPHESIZING

Children's behavior improves slowly; 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. As a "prophesizer," the therapist can help prepare families for future relapses not only in their children's behavior, but also in their own behavior. The therapist's role as prophesizer also includes predicting resistance to change as well as forecasting improvement.

Anticipating Problems and Setbacks

One helpful strategy the therapist may use to prevent disillusionment for parents is to predict setbacks in children's behavior, anticipating potential problems and regression and discussing these with parents before they occur. The therapist can engage in a hypothetical problem-solving discussion of how parents might handle particular problems should they occur. For example, the therapist could prepare families for the negative behavior that is likely to occur when children encounter changed circumstances such as a prolonged illness, or a return from a week's visit with relatives or the other parent, or the arrival of stepsiblings who come to stay for summer vacation. After an episode of particularly difficult behavior



PROPHESIZING SETBACKS

in public, the therapist could collaborate with parents to prepare a plan for dealing with the behavior more successfully next time. 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, when the "worst" does not happen, they are pleased with themselves and their progress.

The therapist also needs to prepare parents for the fact that there will be inevitable relapses in their own parenting behavior 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," or focus on positive alternatives. Here is an example of how the therapist might start preparing parents for relapses by reframing the usual interpretation.

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 s/he is 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 make-up." These feelings will lead to increased resistance. When parents are prepared in advance, they need not be surprised or anxious when these feelings occur; they can perceive these reactions 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 to return to the old way of doing things.

OR

You will probably feel awkward praising at first, especially if you haven't done much of this in the past. You may even feel your praise sounds 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 genuinness will come later. The more you practice, the more natural it will become.

OR

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

OR

We all find it difficult to change; indeed it can be painful. We get used to the figurative "goggles" or "specs" through which we look at the world in general, and our child in particular. To have to put on a different set of goggles can be quite confusing at first. We feel comfortable with what's familiar; so the new perspective is strange and rather scary. But that feeling soon wears off.

In addition, it is important also to tell parents to call in if they are having difficulties with any of the assignments, thereby indicating your willingness to listen to their resistance.

Another strategy to use when discussing resistance to change is to help parents understand that change is not without cost. Here it can be helpful to ask the parents to list the pros and cons of adopting a certain approach. For example, here is how we would list out the advantages and disadvantages of yelling and screaming.

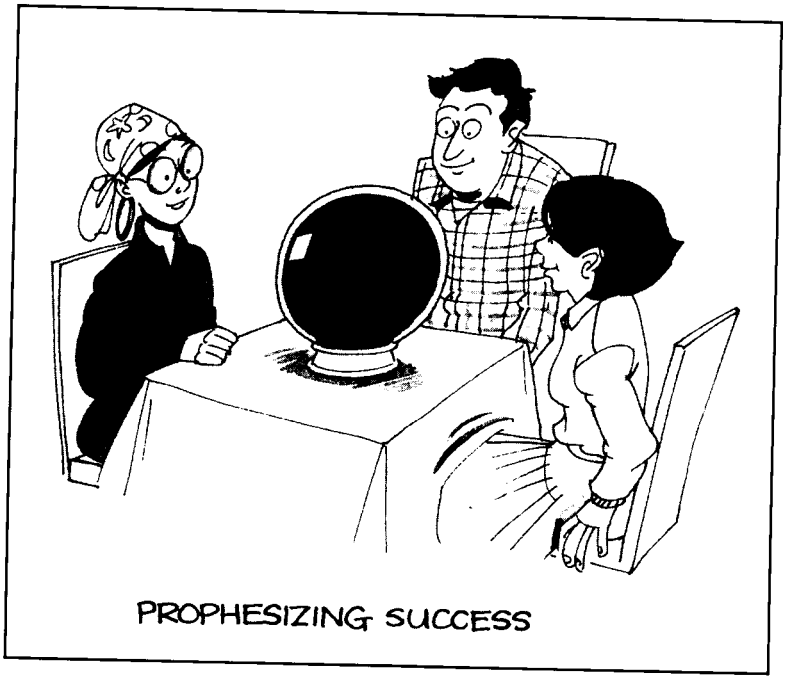
THERAPIST: You find it difficult to give up the anger and resentment you feel all the time for your youngster's misdemeanors. Let's try to see why it is so hard. We'll make two columns headed "advantages" and "disadvantages" of letting go of anger.

PARENT: Advantages—I'd feel better; I'd be less tense; I'd be more rational. Disadvantages—It would look as if his behavior was unimportant to me; I'd lose self-respect; People may think I don't care in my rearing of children.

THERAPIST: You can see that there are some good reasons, to your mind, to not give up your anger. So change is costly. What you need to think through are the relative costs of changing as opposed to not changing.

Predicting Positive Change and Success

The therapist should build parents' expectations for positive change in behavior if they do persist with the assignments and implement the program. It is important for the therapist to express confidence and optimism in the parents' ability to successfully carry out 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.

OR

We've worked with a large number of families now and, although we don't have perfect success, we've found at least two-thirds of parents are able to make impressive changes in their children's behaviors.

It is also important to predict that other family members can benefit from the program, even if they do not attend the sessions. For indeed, research (Patterson, 1982) has suggested that all members of the aggressive child's family are victims; they all 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 pay-off for themselves, they may actively sabotage the participating members' efforts to change. The therapist should therefore work with the participating members to see how the program can be extended in a nonintrusive way to other family members. For example, the therapist can 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 which has been started with the target child. This reaction should be 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 to praise and use Time Out competently, they will soon find fathers following suit.

The role of therapist as prophesizer is consistent with a collaborative model because the therapist brings his/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 backgrounds of alcohol or spouse abuse—and the parents bring their ideas and insights to bear on planning how to deal with those possible reactions. It should be obvious that the therapist can prophesize effectively only if s/he has collaborated with the parents to understand their situation. Moreover, by anticipating problems beyond the 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 in which the therapist collaborates with parents in multiple roles in order to help the parents gradually gain the knowledge, control, and competence they need to cope effectively with the stresses of having a conduct-disordered child, including managing their child's behavior. To put it differently, the "script" for the parents involves learning more effective coping strategies and parenting skills so that ultimately child behavior problems are reduced and social competence is strengthened. Several themes are constant throughout the therapy process as part of this coping model "script" for parents.

Theme No. 1: Parents Learning to Problem-solve

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 parents have come to us initially with the belief that there is a single cause for the child's misbehaviors and consequently a single solution for the problem. The goal is for parents to come to realize by the end of the program that there is no single magical solution or recipe for parenting. Rather, parents become confident in their own ability to think sequentially and to analyze parent–child interactions, to search for external causes of misbehavior (as opposed to attributing it to the child's "bad" nature) and to generate a rich smorgasbord of possible solutions. They acquire the problem-solving strategies necessary to evaluate possible solutions in terms of their desirability and relevance, to commit themselves to trying them out, and to evaluate whether or not a particular solution is working. In essence, by the end of the therapy the parents have become their own therapists.

Theme No. 2: Parents "Coming to Terms"

The therapist gradually helps parents come to terms with the realistic facts concerning their child's temperament. They must learn to manage the anger and grief related to the loss of their hoped-for "ideal" child and learn 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—parents must be helped to face the fact that they must invest a great deal of time and energy in the hard work of anticipating, monitoring, and problem-solving 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 pay-offs (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 s/he 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 as play, praise, and problem-solving must be repeated hundreds of times to be effective.

THERAPIST: Your child needs to have hundreds of chances to try to learn from his mistakes. Learning more appropriate social skills is just like when she was a baby and was learning how to walk. Do you remember how often she tried to get up and fell down or how long she held on to something before she could take off on her 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 she does not injure herself), so must you support the child who is developing her 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 child with diabetes, if parents withdraw the treatment, 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 moondust?"

Theme No. 3: Parents Gaining Empathy for the Child

Besides helping parents come to terms with the hard work of parenting, it is also important to help them understand, empathize with, and accept their child's unique personality. It is especially hard for parents of "difficult" and demanding children to remain patient, to be constantly "on guard" for monitoring, and to limit set 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 their environment. Information about typical developmental struggles can help build not only patience, but empathy. 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 No. 4: Parents aren't Perfect

Coping effectively implies coming 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 No. 5: Parents "Refueling" to Ensure Maintenance

Along with parents becoming more confident and knowledgeable in their parenting skills and their 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?" "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 can suggest that parents babysit for each other so they can get time away from their children. Monthly "booster shots" for the groups with the therapist can also be scheduled routinely so that there is a structure of ongoing support.

Theme No. 6: Parents Feeling Empowered

As we discussed earlier in this chapter, one of our primary goals in therapy is to help parents feel empowered so that they feel confident about themselves, their parenting skills, and their ability to cope with the new situations in which they and their children will find themselves over the course of time at home or at school. Empowerment is the antithesis of dependence on the therapist. It emcompasses competence, but it is more,

namely, the *conviction* of one's own competence, a sense of security about one's own abilities and capacities. A collaborative therapist empowers clients not only through building skills, but through continual validation of the client.

We empower parents using a three-pronged approach: first, by giving them the knowledge base concerning children's developmental needs, behavior management principles, and individual or temperamental differences and how these affect social relationships; second, by helping them learn the important skills involved in communication building, social relationships, problem-solving, tactical thinking, and enhancing their children's academic skills; third, by accepting and respecting their values and beliefs and trying to understand how these impact their family life, rules, and relationships. The specific content and processes we use have been described earlier and are outlined in Table 4.1.

EPILOGUE: SUPPORT FOR THE THERAPIST

The therapist's conscious use of a variety of roles such as collaborator, empowerer, supporter, teacher, interpreter, leader, and prophesizer helps to change parents' behaviors and attitudes, to alter their attributions about past and present behaviors, and most importantly to increase their perceived self-efficacy and their range of effective coping skills. In this sense, the therapist's role with parents is a model for the kind of relationship we are encouraging parents to develop with their children—in both cases, a nonauthoritarian, nonpaternalistic relationship.

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. Collaboration requires a considerable degree of clinical skill—more so than other models, such as that of adviser, listener, or analyst (Table 4.2). It is important that the therapist also has a support system in which s/he can analyze a difficult situation or group problem with colleagues and plan the most effective treatment strategy. By discussing a parent's situation with other therapists, it is possible to brainstorm and problem-solve on how to reframe it, interpret it, or explain it in a different way so it makes sense to the parent, as well as to decide which role the therapist should assume in this situation. The added support and objectivity of colleagues can help the therapist immensely, sustaining enthusiasm and the will to persist in the face of highly resistant families.

Table 4.1 Sources of increased self-empowerment

	CONTENT	PROCESS
KNOWLEDGE		
Child development	Developmental norms and tasks	Discussion
Behavior management	Behavioral (learning) principles	Books/pamphlets to read
Individual and temperamental differences	Child management (disciplinary strategies)	Modeling (videotape, live role play, role reversal, rehearsal)
	Relationships (feelings)	Metaphors/analogies
	Self-awareness (self-talk, schema, attributions)	Homework tasks
	Interactions (awareness of contingencies, communications)	Networking
	Resources (support, sources of assistance)	Developmental counseling
	Appropriate expectations	Videotape viewing and discussion
	Parent involvement with children	Self-observation/recording at home
		Discussing records of parents' own data
		Teaching, persuading
SKILLS		
Communication	Self-restraint/anger management	Self-reinforcement
Problem-solving (including problem analysis)	Self-talk (depressive thoughts)	Group and therapist reinforcement
Tactical thinking (use of techniques/methods)	Attend–ignore	Self-observations of interactions at home
	Play–praise–encourage	Rehearsal
Building social relationships	Contracts	Participant modeling
Enhancing children's academic skills	Consistent consequences	Homework tasks and practice

continued

Table 4.1 *(continued)*

	CONTENT	PROCESS
	Sanction effectively (Time Out, loss of privileges, natural consequences) Monitoring Social/relationship skills Problem-solving skills Fostering good learning habits Self-assertion/confidence Empathy for child's perspective Ways to give and get support	Video modeling and feedback Self-disclosure Therapist use of humor/optimism Relaxation training Stress management Self-instruction Visual cues at home
VALUES		
Strategic thinking (working out goals, philosophy of child rearing, beliefs)	Treatment/life goals Objectives (targeted child behaviors) Ideologies Rules Roles Relationships Emotional barriers Attributions Prejudices Past history	Discussion/debate Sharing Listening Respecting/accepting Negotiating Demystifying Explaining/interpreting Reframing Resolving conflict Clarifying Supporting Adapting

Bused on Herbert, 1988.

Table 4.2 Checklist for evaluating the collaborative process

Please evaluate the parent group leader's sessions based on the following criteria:

	Doing Well	Could be Improved	Not Observed	Comments
I. LEADER GROUP PROCESS SKILLS				
Builds rapport with each member of group				
Encourages everyone to participate				
Models open-ended questions to facilitate discussion				
Reinforces parents' ideas and fosters parents' self-learning				
Encourages parents to problem-solve when possible				
Fosters idea that parent will learn from each others' experiences				
Helps parents learn how to support and reinforce each other				
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 where parents feel they are decision-makers and discussion and debate are paramount.				
II. LEADER LEADERSHIP SKILLS				
Establishes ground rules for group				
Started and ended meetings on time				
Explained agenda for each session				

continued

Table 4.2 (*continued*)

	Doing Well	Could be Improved	Not Observed	Comments
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 session				

III. LEADER RELATIONSHIP BUILDING SKILLS

Uses humor and fosters optimism

Normalizes problems when appropriate

Validates and supports parents' feelings (reflective statements)

Shares personal experiences when appropriate

Fosters a partnership or collaborative model (as opposed to an "expert" model)

Fosters a coping model as opposed to a mastery model of learning

Reframes experiences from the child's viewpoint and modifies parents' negative attributions

Strategically confronts, challenges and teaches parents when necessary

Identifies and discusses resistance

Maintains leadership of group

Advocates for parents

IV. LEADER KNOWLEDGE

Demonstrates knowledge of content covered at session

Explains rationale for principles covered in clear, convincing manner

continued

Table 4.2 (*continued*)

	Doing Well	Could be Improved	Not Observed	Comments
Prepares materials in advance of session and is "prepared" for group				
Integrates parents' ideas and problems with important content and child development principles				
Uses appropriate analogies and metaphors to explain theories or concepts				
V. LEADER METHODS				
Uses videotape examples efficiently and strategically to trigger group discussion				
Uses role play and rehearsal to reinforce learning				
Reviews homework and gives feedback				
Uses modeling by self or other group members when appropriate				
VI. PARENTS' RESPONSES				
Parents appear comfortable and involved in session				
Parents complete homework, ask questions and are active participants				
Parents complete positive evaluations of sessions				

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In sum, it is important for the therapist also to view him/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 by each family's gradual successes. From the therapist's point of view, one important advantage of the collaborative group therapy model is that it creates a feeling of support for the therapist because of the joint ownership of solutions and outcomes. 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. Lastly, the collaborative process constantly provides new learning for the therapist, keeping us challenged, stimulated, and growing in our professional lives.

REFERENCES

Alexander, J.F., Barton, C., Schiavo, R.S. & Parsons, B.V. (1976). Systems-behavioral intervention with families of delinquents: Therapist characteristics, family behavior, and outcome. *Journal of Consulting and Clinical Psychology*, **44**, 656–664.

Backeland, F. & Lundwall, L. (1975). Dropping out of treatment: A critical review. *Psychological Bulletin*, **82**, 738–783.

Bandura, A. (1977). Self-efficacy: Towards a unifying theory of behavioural change? *Psychological Review*, **84**, 191–215.

Bandura, A. (1982). Self-efficacy mechanisms in human agency. *American Psychologist*, **37**, 122–147.

Bandura, A. (1989). Regulation of cognitive processes through perceived self-efficacy. *Developmental Psychology*, **25**, 729–735.

Beck, A.T., Rush, A.J., Shaw, B.F. & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.

Behrens, M.L. (1954). Child rearing and the character structure of the mother. *Child Development*, **25**, 225–238.

Birchler, G. (1988). Handling resistance to change. In I. Falloon (Ed.), *Handbook of behavioral family therapy* (pp. 128–155). New York: Guilford.

Brammer, L.M. (1988). *The helping relationship: Process and skills* (4th ed.). Englewood Cliffs, NJ: Prentice-Hall.

Brown, G.W. & Harris, T. (1978). *Social origins of depression*. London: Tavistock.

Dumas, J.E. & Wahler, R.G. (1983). Predictors of treatment outcome in parent training: Mother insularity and socioeconomic disadvantage. *Behavioral Assessment*, **5**, 301–313.

Dweck, C.S. (1975). The role of expectations and attributions in the alleviation of learned helplessness. *Journal of Personality and Social Psychology*, **31**, 674–685.

Eisler, R.M., Hersen, M. & Agras, W.S. (1973). Effects of videotape and instructional feedback on nonverbal marital interactions: An analogue study. *Behavior Therapy*, **4**, 5510–5558.

Gottman, J.M. & Leiblum, S.R. (1974). *How to do psychotherapy; and how to evaluate it: A manual for beginners*. New York: Holt, Rinehart, and Winston.

Herbert, M. (1978). *Conduct disorders of childhood and adolescence: A social learning perspective*. Chichester, UK: Wiley.
Herbert, M. (1980). Socialization for problem resistance. In P. Feldman & J. Orford (Eds.), *Psychological problems: The social context*. Chichester, UK: Wiley.
Herbert, M. (1988). *Working with children and their families*. Leicester, UK: British Psychological Society.
Janis, I. L. & Mann, L. (1977). *Decision making: A psychological analysis of conflict, choice, and commitment*. New York: Free Press.
Lynch, M.A. & Roberts, J. (1977). Predicting child abuse: Signs of bonding failure in the maternity hospital. *British Medical Journal*, **278**, 624–636.
McMahon, R.J. & Forehand, R. (1984). Parent training for the noncompliant child: Treatment outcome, generalization, and adjunctive therapy procedures. In R.F. Dangel & R.A. Polster (Eds.), *Parent training: Foundations of research and practice* (pp. 298–328). New York: Guilford.
Meichenbaum, D. & Turk, D. (1987). *Facilitating treatment adherence: A practitioner's guidebook*. New York: Plenum Press.
Patterson, G. (1982). *Coercive family process*. Eugene, OR: Castalia.
Patterson, G. (1985). Beyond technology: The next stage in developing an empirical base for training. In L.L.'Abate (Ed.), *The handbook of family psychology and therapy* (Vol. 2, pp. 1344–1379). Homewood, IL: The Dorsey Press.
Patterson, G.R. & Forgatch, M. (1985). Therapist behavior as a determinant for client noncompliance: A paradox for the behavior modifier. *Journal of Consulting and Clinical Psychology*, **53**, 846–851.
Patterson, G.R. & Chamberlain, P. (1988). Treatment process: A problem at three levels. In L.C. Wynne (Ed.), *The state of art in family therapy research: Controversies and recommendations* (pp. 189–223). New York: Family Process Press.
Rogers, C.R. (1951). *Client-centered therapy*. Boston, MA: Houghton-Mifflin.
Seligman, M.E.P. (1975). *Helplessness*. San Francisco, CA: Freeman.
Spitzer, A., Webster-Stratton, C. & Hollinsworth, T. (1991). Coping with conduct-problem children: Parents gaining knowledge and control. *Journal of Clinical Child Psychology*, **20**, 413–427.
Stuart, R.B. (1980), *Helping couples change: A social learning approach to marital therapy*. New York: Guilford Press.
Truax, C.F. & Carkhuff, H.R. (1967). *Toward effective counseling and psychotherapy*. Chicago, IL: Aldine.
Twentyman, C.T. & McFall, R.M. (1975). Behavioral training of social skills in shy males. *Journal of Consulting and Clinical Psychology*, **43**, 384–395.
Valman, H.B. (1980). The first year of life: mother-infant bonding. *British Medical Journal*, **280**, 308–310.
Wahler, R. (1980). The insular mother: Her problems in parent–child treatment. *Journal of Applied Behavior Analysis*, **13**, 207–219.
Webster-Stratton, C. (1984). A randomized trial of two parent training programs for families with conduct disordered children. *Journal of Consulting and Clinical Psychology*, **52**(4), 666–678.
Webster-Stratton, C. (1985). The effects of father involvement in parent training for conduct problem children. *Child Psychology and Psychiatry*, **26**, 801–810.
Webster-Stratton, C. (1990a). Long-term follow-up of families with young conduct problem children: from preschool to grade school. *Journal of Clinical Child Psychology*, **19**(2), 144–149.
Webster-Stratton, C. (1990b). Enhancing the effectiveness of self-administered

videotape parent training for families with conduct-problem children. *Journal of Abnormal Child Psychology*, **18**, 479–492.

Webster-Stratton, C., Kolpacoff, M. & Hollinsworth, T. (1988). Self-administered videotape therapy for families with conduct-problem children: Comparison with two cost-effective treatments and a control group. *Journal of Consulting and Clinical Psychology*, **56**(4), 558–566.

Webster-Stratton, C., Kolpacoff, M. & Hollinsworth, T. (1989). The long-term effectiveness and clinical significance of three cost-effective training programs for families with conduct problem children. *Journal of Consulting and Clinical Psychology*, **57**(4), 550–553.

Webster-Stratton, C. & Herbert, M. (1993). What really happens in parent training? *Behavior Modification*, **17**, 407–456.